Name: _____ Date: _____

Date of Birth: _____ Phone: _____

Home Address: _____

Email: _____

Occupation: _____Sex: _____ Marital Status:_____

Primary Complaints:

1)_____ 2)_____

3)_____ 4)_____

How did you learn of Dr. Valorie Prahl or Integrative Health Services?

☐ Newspaper Ad ☐ Referral (Name: _____)

☐ Facebook ☐ Internet Search

How long have you suffered with these problems? _____

Known Allergies:

_____

_____

Any other complaints:

_____

_____

_____

Current Medications (over-the-counter or prescription):

_____

_____

Past Surgeries:

_____

_____

Would you like improvement with any of the following?

☐ Digestion: reflux, gas, constipation

☐ Sense of well being

☐ Sleep: Falling asleep or staying asleep

☐ Energy

What have you tried doing to resolve this problem that DID NOT work?

_____

_____

Have you become discouraged or stressed about handling this problem?

_____

_____

When your problem is at its worst, how does it make you feel? _____

_____

_____

What is this problem keeping you from doing?_____

_____

How is this problem affecting your life?_____

_____

_____

How does this problem interfere with the following areas in your life?

Work: _____

Family: _____

Hobbies: _____

Life: _____

Changes in Sex Drive:_____

When it is at its worst, how much older does this make you feel? _____

Do you know how this problem may have started?

_____

_____

What effect does this have on your body functions?

_____

_____

What is the purpose of your visit to Integrative Health Solutions?

- ☐ Resolve my immediate problem
- ☐ Adopt a lifestyle program for optimized living
- ☐ Other: _____

How have you taken care of your health in the past?

- ☐ Medications
- ☐ Routine medical
- ☐ Exercise
- ☐ Diet and Nutrition
- ☐ Holistic
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other: _____

How did the previous methods work for you?

_____

_____

_____

What are you afraid your health problems will negatively impact if things do not change?

- ☐ Job
- ☐ Kids / Grandkids
- ☐ Marriage
- ☐ Sleep
- ☐ Freedom
- ☐ Future abilities
- ☐ Finances
- ☐ Time

Are there any health conditions you are afraid this might turn into?

- ☐ Diminished Future abilities
- ☐ Stress
- ☐ Weight gain
- ☐ Heart disease
- ☐ Depression
- ☐ Surgery
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Other _____

What would be different or better without this problem?

- ☐ Diminished stress
- ☐ More energy
- ☐ Higher self-esteem
- ☐ Higher body confidence
- ☐ Better and more restful sleep
- ☐ Improved performance at work
- ☐ Better outlook on life
- ☐ Improved family relationships
- ☐ Better sex drive
- ☐ Other: _____

Where do you picture yourself in the next 3-5 years if this problem is not taken care of? Please be specific!

_____

_____

_____

_____

In 3 years, if we were to sit down, discuss your life, and look back on today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list items!)

_____

_____

_____

_____

_____

What potential barriers do you foresee that would prevent these things from happening?

_____

_____

Do you feel it is possible to eliminate or prevent these potential barriers? How?

_____

_____

What are your strengths that will enable you to accomplish your goals?

_____

_____

Rate on a scale of 1-10, with 10 being the highest:

_____ How important is it for you to resolve your health concerns?

_____ Do you feel that you are coachable and would enjoy a mentor in helping you?

_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Thank You!

CONSENT POLICY

Consent to Treatment and Participation

I hereby request and consent to the performance of treatment by Valorie J. Prahl, DC, DACBN, which may include but is not limited to health coaching, chiropractic care, functional medicine procedures, diagnostic tests and challenges, and the recommendations of specific herbal supplements and/or dietary protocols. I understand that these practices and protocols are traditionally considered safe, and that some may be inappropriate during pregnancy. Some possible side effects of herbal or nutritional supplements are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a clinical member who is caring for me if I am or become pregnant.

I understand that the primary treatment used by doctors of chiropractic is spinal manipulative therapy. There are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Though there is no direct causative link that is provable and the incidence is extremely rare, however, some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The chiropractor will make every reasonable effort during the examination to screen for contraindications to care; however if I have a condition that would otherwise not come to the chiropractor's attention, I understand it is my responsibility to inform the chiropractor.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand that Dr. Prahl is not a medical doctor, and cannot manage my pharmaceutical medications.

I understand the clinical and administrative staff may review my patient records and lab reports but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of treatments and other procedures and have an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

……

By signing below I am agreeing and acknowledging consent to everything listed above.

Signature – by typing this serves as your signature	Date

INTEGRATIVE HEALTH SOLUTIONS – PRESCRIBED MEDICATION

I coach client members towards wellness using a holistic approach. I am not a medical doctor. As a functional wellness and integrative practitioner, I study and teach the complex ways lifestyle, diet, nutrition, genetics, the environment, and other factors that influence health. I utilize objective and subjective testing to help uncover these specifics. I believe in a deep and undeniable connection between the mind, spirit, and body.

I do not claim to diagnose, treat, or cure specific diseases or conditions. When you change your lifestyle and other habits, your pharmaceutical medication may need to be adjusted or changed by your prescribing physician. It is extremely important that you do not adjust the dosage by yourself or go off of any medication without the guidance and oversight of the prescribing physician. We cannot advise you on your prescription medications; we can only stress that you must continue care with the prescribing physician while you are on such medication.

Thank you,

Dr. Valorie Prahl

Prahl Health & Healing

Integrative Health Services

_____

I have read this disclaimer and understand its content. I understand that, if my prescribing physician makes any changes or adds to my prescription medications in any manner, I will inform Integrative Health Solutions doctor or staff.

By signing below I am agreeing and acknowledging consent to everything listed above.

Signature – by typing this serves as your signature	Date

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the

information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement official's information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting.

Others Involved in Your Healthcare: With your permission we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to Privacy Officer:
Valorie J. Prahl, DC, DACBN, 1006 West 8th St. Cedar Falls, IA 50613