



Triad Of Health

FAMILY HEALING CENTER

4340 Redwood Highway

Suite D318

San Rafael, CA 94903

415.459.4313 Phone

www.TriadOfHealth.net

Welcome to Triad Of Health!

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 as possible, so that your body can function optimally.

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

ABOUT YOU

Today's Date _____

Name _____

Date of Birth ____/____/____

Address _____

SS# ____/____/____

Height _____ Weight _____

Age _____ Sex _____

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

MAIN HEALTH CONCERN

What is your biggest health concern? _____

How long have you had this condition/concern? _____

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 it interfering with your 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 for surgery? _____

Have you ever had any mental or emotional disorders? _____

YOUR CURRENT CONDITION

Please list any natural supplements you currently take and for what conditions (not hormones): _____

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

Do you have any dental problems? _____ Dr. _____

Do you wear arch supports? _____ Heal lifts? _____ Special shoes? _____

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

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

Please describe all body piercings and/or tattoos wherever they may be located _____

Do you wear eyeglasses? Yes No If yes, when did you last get your prescription fulfilled (# of months ago)? _____

Describe your present exercise habits: _____

Please list the main health problems in your family. Include any medications they may use.

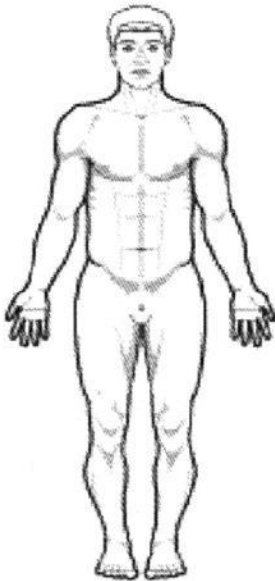
Name:

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 where you have the pain. 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 _____

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

METABOLIC ASSESSMENT FORM

PART I

Please list your 4 major health concerns in the order of their importance:

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

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. Form credited to Datis Kharrazian*

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	
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	
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

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? Yes No If yes, how many times a day: _____ Do you smoke pot? Yes No If yes, how often? _____

Other drugs? Yes No If yes, what and how often? _____

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

Please list any medications you are currently taking and for what conditions. (Include any bioidentical hormones you are currently using such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.). If hormones, what doses and for how long? Are they oral or sublingual, patch, cream, or gel? How do you apply product? How long have you taken these medications or hormones for? _____

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Notice Of Privacy Practices (HIPAA). Effective date: April 14, 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 Triad Of Health, 4340 Redwood Highway, Suite D318, San Rafael, CA 94903. 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.

5. 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.

6. 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.**

7. 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.

You are giving Triad Of Health permission to communicate with you by fax, email and phone conversation. We may take photos of you and reserve the right to use your photos in promotional material unless you say otherwise. To repeat, we have permission to use your image in any videos, testimonials or promotional materials.

(patient signature)

(today’s date)

THREE DAY DIET DIARY

Please write down everything that you have had to eat and drink 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			

PATIENT POLICIES

Please read and initial at the beginning of each paragraph that you have read and agree to the policies.

- _____ There is a 48-business hour cancellation policy. (The term “business hours” refers to banking hours Monday thru Friday from 9a.m. to 5p.m.) Kindly give 48-Business hours’ notice if you need to cancel or reschedule an appointment. If you give 24 hours’ notice and are able to reschedule within 2 weeks then you will not be charged a cancellation fee. If you miss your appointment and do not give us notice you will be charged the FULL FEE for that visit. If you are receiving any type of pre-existing special offer or discount on services, that discount will NOT apply to the missed visit. You will be responsible for the FULL fee for the missed visit. The only exception to this rule would be if there was a local emergency or for a medical emergency. If there is a medical emergency you will need a note from the attending physician (or hospital) in order not to be charged the missed visit fee. Thank you for your cooperation.
- _____ Payment in full is expected at the time of service. You may pay with MasterCard, Visa, Discover, check, or cash.
- _____ Please fill out your chart when arriving to each appointment. If the chart is not readily available then please ask for it.
- _____ Please try to wear cotton or natural fiber clothing to your treatment session. No dresses or skirts unless pants are worn underneath.
- _____ Next, please take off all of your jewelry, metal objects, belt, and or wallet. This includes earrings, belly button rings, toe rings, hand rings, watches, etc.... there should be a small ceramic tray for you to put these things in or an area of the treatment room.
- _____ Once you have entered the treatment room, please sit on the treatment table facing the wall with charts on it.
- _____ The doctor recommends a certain frequency of care. Whatever schedule is recommended, for maximum results it is necessary to keep appointments or reschedule them within a 2 week period (maximum of 3 months). You will lose time and money if you do not keep your appointments.
- _____ These therapies change lives. This is very well documented. In order to have life changing results with these therapies it is necessary to make the appropriate lifestyle changes and also to follow up on any referrals given to other health care providers. You agree to this and/or understand that your level of results with these therapies will be drastically compromised should you be unable to make the appropriate lifestyle changes or follow up on any needed referrals. Remember that Triad Of Health and the Doctor will be supporting you every step of the way.

_____ All payments are due at the time of the treatment visit. By signing below, you agree that you have been clearly explained Dr. Ilya's fees and understand clearly that Dr. Ilya bills for his time and does not bill a per session fee. You are responsible for all payments. Should nutrients be needed, payment for these items are also due at the time of the treatment visit. Any fees not paid within a 30 day period will not only be sent out to a collection agency, but a 10% monthly finance charge will begin to accrue as well.

_____ Should you want to bill your insurance company for care, a receipt for service will be given to you at each follow up visit – not at the visit that the service was provided. You will be taught how to bill your insurance company. Triad Of Health and its staff will not participate in this process. At Triad Of Health we support “patient centered” care which does not include playing a game with insurance companies on your behalf. We will empower you to gain more control of your health insurance, financial status, health and numerous other areas of your life.

_____ There are no refunds or returns for nutrients purchased. The Triad Of Health office may choose to make exceptions for this policy. For example, if there is an obvious manufacturing defect with the product the Triad Of Health office is likely to take the product back and credit your account. If you have an accident or need to be seen before your scheduled appointment, the Triad Of Health office is likely to take back any unopened nutrients and credit your account. Returned supplements might be credited to your account but may never be returned for re-imbursement. All nutrients brought back for credit must be brought back to the office within 60 days of being distributed unless you can document that you have been out of the country for more than 7 weeks. Books may not be returned for credit once sold. Non-nutrients may not be returned for credit once sold. If the Triad Of Health office chooses to accept a return, taxes will be taken out of the monies credited to your account.

_____ If you have nutrients that you have been using that you would like the Doctor to evaluate, there will be a \$35 fee assessed in addition to the regular service fee in order to evaluate these nutrients. You could save yourself some money by not bringing them in as a large number of patients need very few, if any supplements after a proper treatment.

_____ In order to schedule, reschedule or cancel an appointment, such a cancellation must be done by phone. Because email is unreliable and may get lost in cyberspace, all important communications will be conducted by phone. Should you attempt to reschedule an appointment by email and your email is not received, you will still be responsible for that visit. The visit must be rescheduled by phone (not text message). Voicemail is acceptable.

Patient Name — Please Print

Patient or Legal Guardian Signature

Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

Like all forms of health care Chiropractic care offers tremendous benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at Triad Of Health Family Wellness Clinic, a health history and physical examination will be completed. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

The information I have provided on these forms is true and accurate to the best of my knowledge. I give Dr. Ilya Skolnikoff permission to render care to me.

Patient Name — Please Print

Patient or Legal Guardian Signature

Date

Witness Signature (Dr. or Office Staff)

Date

Drug Awareness Disclosure Form

I, _____, acknowledge that any and all information, advice and / or feedback regarding prescription medications I receive from Dr. Ilya Skolnikoff and any of his affiliated practitioners and physicians is for informational purposes only. I acknowledge that it is not a specific recommendation to alter the dosage, stop altogether, or begin any prescription medication whatsoever.

By signing this I have acknowledged that I am solely responsible for any alterations I make in my medications. I also realize that it is my responsibility to coordinate any such changes with the prescribing physicians, pharmacists or any others in order to safely and properly do so.

Date _____

Signature _____