

TRIAD OF HEALTH

45 Mitchell Boulevard
Suite 10
San Rafael, CA 94903
415/459.4313 Phone
www.TriadOfHealth.net

Step 1: Please take the time to fill out the new patient paperwork that will help us better understand your current symptoms, personal history, and health goals. The more information we have, the more effective our Doctors will be in helping you with your condition.

Step 2: The Doctor will then review and discuss your detailed responses.

Step 3: An appropriate examination will then be done to determine your diagnosis and see if our methods of health care are appropriate for your condition. Give yourself about 1 hour of time for the exam. After the exam we will schedule an appointment for you to come back and then be advised as to whether or not you will need to have labs or X-rays conducted.

Step 4: The Doctor will go over the Report of Findings where you will be informed of how we feel that we can help you and what would be the best course of action to take in order for you to reach your health goals.

Step 5: Once you clearly understand your case and diagnosis, treatment recommendations will be given to you. Your treatment plan will be tailored to your diagnosis and health goals. If you are comfortable with the findings and excited about the plan for new health and a new life, treatment will begin and continue as long as you keep making dramatic progress and your health goals have been met.

Our goal is to help you achieve your health goals as quickly and reasonably as possible, so the body can function the way it was created.

The Highest Good is to find the Structural, Chemical and Emotional Causes of the Health Challenge and then to Treat the Cause and not the Symptom!

About You

Name_____ Date of Birth_____/_____/_____

Address_____ SS#_____/_____/_____

_____ Height_____ Weight_____

_____ Age_____

Marital Status S M D W Occupation_____

Telephone (Home)_____ # of children_____

Telephone (Cell)_____ Email_____

Telephone (Work)_____ Referred by_____

Person Responsible for account Self / Spouse / Parent

Is your condition a result of an auto injury? Yes / No

Is your condition a work related injury? Yes / No

Present Chief Complaint

What is the main reason you are here?_____

How long have you had this condition?_____

Is your problem getting better, worse or is it constant?_____

If worse, what time of day is the most difficult?

_____ morning_____ afternoon_____ evening_____ night

Is this interfering with work?_____ Sleep_____ Exercise_____ Other_____

What do you believe is wrong with you?_____

List other problems you have now_____

List past operations and dates_____

Have you ever been hospitalized other than surgery?_____

Have you ever had any mental or emotional disorders?_____

Have you had any other injury in the past two years?_____

Your Current Condition

Are you taking medication? _____ Describe _____

Are you taking nutritional supplements? _____ Describe _____

Are you allergic to any foods, drugs, etc? _____

Do you have any dental problems? _____ Dr. _____

Do you wear arch supports? _____ Heal lifts? _____ Special shoes? _____ What is your shoe size? _____

Date of your last physical exam? _____ Dr. _____ Blood test? _____

(Women) Do you have a belly button ring or other piercing other than the ear lobe? _____

(Women & Men) Please describe all body piercings and or tattoos wherever they may be located _____

Habits (describe with amounts):

Alcohol _____ Coffee _____

Cigarettes _____ Drugs not listed above _____

Describe you present exercise habits: _____

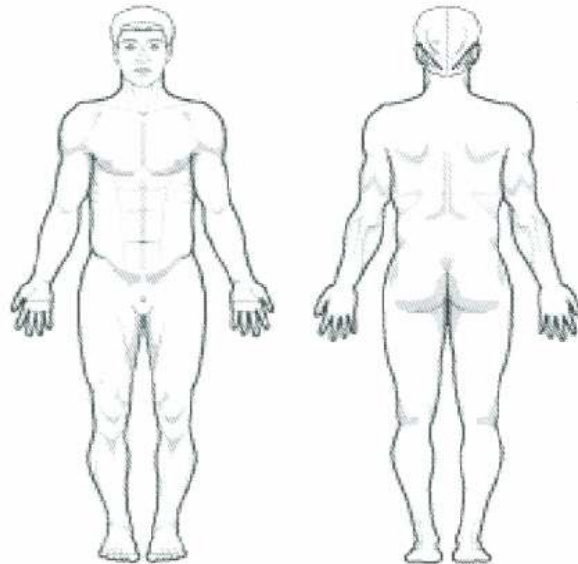
Please list the main health problems in your family:

Name:	Relation:	Problem:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pain Severity Level

Draw a line from each type of pain / symptom That you are experiencing to the corresponding Area of your body. Using the chart below, rate Each pain / symptom by writing the level # on Each line.

- Achy _____
- Burning _____
- Cramping _____
- Dull _____
- Electric Shock _____
- Numbness _____
- Radiating _____
- Sharp _____
- Shooting _____
- Stabbing _____
- Stiffness _____
- Swelling _____
- Throbbing _____
- Tingling _____
- Other _____



Pain Severity (circle number)	None	Mild			Moderate				Severe		
	0	1	2	3	4	5	6	7	8	9	10
ADL= Activities of Daily Living	No Pain	Annoying Pain; Aware of discomfort; Able to do activities; soreness, ache, stiff			Pain causes you to slow down; Takes longer to complete work; May be unable to do demanding work; Hurt, pain, very sore				Pain limits your ADL; Some difficulties with sleep; sharp pain, stabbing		

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II **Please circle the appropriate number “0 - 3” on all questions below.** **0 as the least/never to 3 as the most/always.**

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue of “fuzzy” debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3
Category III				
Stomach pain, burning, or aching 1- 4 hours after eating	0	1	2	3
Do you frequently use antacids?	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category IV				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category V				
Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes	No		
Category VI				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category VII				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category VIII				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

*Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.*

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Males Only)

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males Only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)

Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal?	_____			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

PART III

How many alcohol beverages do you consume per week? _____ How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____ How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you workout? _____

List the three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____

Do you smoke? _____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

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48 Hour Cancellation Policy

You are expected to keep all appointments as scheduled in order to ensure maximum progress with your case. If for some reason you cannot make an appointment, please call at least 48 hours in advance in order to reschedule. You will need to reschedule that appointment within the next 2 weeks. Without this 48 hour courtesy call your account will be charged for the full visit amount. If you have been granted some type of pre-payment plan or other discount, that pre-payment plan or discount cannot and will not qualify for the missed appointment. The full amount of your missed visit will be deducted from your pre-payment plan. An exception to this rule would be if someone is dying or in the hospital or there is a national or local emergency. Thank you for your cooperation.

Name: _____

X _____ Date: _____

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Notice Of Privacy Practices (HIPAA). Effective date: April 14th 2003

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

A. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

5. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

B. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Dr. Ilya Skolnikoff, D.C. at (415) 459-4313 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Doctor at (415) 459-4313. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Doctor at (415) 459-4313 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Doctor at (415) 459-4313. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Doctor at (415) 459-4313.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Doctor at (415) 459-4313. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note:* we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact The Doctor at (415) 459-4313.

(patient signature)

(today's date)

Three Day Diet Diary

Please write down everything that you have eaten during the previous 3 days. This will ensure that you receive the best care and diagnosis possible.

	Today	Yesterday	2 Days Ago
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Notes			