DUGGARWELLNESS
Functional Medicine & Transformational Nutrition

New Patient Intake Packet

Intake Packet Instructions

Please read these instructions carefully

1. This form must be printed and filled out manually or by using a PDF program like Adobe. Do NOT fill this out in your web browser.

2. Please give yourself enough time to fill this packet out completely. It is very comprehensive and may take an hour or more.

3. Take your time telling your story. The more we know, the better we can help.

4. If you are not sure how to answer, leave a question mark next to the question.

5. When you are done, please scan and email this form back to our office 24 hours prior to your initial appointment with Dr. Duggar. Emails can be sent to office@iamwellness.com

Demographic Information

Date: _____

Name _____
First *Middle* *Last*

Preferred Name _____

Date of Birth _____ Place of Birth _____

Age _____ Gender O Male O Female

Primary Address _____

_____

Primary Phone _____ Secondary Phone _____
Cell, Home, Work (circle) *Cell, Home, Work (circle)*

Email Address _____

Emergency Contact _____
Name *Relation* *Phone number*

Primary Care Doctor _____
Name *Phone* *FAX*

Marital Status O Single O Married O Divorced O Widow(er) O Partnership

Genetic Background O African O European O Native American O Mediterranean
O Asian O Ashkenazi O Middle Eastern O Caucasian
O Other: _____

Highest Education level O High School O Under-Graduate O Post Graduate

Occupation _____ Hours per week _____

Nature of Business _____

How did you learn about our office? _____

Have you attended a presentation by Dr. Duggar or Tammie? O Yes O No

Have you signed up for any free programs on our website? O Yes O No

Are you already receiving our practice email newsletters? O Yes O No

Establishing Your Health and Wellness Goals

After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated or distracted and failed in their attempt to get well. After careful review, I have discovered several reasons why some people succeed and why others fail. The most important determining factors are a clear and powerful desire to improve and specific goals and action steps to accomplish those goals. When you have decided to change and you know your reasons, you create an internal power that can propel you past perceived obstacles to achieving health and wellness.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

What do you hope to achieve by seeking care in our office? _____

_____

If you could permanently eliminate three health problems, what would they be?

1. _____
2. _____
3. _____

What activities have you been unable to do due to your present symptoms? _____

_____

_____

When was the last time you remember feeling well? _____

On a scale of: 5 (very willing to 1 (not willing), how willing are you to:

	5	4	3	2	1
Significantly change your diet	O	O	O	O	O
Take nutritional supplements daily	O	O	O	O	O
Keep a record of everything you eat	O	O	O	O	O
Modify your lifestyle (e.g. work demands, sleep habits)	O	O	O	O	O
Practice relaxation techniques	O	O	O	O	O
Engage in regular exercise	O	O	O	O	O
Have periodic lab tests to assess progress	O	O	O	O	O

Are there any specific obstacles that you foresee that would stand in your way of making lifestyle changes that will favor healing? _____

_____

Current Health Concerns

Please provide us with current and ongoing problems

SYMPTOM	DATE OF ONSET	SEVERITY/FREQUENCY	TREATMENT	RESULTS
EX: Headaches	May 2016	2 x per week	Ibuprofen	No improvement

What diagnoses or explanations have you received for any of these issues? _____

_____

_____

_____

What treatments/providers have you seen/tried for your conditions?

O Western medicine	O Chiropractic	O Massage	O Yoga	O Acupuncture
O Nutritional therapy	O Homeopathy	O Reiki	O Iridology	O Biofeedback
O Chinese medicine	O Essential Oils	O Colonics	O Foot Zone	O Physical Therapy

Have you lost time from work or school in the past year due to these conditions? _____

_____

What treatments have improved your health? _____

_____

What treatments have worsened your health? _____

_____

What do you consider a realistic window of time to see changes in your health under our care? _____

What are you looking for in a healthcare practitioner? _____

_____

Medical History

Diseases/Diagnosis/Conditions – Check all appropriate boxes and provide dates of onset (mm/yyyy)

Past	Now	Gastrointestinal System
		Irritable Bowel Syndrome
		Inflammatory Bowel Disease
		Crohn's
		Ulcerative Colitis
		Gastritis or Peptic Ulcer Disease
		GERD (reflux)
		Celiac Disease
		Gallstones
		Other

Past	Now	Cardiovascular System
		Heart Attack
		Heart Disease
		Stroke
		Elevated Cholesterol
		Arrhythmia (irregular heartbeat)
		Hypertension (high blood pressure)
		Rheumatic Fever
		Mitral Valve Prolapse
		Other

Past	Now	Metabolic/Endocrine System
		Type 1 Diabetes
		Type 2 Diabetes
		Hypoglycemia
		Insulin Resistance/Pre-Diabetes
		Hypothyroid (Low thyroid)
		Hyperthyroid (Overactive thyroid)
		Polycystic Ovary Syndrome (PCOS)
		Infertility
		Weight Gain
		Weight Loss
		Frequent Weight fluctuations
		Bulemia
		Anorexia
		Binge Eating Disorder
		Night Eating Disorder
		Other Eating Disorder
		Other

Past	Now	Skin
		Eczema
		Psoriasis
		Acne
		Other

Past	Now	Cancer
		Lung Cancer
		Breast Cancer
		Colon Cancer
		Ovarian Cancer
		Prostate Cancer
		Skin Cancer
		Brain Cancer
		Lymphoma
		Other

Past	Now	Genital & Urinary System
		Kidney Stones
		Gout
		Interstitial Cystitis
		Frequent Urinary Tract Infections
		Frequent Yeast Infections
		Erectile Dysfunction/ Sexual Dysfunction
		Other

Past	Now	Musculoskeletal System
		Osteoarthritis
		Fibromyalgia
		Chronic Pain
		Back Injury
		Neck Injury
		Scoliosis
		Shoulder Injury
		Knee Injury
		Other Joint Injury
		Other

Past	Now	Neurological/Mood
		Depression
		Anxiety
		Bipolar Disorder
		Schizophrenia
		Headaches
		Migraines
		ADD/ADHD
		Autism Spectrum Disorder
		Mild Cognitive Impairment
		Memory Problems
		Alzheimer's
		Parkinson's
		Multiple Sclerosis
		ALS

Medical History *(continued)*

Past	Now	Immune/Inflammatory
		Chronic Fatigue Syndrome
		Autoimmune Disease
		Rheumatoid Arthritis
		Lupus
		Immune Deficiency Disease
		Sexually Transmitted Disease
		Frequent Infections
		Food Allergies
		Environmental Allergies
		Multiple Chemical Sensitivities
		Latex Allergy
		Hepatitis
		Mononucleosis
		Epstein Barr Virus
		Lyme's Disease
		Chicken Pox
		German Measles
		Measles
		Mumps
		Whooping Cough
		Other

Past	Now	Respiratory System
		Asthma
		Chronic Sinusitis
		Bronchitis
		Emphysema
		Pneumonia
		Tuberculosis
		Sleep Apnea
		Other

	Preventative/Diagnostic Tests
	Full Physical Exam
	Bone Density Test
	Colonoscopy
	Cardiac Stress Test
	EBT Heart Scan
	EKG
	Hemoccult Test (blood in stool)
	MRI
	CT Scan
	Upper Endoscopy
	Upper GI Series
	Ultrasound
	Mammogram
	Thermography
	X-Ray
	Other

	Surgeries
	Appendectomy
	Tonsillectomy
	Gall Bladder
	Hernia
	Hysterectomy +/- Ovaries
	Joint Replacement (knee/hip)
	Heart Surgery
	Angioplasty (Stent)
	Pacemaker
	Breast Augmentation/Reduction
	Liposuction
	C-Section
	Prostate
	Other

Gynecological History

For Women Only

Obstetric History (check box if "yes" and provide # of events)

	Pregnancies		Post-Partum Depression
	Caesarian		Toxemia
	Vaginal Deliveries		Gestational Diabetes
	Miscarriage		Baby over 8 lbs.
	Abortion		Breast Feeding
	Living Children		How Long?

Menstrual History and Contraception

Age at First Period _____ Menses Length _____ Length of Menstrual Cycle_____

Do you often skip periods? O Yes O No If yes, how long? _____

Typically Painful? O Yes O No Typically Clotting O Yes O No

Contraception methods in use: O Birth Control Pills O Hormone Patch O Nuva Ring
O Partner Sterilized O Condom/Diaphragm O IUD

Women's Disorders/ Hormones Imbalances

Do you experience breast tenderness, water retention, irritability or other PMS symptoms in the second half of your cycle? O Yes O No

Do you experience: O Infertility O Fibrocystic Breasts O Endometriosis
O Fibroids O Painful Periods O Heavy Bleeding
O PMS

Last Mammogram _____ Breast biopsy? O Yes O No O Normal O Abnormal
Last PAP test _____ O Normal O Abnormal
Last Bone Density _____ O Normal O Abnormal (Osteoporosis/Osteopenia)

Are you in Menopause? O Yes O No If so, age at menopause _____

Do you experience: O Hot Flashes O Mood Swings O Memory Problems
O Vaginal Dryness O Low Libido O Weight Gain
O Incontinence O Palpitations O Headaches

Use of hormone replacement therapy (HRT): O Currently O In the past O Never

If so, what type? O Progesterone O Estrogen O Ogen O Estrace
O Premarin O Provera O Other _____

Men's Health History

For Men Only

Have you had a PSA test O Yes O No Last PSA test date _____

PSA Level: O 0-2 O 2-4 O 4-10 O >10

Do you experience:

O Prostate Enlargement O Prostate Infection O Change in Libido
O Impotence O Difficulty Obtaining Erection O Difficulty Maintaining Erection
O Blood in Urine O Blood in Semen
O Urgency/Hesitancy/Loss of bladder control
O Urination at night O Yes O No If yes, how many times a night? _____

Medications & Supplements

Current Medications

Medication	Dose	Frequency	Started *(month/year)*	Reason for Use

Do your medications ever cause you unusual side effects or problems? O Yes O No
Describe: _____
Have you had prolonged or regular use of NSAIDS, Motrin or Aspirin? O Yes O No
Have you had prolonged or regular use of Tylenol? O Yes O No
Have you had prolonged or regular use of acid blocking drugs? O Yes O No
Frequent use of Antibiotics > 3 times/year O Yes O No
Long term antibiotics O Yes O No
Use of steroids (prednisone, nasal allergy inhalers) in the past O Yes O No
Use of oral contraceptives O Yes O No

Current Nutritional Supplements
(Vitamins/Minerals/Herbs/Homeopathy)

Supplement & Brand	Dose	Frequency	Started *(month/year)*	Reason for Use

5 Key Systems Questionnaire

Structural Health

Was your birth process complicated? _____

Have you had any significant falls or accidents in your life? _____

Do you play sports currently or did you as a youth? _____

Have you ever sprained a joint or fractured a bone? _____

Have you ever been diagnosed with scoliosis, osteoporosis, disc degeneration, arthritis or any other bone or joint disease? _____

Have you had any surgeries on your bones or joints? _____

Have you had any car accidents (even minor ones)? _____

Do you sit or stand for prolonged periods of time? _____

Over the past 3-4 months, have you felt:

0 = No, does not occur *1 = Yes, minor, rare (monthly)*
2 = Yes, moderate, occasional (weekly) *3 = Yes, severe, frequent (daily)*

	0	1	2	3
Neck pain	O	O	O	O
Upper or mid-back pain	O	O	O	O
Lower back pain	O	O	O	O
Joints or muscles stiff	O	O	O	O
Difficult to pick something up from the floor	O	O	O	O
Painful joint motion	O	O	O	O
Difficult to open jars that were previously easy	O	O	O	O
Joint swelling or stiffness in fingers, hands, wrists, elbows or shoulders	O	O	O	O
Joint swelling of stiffness in toes, feet, ankles, knees or hips	O	O	O	O
Difficult or painful going from sitting to standing	O	O	O	O
Prolonged sitting increases pain or symptoms	O	O	O	O
Shooting/aching/tingling sensations down one or both legs	O	O	O	O
Burning/throbbing/stabbing muscle pains	O	O	O	O
Muscle cramps or spasms	O	O	O	O
Points on your body are extra sore and tender to touch	O	O	O	O
Tension or headaches that start in the back of your neck	O	O	O	O
Jaw clicking or popping	O	O	O	O
Difficult to open your mouth and chew	O	O	O	O
Numbness in hands or wrists	O	O	O	O
Limping or favoring one leg	O	O	O	O

Structural system symptom score _____

5 Key Systems Questionnaire *(continued)*

Neurological/Mental Health

Have you ever suffered a concussion (even minor)? _____

Have you ever suffered bouts of prolonged depression? _____

Have you ever suffered bouts of prolonged anxiety? _____

Have you ever needed medication to manage a mental illness? _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? _____

_____

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it so that we can support you and optimize your treatment outcomes

Over the past 3-4 months, have you felt:

0 = No, does not occur *1 = Yes, minor, rare (monthly)*

2 = Yes, moderate, occasional (weekly) *3 = Yes, severe, frequent (daily)*

	0	1	2	3
Memory noticeably declining	O	O	O	O
Difficulty learning new things	O	O	O	O
Difficulty with concentration and focus	O	O	O	O
Temperament generally getting worse	O	O	O	O
High stress levels in any area of your life	O	O	O	O
Lack of time for yourself	O	O	O	O
Feelings of loss of direction or purpose	O	O	O	O
Feeling that you are undeserving of good things in your life	O	O	O	O
Feelings of sadness or depression for no reason	O	O	O	O
Feelings of inner rage or anger	O	O	O	O
Feelings of hopelessness	O	O	O	O
Self-destructive feelings	O	O	O	O
Preference to isolate yourself from others	O	O	O	O
Loss of your temper when under stress	O	O	O	O
Feelings of panic or anxiety	O	O	O	O
Feelings of dread or impending doom	O	O	O	O
Knots in your stomach	O	O	O	O
Difficulty turning off your mind and relaxing	O	O	O	O
Negative feelings about yourself	O	O	O	O
Loss of interest in creative hobbies/pursuits	O	O	O	O

Neurological system symptom score _____

5 Key Systems Questionnaire *(continued)*

Hormonal Health

Are you currently overweight? _____

When was the last time you were at your ideal weight? _____

Have you repeatedly gained and lost weight on diets? _____

Over the past 3-4 months, have you felt:

0 = No, does not occur *1 = Yes, minor, rare (monthly)*
2 = Yes, moderate, occasional (weekly) *3 = Yes, severe, frequent (daily)*

	0	1	2	3
Fatigue that is relieved by eating	O	O	O	O
Sleepiness in the afternoon	O	O	O	O
Awaken at night, hard to get back to sleep	O	O	O	O
Irritable or shaky before meals	O	O	O	O
Frequent thirst and urination	O	O	O	O
Easily fatigued with minor exertion	O	O	O	O
Difficulty falling asleep at night	O	O	O	O
Slow starter in the morning	O	O	O	O
Clench or grind teeth at night	O	O	O	O
Lightheaded when standing up suddenly	O	O	O	O
Difficult gaining or losing weight	O	O	O	O
Intolerance to high temperatures	O	O	O	O
Feel cold or chilled when others are fine	O	O	O	O
Loss or thinning of outer 1/3 of eyebrows	O	O	O	O
Coarse, dry hair or dry skin	O	O	O	O
Females only				
Mood changes associated with menstrual cycle (PMS)	O	O	O	O
Breast tenderness associated with menstrual cycle	O	O	O	O
Variations in menstrual cycle (length, flow, cramps)	O	O	O	O
Loss of sexual desire	O	O	O	O
Males only				
Urgency/Hesitation or other difficulty with urination	O	O	O	O
Decreased sexual function	O	O	O	O
Loss of sexual desire	O	O	O	O
Loss of lean muscle/ increase in belly fat	O	O	O	O
Decreased physical stamina	O	O	O	O

Hormonal system symptom score _____

5 Key Systems Questionnaire *(continued)*

Digestive Health

How often have you traveled to a foreign country? _____

How often do you camp in the wilderness? _____

Bowel Habits

Frequency: O > 3/week O 1-3/day O 4-6/day O 2-3/day O <2/week

Consistency: O Soft, well-formed O Often floats O Difficult to pass O Diarrhea
O Thin, narrow O Small, hard O Loose, not watery

Color: O Medium brown O Very dark/Black O Greenish O Blood visible
O Greasy, shiny appearance

Over the past 3-4 months, have you felt:

0 = No, does not occur *1 = Yes, minor, rare (monthly)*
2 = Yes, moderate, occasional (weekly) *3 = Yes, severe, frequent (daily)*

	0	1	2	3
Heartburn or acid reflux	O	O	O	O
Bloating and belching after eating	O	O	O	O
Bad breath	O	O	O	O
Stomach upset by taking vitamins	O	O	O	O
Feel better when you don't eat	O	O	O	O
Sleepy after meals	O	O	O	O
Undigested food visible in stools	O	O	O	O
Food sensitivities to wheat, dairy or other foods	O	O	O	O
Have strong food cravings	O	O	O	O
Alternating periods of diarrhea and constipation	O	O	O	O
Asthma, sinus infections or stuffy nose	O	O	O	O
Environmental allergies, hay fever	O	O	O	O
Itching around anus	O	O	O	O
Tongue has whitish coating on the back	O	O	O	O
Fungal or yeast infections	O	O	O	O
Symptoms increase with intake of sugar, starches or alcohol	O	O	O	O
Less than one bowel movement per day	O	O	O	O
Stools are not well formed (loose)	O	O	O	O
Blood in stool	O	O	O	O
Excessive lower bowel gas	O	O	O	O

Digestive system symptom score _____

5 Key Systems Questionnaire *(continued)*

Detoxification/Environmental Health

Do you consume diet or regular carbonated soft drinks or energy drinks on a weekly basis?

_____

Do you smoke or chew tobacco? If so, how much? _____

Do you drink alcohol? If so, how much? _____

Do you get your house treated for bugs or have your lawn chemically treated? _____

Do you have "silver" amalgam fillings in your teeth? _____

Do you drink from plastic containers or unfiltered tap water? _____

Are you exposed to chemicals in the workplace? _____

Over the past 3-4 months, have you felt:

0 = No, does not occur *1 = Yes, minor, rare (monthly)*
2 = Yes, moderate, occasional (weekly) *3 = Yes, severe, frequent (daily)*

	0	1	2	3
Pain between the shoulder blades after eating fatty foods	O	O	O	O
Stomach upset by greasy foods	O	O	O	O
Frequent or persistent nausea	O	O	O	O
Gall bladder attacks (if gall bladder has been removed, mark 3)	O	O	O	O
Pain under right side of ribs	O	O	O	O
Bitter taste in mouth, especially after meals	O	O	O	O
Migraine or cluster headaches	O	O	O	O
Bags or dark circles under eyes	O	O	O	O
Excessive mucus formation	O	O	O	O
Chronic cough or need to clear throat often	O	O	O	O
Overweight or obesity	O	O	O	O
Water retention and/or edema	O	O	O	O
Frequent illness	O	O	O	O
History of drug or alcohol abuse	O	O	O	O
History of hepatitis	O	O	O	O
Long-term use of prescription/recreational drugs	O	O	O	O
Sensitive to chemicals (perfumes, cleaners, etc.)	O	O	O	O
Sensitive to tobacco smoke	O	O	O	O
Sensitive to MSG, Aspartame, Caffeine	O	O	O	O
Chronic fatigue or fibromyalgia	O	O	O	O

Detoxification system symptom score _____

7 Pillars Lifestyle Questionnaire

Nutrition

Height (feet/inches) _____ Current Weight _____ Desired Weight _____

Highest Adult Weight _____ Lowest Adult Weight _____ Body Fat % _____

How often do you weight yourself? O Daily O Weekly O Monthly O Rarely/Never

Do you grocery shop? O Yes O No If no, who does the shopping? _____

Do you cook? O Yes O No If no, who does the cooking? _____

Do you read food labels? O Yes O No

How many meals do you eat out per week? O 0-1 O 1-3 O 3-5 O >5 meals/week

Have you made any changes in your eating habits because of your health? O Yes O No

Do you currently follow a special diet or nutritional program? O Yes O No

O Gluten-Free O Diabetic O Dairy restricted O Vegetarian O Vegan

O Paleo O Other: _____

Please tell us if there is anything special about your diet that we should know _____

_____

Check all the behaviors or beliefs that apply to your current lifestyle and eating habits

	Erratic eating patterns		Love to eat
	Fast eater		Eat only because I have to
	Late night eating		Have a negative relationship with food
	Dislike healthy food		Struggle with eating issues
	Spouse or family doesn't like healthy food		Emotional eater (sad, lonely, depressed etc.)
	More than 50% of meals away from home		Eat too much when under stress
	Travel frequently		Eat too little when under stress
	Non-availability of healthy foods		Don't care to cook
	Do not plan meals or menus		Eating in the middle of the night
	Reliance of convenience		Confused by nutrition advice
	Poor snack choices		Family members have special dietary needs
	Time constraints		Eat too much

Nutrition – Food Diary

Food	Freq.	Often	Occas.	Seldom	Never
Alcoholic beverages	○	○	○	○	○
Eat out at restaurants	○	○	○	○	○
Pastries, cookies, candy, ice cream etc.	○	○	○	○	○
White flour: bread, pasta, pancakes etc.	○	○	○	○	○
Added sugar to coffee, tea, cereals etc.	○	○	○	○	○
Sodas or soft drinks	○	○	○	○	○
Diet soft drinks	○	○	○	○	○
Fruit juices	○	○	○	○	○
Artificial sweeteners (NutraSweet, saccharin, etc.)	○	○	○	○	○
Natural sweeteners (honey, maple syrup, agave etc.)	○	○	○	○	○
Breakfast cereals (Check: ☐ hot ☐ cold)	○	○	○	○	○
Packaged foods: chips, crackers, puffs etc.)	○	○	○	○	○
Vegetable oils (sunflower, safflower, canola, corn, soy)	○	○	○	○	○
Margarine or tub vegetable oil spreads	○	○	○	○	○
Deep-fried foods	○	○	○	○	○
Olive oil	○	○	○	○	○
Avocados	○	○	○	○	○
Saturated fats (butter, ghee, lard, coconut, palm, tallow)	○	○	○	○	○
Fatty fish (salmon, mackerel, sardines, herring)	○	○	○	○	○
Nuts and seeds (including nut/seed butters)	○	○	○	○	○
Pasteurized dairy (Check: ☐ nonfat, ☐ low-fat, ☐ whole	○	○	○	○	○
Raw dairy (Check: ☐ nonfat, ☐ low-fat, ☐ whole	○	○	○	○	○
Fermented dairy (yoghurt, kefir, cheese)	○	○	○	○	○
Eggs (Check: ☐ free-range, ☐ pastured ☐ organic, ☐ conventional	○	○	○	○	○
Poultry or fowl (chicken, turkey, duck etc.)	○	○	○	○	○
Pork	○	○	○	○	○
Red meat (beef, lamb)	○	○	○	○	○
Processed meats (bacon, sausage etc.)	○	○	○	○	○
Organ meats (liver, kidney, sweetbreads, etc.)	○	○	○	○	○
Soy products (tofu, tempeh, soy milk, edamame)	○	○	○	○	○
Salads, uncooked vegetables	○	○	○	○	○

Food	Freq.	Often	Occas.	Seldom	Never
Fermented vegetables (sauerkraut, kimchi, etc.)	O	O	O	O	O
Non-starchy vegetables (greens, squash, carrots)	O	O	O	O	O
Starchy vegetables (potatoes, yams, sweet potatoes)	O	O	O	O	O
Fresh fruits	O	O	O	O	O
Beans and legumes	O	O	O	O	O
Whole grains with gluten (wheat, rye, barley)	O	O	O	O	O
Alternative grains (quinoa, buckwheat etc.)	O	O	O	O	O
Herbs and spices (fresh or dried)	O	O	O	O	O
Chocolate (Check ☐ milk ☐ dark)	O	O	O	O	O
Herbal teas	O	O	O	O	O
Coffee (Check ☐ regular ☐ decaffeinated)	O	O	O	O	O
Caffeinated teas (Check ☐ black ☐ green)	O	O	O	O	O
Salt (Check ☐ iodized ☐ sea salt)	O	O	O	O	O

Exercise

Do you exercise regularly? O Yes O No

Current exercise program: (List activity, intensity, number of sessions per week and duration)

Activity	Type/Intensity	Frequency per week	Duration in minutes
Walking/Jogging			
Cardio/Aerobics			
Strength training			
Yoga/Pilates			
Dance/Zumba			
Sports or leisure activities			
Other: (List below)			

What's your level of motivation for including exercise in your life? O Low O Medium OHigh

List problems that limit activity: _____

_____

Do you feel unusually fatigued after exercise? _____

_____

Do you usually sweat when exercise? O Yes O No

Sleep and Rest

Average number of hours you sleep at night O >10 O 8-10 O 6-8 O <6

Do you have trouble falling asleep? O Yes O No

Do you feel rested upon awakening? O Yes O No

Do you snore? O Yes O No

Do you use sleeping aids? O Yes O No

What time do you go to bed? _____

What time do you wake up? _____

Psychosocial/Stress Coping

Do you feel significantly less vital than you did a year ago? O Yes O No

Are you happy? O Yes O No

Do you feel your life has meaning and purpose? O Yes O No

Do you still believe stress is presently reducing the quality of your life? O Yes O No

Do you like the work you do? O Yes O No

Have you ever experienced major losses in your life? O Yes O No

Do you spend most of your time fulfilling responsibilities and obligations? O Yes O No

Would you describe your childhood family experience as happy and secure? O Yes O No

Have you ever sought counselling? O Yes O No

Are you currently in therapy? O Yes O No

Do you feel you have an excessive amount of stress in your life? O Yes O No

Daily Stressors: Rate on scale 1 – 10 (1=minimal stress, 10=very high stress)

Work _____ Family _____ Social _____ Finances _____ Health _____

Do you practice meditation or relaxation techniques? O Yes O No

Check all that apply

O Yoga O Meditation O Imagery O Tai Chi/Chi Gong O Prayer

Resources for emotional support

O Spouse O Family O Friends O Religious/Spiritual O Pets

Informed Consent for Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect own your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing dwelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well---being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and hot/cold packs, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a clot with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care of not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one per one million to two million cervical adjustments.

It is also important to that you understand that there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter medications, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current of future recommendation to receive chiropractic care and nutritional and lifestyle advice as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek care from this office.

_____	_____	_____
Signature of patient or patient representative	Date	Indicate relationship if signing for patient

_____	_____
Signature of office representative	Date

Financial Policies

To maintain compliance with various state and federal regulations, we have adopted the following financial policies.

- Our clinic has established a single fee schedule that applies to all patients for each service provided.
- You may be entitled to a network or contractual discount under the following circumstances:
    - You are covered by a State or Federal program with a mandated fee schedule i.e. Medicare
    - You are a member of our Wellness Circle Program or any other Discount Medical Plan Organization our office participates with.
- If you do not meet any of the circumstances above, you will be required to pay the full fee at the time of service unless we have approved in advance to accept a partial payment.
- Missed Appointments - Failing to provide adequate notice (24- hours) of your inability to keep an appointment will incur a charge equal to 50% of the scheduled service.
- A $25 charge will be applied in the event of a check returned with Not Sufficient Funds.
- Refunds – There are no refunds extended for services that have already been received. If you have elected to pre-pay for any part of your care, unused portions of your care MAY be eligible for a refund. The conditions for a refund will be carefully explained prior to your agreement to receive "pre-pay eligible" services.
    - Refunds for supplements must meet the following criteria:
        - The bottle or package must be unopened.
        - The return must be within 30 days of purchase and the product must not have passed its expiration date.
        - A 15% handling fee will be applied unless the product is being exchanged for another product at that time.
    - Refunds for lab testing must be requested within 30 days of obtaining test kits, otherwise refund will be awarded as in-office credit.
- If your account is not paid within 30 days of the date of service and no financial arrangements have been agreed upon in writing, a finance charge of 2% per month (annual percentage rate 24%) of the unpaid balance will be added monthly. Should the balance remain unpaid for 60 days after the date of service the balance will be sent to collections and the responsible party agrees to pay all collection fees and all legal fees, with or without suit, including attorney fees and court costs.
- Special information for Auto Accidents: Our office will submit claims for you if you have been injured in an Auto Accident. Utah Personal Injury Protection Benefits include a minimum of $3,000 for initial health care expenses. Once this limit is reached, patients will be required to pay for all services at the time they are received. It is the patient's responsibility to fill out and return their PIP benefits application to their insurance company in a timely manner. Your insurance company will not pay on claims until this application has been received. Since we are unaware of other health services you may have received, we cannot be responsible to keep track of your PIP balance/benefits.
- If this is a personal injury case, signing this agreement acts as a lien and all parties will be paid on services rendered.
- I hereby assign all health eligible insurance benefits to which I am entitled to Dr. Jerald W. Duggar, 140 N Main Bountiful, UT 84010. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment, via Fax Transmittal, e---mail or hard copy. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my insurance status.

Signature of Responsible Party: _____ Date:_____

HIPPA Privacy Policies

At Duggar Wellness we understand that your medical and health information is private. We know that respect for that privacy is a critical part of our relationship. We are committed to protecting the privacy of your protected health information that is in our possession. We follow strict federal and state laws that require us to maintain confidentiality of your health information. This "Notice of Privacy Practices" was created to help you understand our legal duties to protect your health information, as well as your rights in regards to your health information.

How We May Use Your Health Information

When you receive care at our office we may use your health information for treating you, billing for services rendered and conducting our normal business operations. The following are examples of how we use and disclose your health information: Treatment - We keep records of the care and services provided to you. We use these records to deliver quality care to meet your needs. We may share your health information with a specialist or representative who will assist in your treatment. Payment- We keep billing records that include payment information and documentation of services provided to you. Your information may be used to obtain payment from your insurance company or any third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that need prior notice or authorization. Health Care Operations - We use health information to continually improve the quality and effectiveness the health care services we provide. We may use your health information to train staff and students, provide customer services, and conduct required business duties.

We may also use your health information to: Recommend treatment alternatives, tell you about health services and products that may benefit you, share information with family or friends who are involved in your care or payment for your care and share information with third parties who assist us with treatment, payment and health care operations.

Specific Agreements (Please Circle)

Y / N - I agree to allow Duggar Wellness to call my home and/or work to remind me of appointments or advise me of issues related to my care.

Y / N - I agree to allow Duggar Wellness to correspond to me via email regarding my personal health matters (lab reports etc.) as well as other information regarding general health issues.

We may sharing your health information: For public health purposes such as reporting communicable diseases, work---related illness and injuries, or other diseases and injuries permitted by law; reporting deaths; and reporting reactions to drugs or problems with medical devices, to protect victims of abuse, neglect or domestic violence, for lawsuits and similar proceedings, when requested by law enforcement as required by law or court order, for Workers' Compensation or other similar programs if you are injured at work. Our office will obtain your written authorization before using or disclosing your health information other than those instances listed above (or as otherwise permitted and required by law). You may revoke your authorization at any time with a written statement.

Our Privacy Responsibilities: We are required by law to do the following: Maintain the privacy or your health information, provide this notice that describes the ways we may use and share your health information, follow the terms of the notice currently in effect.

Your Individual Rights: You may request restrictions on how we use and share your information. (However, we may not be required by law to honor these requests.) You may inspect and request a copy of your health information (Fees may apply). You may make a written request for corrections or additions to your health information. You may request and additional copy of this notice. You may request an accounting of certain disclosures of your health information made by

us. This would exclude an accounting of disclosures made for treatment, payment or health care operations. This excludes disclosures prior to April 14, 2007.

We at I Am Wellness take the matters described in this "Notice of Privacy Practices" very seriously because of our relationship with you and the legal requirements that we comply with this notice. We reserve the right to update and make changes to this notice at any time. You may request a copy of this notice from any employee at our office.

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, please feel free to contact our Privacy Coordinator:

Tammie Duggar
(801)-677-7878

I have received/reviewed a copy of this office's Notice of Privacy Practices.

_____ _____
Signature of patient or guardian Date

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence---giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back---up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party
in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non---economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here
Effective as of the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____	_____	_____
Signature of patient or patient representative	Date	Indicate relationship if signing for patient

_____	_____
Signature of office representative	Date