





## Osborne Family Chiropractic

734 Cambridge Blvd. Suite 100 • O'Fallon, IL 62269

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Corey A. Osborne DC, DCBCN, DCCN, BCIM • Brandon M. Daniels DC

### OFFICE FINANCIAL POLICY

Thank you for choosing us as your Health Care Provider. Our office is dedicated to rendering the highest quality of care possible, to make you the **absolute healthiest you can be**. We also go to great lengths to make your experience here a pleasant one. For that reason, we wish to inform you of our policies, so that we can all avoid problems or confusion in the future.

1. We accept all major credit cards, checks and cash.
2. **All patients** are considered on a cash basis until an explanation of benefits (EOB) is received from their respective insurance and the coverage is confirmed.
3. All nutritional supplements are non-covered items and payment is expected upon receipt. **Supplements cannot be returned once they have left the office. This is because the FDA deems supplements as food items.**
4. Acupuncture is considered a cash or a non-covered service unless otherwise verified by the patient with their insurance.
5. Applied Kinesiology, K-Laser therapy and vial testing are considered a cash only, non-covered service; therefore, the payment is due at the time of service.
6. All Nutrition cases will be sent to insurance (where applicable) but may be a non-covered service. In that case, the patient will be responsible for all charges.

### For INSURANCE Patients:

1. Quoted insurance benefits are **NOT** a guarantee of payment until it is processed.
2. **Insurance assignment** means that we will receive checks directly from your insurance company on your behalf (so that you don't have to pay us in full for services rendered at each and every visit). This service is done as a **courtesy** to you and **only** for **In-Network** insurance providers (Blue Cross Blue Shield and Medicare). For patients with out of network insurance policies, a superbill may be provided upon request, to be submitted for possible reimbursement.
3. We accept assignment for Active treatment plans only. Any follow-up visits/maintenance care will be payable when services are rendered. Once you have been discharged from active care and placed on enhancement/maintenance care, we will continue to file your In-Network insurance but require full co-payment and/or non-covered service payment at the time of service.
4. We gladly do the work of processing your **In-Network insurance claim and sending in the bills, as well as doing a reasonable degree of follow-up, but please remember that your insurance policy is a contract between you and your insurance company. You are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason.** We are only a third party, they are not responsible to us, so your balance remains your responsibility **whether your insurance company pays or not.**
5. This office will resubmit a claim **ONE TIME**. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
6. Upon receiving any worksheets or EOB's (Explanation of Benefits) from your insurance company that you have questions about, please bring them to our attention. If you should receive a check from your insurance company, while OFC has assignment, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check-it will not come from your insurance company. All insurance payments, **regardless of which company issues a check first**, are applied to your account as long as any balance is due.
7. Any services not covered or coverage reductions by your insurance will be the patient's responsibility, unless we are contracted with your insurance.
8. If you have questions concerning this or any other matter, please speak with the front desk prior to seeing the doctor.
9. Should you discontinue care for any reason, other than being discharged by Dr. Osborne or Dr. Daniels, you agree that any and all balances become due immediately and payable in full, since it may become difficult for us to follow-up on your insurance claim. It will become your responsibility to be reimbursed by your insurance company.

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OFFICE (618) 622-9780 ● FAX (618) 622-9782



ADDITIONAL INFORMATION

1. Payment is required at the time of service. Any balance carried over 60 days, other than previously agreed upon financial arrangements, will become an interest accruing account. Any balance over 90 days will be turned over to a collection agency and *you will be responsible for any collection fees, attorney fees, and/or court costs accrued.*
2. We require at least a 24-hour notice of cancellation. A fee of \$45 will be assessed for missing 2 visits within a (1) year calendar period. For every missed appointment after that, the patient will be charged the \$45 fee. The fee will have to be paid before you can schedule any follow up appointments.
3. At the discretion of the Doctor and staff, we will schedule (1) Saturday per month appointments. If there is a cancellation without a 24-hour notice, a fee of \$50 will be assessed. If there is a no call/no show, the patient will no longer have the ability to schedule appointments on a Saturday. The fee will have to be paid before you can schedule any follow up appointments.
4. Dr. Osborne or Dr. Daniels may suggest laboratory work be done in order to create a care plan for you. You have the right to choose a lab for the testing, one of which OFC may not have any affiliation, but it is not guaranteed your insurance company will cover the charges. Therefore, you will be held responsible for the bill in its entirety and it could result in a significantly larger balance. We will work with you to find the best pricing option, which is usually the cash discount price.
5. We do not accept Workers Compensation (Work Comp) cases. We will only accept Personal Injury (PI) cases if they are submitted through your Medical Payments policy under your Auto Insurance. If you do not have Medical Payments under your auto insurance, you will be responsible for the full payment at the time of service.
6. There will be a \$10 service charge for all returned checks.

Since the information, policies, and benefits described here are subject to change, I acknowledge that revisions to the financial policy may occur. All such changes will be communicated through official notices, and I understand the revised information may supersede, modify, or eliminate existing policies.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient's  
Signature \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_



# =OFC=

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### About you

Today's Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ E-mail \_\_\_\_\_

Patients Name \_\_\_\_\_ What do you prefer to be called? \_\_\_\_\_  
Last First MI

DOB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_ Male/ Female SS# \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Referred By: \_\_\_\_\_ Employer: \_\_\_\_\_

How Long: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employers Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Status: Married Single Divorced Separated Widowed

### Reason for Visit

The reason for this visit is a result of: (circle one) Work Sports Auto Trauma Chronic Onset of condition: \_\_\_\_\_

Briefly explain where pain is located \_\_\_\_\_

### Insurance

Company Name: \_\_\_\_\_ Insured Name (if different from yours) \_\_\_\_\_

SS# \_\_\_\_\_ Relation: \_\_\_\_\_ DOB \_\_\_\_\_

Insured Employer: \_\_\_\_\_

### In Event of Emergency

Who should we contact? \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_



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**Patient Questionnaire**

*In order for us to comply with federal standards, please answer the following questions:*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Preferred Language?**

- English
- Spanish
- Other \_\_\_\_\_

**Race?**

- I do not wish to provide this information
- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Pacific Islander

**Ethnicity?**

- I do not wish to provide this information
- Hispanic or Latino
- Non-Hispanic or Non-Latino

**Smoking Status?**

- Current every day smoker
- Current some day smoker
- Former smoker
- Never Smoker

**Do you have any medication allergies?**

- No known medication allergies
- Yes. What? \_\_\_\_\_

**Are you currently taking any medications? Please Print**

- Not currently prescribed any medications
- Yes...

What? \_\_\_\_\_ mg                      What? \_\_\_\_\_ mg

What? \_\_\_\_\_ mg                      What? \_\_\_\_\_ mg





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**CONSENT TO TREAT**

I hereby request and consent to the performance of chiropractic adjustments and other procedures on me or on \_\_\_\_\_ by Corey A. Osborne DC, DCBCN, DCCN, BCIM, Brandon M. Daniels DC and/or other licensed Doctors of Chiropractic who may be employed by or engaged in practice in the Osborne Family Chiropractic clinic.

I have had an opportunity to discuss with Corey A. Osborne DC, DCBCN, DCCN, BCIM, Brandon M. Daniels DC or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known by the doctor at the time; that is not reasonable to expect the doctor to anticipate or explain all risks and complications: that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedure should know of possible complications which have been alleged. These include, but not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its content, and by signing below, acknowledge my understanding of its contents.

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Relationship/authority if not signed by patient

DOCTOR'S NOTES-

Patient counseled using the following:

Discussion \_\_\_\_\_

Other (please specify) \_\_\_\_\_

X \_\_\_\_\_

\_\_\_\_\_  
Doctor's signature or other



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## HIPAA Notice of Privacy Practices Consent Form

\_\_\_\_\_, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. Patients that have Blue Cross Blue Shield of Illinois (BCBSIL) as their insurance provider: Patient records may be disclosed for risk adjustment activities required by the Patient Protection and Affordable Care Act (PPACA).
4. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; or b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
5. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
6. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
7. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

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8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I furthermore acknowledge that I have the right to authorize access and disclosure of my PHI to anyone of my choosing for scheduling, billing, condition, treatment and prognosis to the following individual(s):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

I request the following restriction(s) to releasing my PHI:

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

**EFFECTIVE DATE**

This Notice is in effect as of 10/14/2013.

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Relationship  
(e.g., Attorney-In-Fact, Guardian,  
Parent if a minor)

Date Signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witness: \_\_\_\_\_



# Brain Health and Nutrition Assessment Form™ (BHNAF)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

## SECTION 1

- Low brain endurance for focus and concentration 0 1 2 3
- Cold hands and feet 0 1 2 3
- Must exercise or drink coffee to improve brain function 0 1 2 3
- Poor nail health 0 1 2 3
- Fungal growth on toenails 0 1 2 3
- Must wear socks at night 0 1 2 3
- Nail beds are white instead of pink 0 1 2 3
- The tip of the nose is cold 0 1 2 3

## SECTION 2

- Irritable, nervous, shaky, or light-headed between meals 0 1 2 3
- Feel energized after meals 0 1 2 3
- Difficulty eating large meals in the morning 0 1 2 3
- Energy level drops in the afternoon 0 1 2 3
- Crave sugar and sweets in the afternoon 0 1 2 3
- Wake up in the middle of the night 0 1 2 3
- Difficulty concentrating before eating 0 1 2 3
- Depend on coffee to keep going 0 1 2 3

## SECTION 3

- Fatigue after meals 0 1 2 3
- Sugar and sweet cravings after meals 0 1 2 3
- Need for a stimulant, such as coffee, after meals 0 1 2 3
- Difficulty losing weight 0 1 2 3
- Increased frequency of urination 0 1 2 3
- Difficulty falling asleep 0 1 2 3
- Increased appetite 0 1 2 3

## SECTION 4

- Always have projects and things that need to be done 0 1 2 3
- Never have time for yourself 0 1 2 3
- Not getting enough sleep or rest 0 1 2 3
- Difficulty getting regular exercise 0 1 2 3
- Feel that you are not accomplishing your life's purpose 0 1 2 3

## SECTION 5

- Dry and unhealthy skin 0 1 2 3
- Dandruff or a flaky scalp 0 1 2 3
- Consumption of processed foods that are bagged or boxed 0 1 2 3
- Consumption of fried foods 0 1 2 3
- Difficulty consuming raw nuts or seeds 0 1 2 3
- Difficulty consuming fish (not fried) 0 1 2 3
- Difficulty consuming olive oil, avocados, flax seed oil, or natural fats 0 1 2 3

## SECTION 6

- Difficulty digesting foods 0 1 2 3
- Constipation or inconsistent bowel movements 0 1 2 3
- Increased bloating or gas 0 1 2 3
- Abdominal distention after meals 0 1 2 3
- Difficulty digesting protein-rich foods 0 1 2 3
- Difficulty digesting starch-rich foods 0 1 2 3
- Difficulty digesting fatty or greasy foods 0 1 2 3
- Difficulty swallowing supplements or large bites of food 0 1 2 3
- Abnormal gag reflex Yes or No

## SECTION 7

- Brain fog (unclear thoughts or concentration) Yes or No
- Pain and inflammation Yes or No
- Noticeable variations in mental speed Yes or No
- Brain fatigue after meals 0 1 2 3
- Brain fatigue after exposure to chemicals, scents, or pollutants 0 1 2 3
- Brain fatigue when the body is inflamed 0 1 2 3

## SECTION 8

- Grain consumption leads to tiredness 0 1 2 3
- Grain consumption makes it difficult to focus and concentrate 0 1 2 3
- Feel better when bread and grains are avoided 0 1 2 3
- Grain consumption causes the development of any symptoms 0 1 2 3
- A 100% gluten-free diet Yes or No

# Brain Health and Nutrition Assessment Form™ (BHNAF)

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

## SECTION 9

- A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease Yes or No
- Family members who have been diagnosed with an autoimmune disease Yes or No
- Family members who have been diagnosed with celiac disease or gluten sensitivity Yes or No
- Changes in brain function with stress, poor sleep, or immune activation 0 1 2 3

## SECTION 10

- A loss of pleasure in hobbies and interests 0 1 2 3
- Feel overwhelmed with ideas to manage 0 1 2 3
- Feelings of inner rage or unprovoked anger 0 1 2 3
- Feelings of paranoia 0 1 2 3
- Feelings of sadness for no reason 0 1 2 3
- A loss of enjoyment in life 0 1 2 3
- A lack of artistic appreciation Yes or No
- Feelings of sadness in overcast weather 0 1 2 3
- A loss of enthusiasm for favorite activities 0 1 2 3
- A loss of enjoyment in favorite foods 0 1 2 3
- A loss of enjoyment in friendships and relationships 0 1 2 3
- Inability to fall into deep, restful sleep 0 1 2 3
- Feelings of dependency on others 0 1 2 3
- Feelings of susceptibility to pain 0 1 2 3

## SECTION 11

- Feelings of worthlessness 0 1 2 3
- Feelings of hopelessness 0 1 2 3
- Self-destructive thoughts 0 1 2 3
- Inability to handle stress 0 1 2 3
- Anger and aggression while under stress 0 1 2 3
- Feelings of tiredness, even after many hours of sleep 0 1 2 3
- A desire to isolate yourself from others 0 1 2 3
- An unexplained lack of concern for family and friends 0 1 2 3
- An inability to finish tasks 0 1 2 3
- Feelings of anger for minor reasons 0 1 2 3

## SECTION 12

- A decrease in visual memory (shapes and images) Yes or No
- A decrease in verbal memory 0 1 2 3
- Occurrence of memory lapses 0 1 2 3
- A decrease in creativity 0 1 2 3
- A decrease in comprehension 0 1 2 3
- Difficulty calculating numbers 0 1 2 3
- Difficulty recognizing objects and faces 0 1 2 3
- A change in opinion about yourself 0 1 2 3
- Slow mental recall 0 1 2 3

## SECTION 13

- A decrease in mental alertness 0 1 2 3
- A decrease in mental speed 0 1 2 3
- A decrease in concentration quality 0 1 2 3
- Slow cognitive processing 0 1 2 3
- Impaired mental performance 0 1 2 3
- An increase in the ability to be distracted 0 1 2 3
- Need coffee or caffeine sources to improve mental function 0 1 2 3

## SECTION 14

- Feelings of nervousness or panic for no reason 0 1 2 3
- Feelings of dread 0 1 2 3
- Feelings of a "knot" in your stomach 0 1 2 3
- Feelings of being overwhelmed for no reason 0 1 2 3
- Feelings of guilt about everyday decisions 0 1 2 3
- A restless mind 0 1 2 3
- An inability to turn off the mind when relaxing 0 1 2 3
- Disorganized attention 0 1 2 3
- Worry over things never thought about before 0 1 2 3
- Feelings of inner tension and inner excitability 0 1 2 3



# Metabolic Assessment Form™

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

## PART I

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

1. \_\_\_\_\_ 4. \_\_\_\_\_  
 2. \_\_\_\_\_ 5. \_\_\_\_\_  
 3. \_\_\_\_\_

## PART II

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

<p><b>Category I</b></p> <p>Feeling that bowels do not empty completely 0 1 2 3</p> <p>Lower abdominal pain relieved by passing stool or gas 0 1 2 3</p> <p>Alternating constipation and diarrhea 0 1 2 3</p> <p>Diarrhea 0 1 2 3</p> <p>Constipation 0 1 2 3</p> <p>Hard, dry, or small stool 0 1 2 3</p> <p>Coated tongue or "fuzzy" debris on tongue 0 1 2 3</p> <p>Pass large amount of foul-smelling gas 0 1 2 3</p> <p>More than 3 bowel movements daily 0 1 2 3</p> <p>Use laxatives frequently 0 1 2 3</p> <p><b>Category II</b></p> <p>Increasing frequency of food reactions 0 1 2 3</p> <p>Unpredictable food reactions 0 1 2 3</p> <p>Aches, pains, and swelling throughout the body 0 1 2 3</p> <p>Unpredictable abdominal swelling 0 1 2 3</p> <p>Frequent bloating and distention after eating 0 1 2 3</p> <p>Abdominal intolerance to sugars and starches 0 1 2 3</p> <p><b>Category III</b></p> <p>Intolerance to smells 0 1 2 3</p> <p>Intolerance to jewelry 0 1 2 3</p> <p>Intolerance to shampoo, lotion, detergents, etc 0 1 2 3</p> <p>Multiple smell and chemical sensitivities 0 1 2 3</p> <p>Constant skin outbreaks 0 1 2 3</p> <p><b>Category IV</b></p> <p>Excessive belching, burping, or bloating 0 1 2 3</p> <p>Gas immediately following a meal 0 1 2 3</p> <p>Offensive breath 0 1 2 3</p> <p>Difficult bowel movements 0 1 2 3</p> <p>Sense of fullness during and after meals 0 1 2 3</p> <p>Difficulty digesting fruits and vegetables; undigested food found in stools 0 1 2 3</p> <p><b>Category V</b></p> <p>Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3</p> <p>Use of antacids 0 1 2 3</p> <p>Feel hungry an hour or two after eating 0 1 2 3</p> <p>Heartburn when lying down or bending forward 0 1 2 3</p> <p>Temporary relief by using antacids, food, milk, or carbonated beverages 0 1 2 3</p> <p>Digestive problems subside with rest and relaxation 0 1 2 3</p> <p>Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine 0 1 2 3</p> <p><b>Category VI</b></p> <p>Roughage and fiber cause constipation 0 1 2 3</p> <p>Indigestion and fullness last 2-4 hours after eating 0 1 2 3</p> <p>Pain, tenderness, soreness on left side under rib cage 0 1 2 3</p> <p>Excessive passage of gas 0 1 2 3</p> <p>Nausea and/or vomiting 0 1 2 3</p> <p>Stool undigested, foul smelling, mucus like, greasy, or poorly formed 0 1 2 3</p> <p>Frequent urination 0 1 2 3</p> <p>Increased thirst and appetite 0 1 2 3</p>	<p><b>Category VII</b></p> <p>Abdominal distention after consumption of fiber, starches, and sugar 0 1 2 3</p> <p>Abdominal distention after certain probiotic or natural supplements 0 1 2 3</p> <p>Lowered gastrointestinal motility, constipation 0 1 2 3</p> <p>Raised gastrointestinal motility, diarrhea 0 1 2 3</p> <p>Alternating constipation and diarrhea 0 1 2 3</p> <p>Suspicion of nutritional malabsorption 0 1 2 3</p> <p>Frequent use of antacid medication 0 1 2 3</p> <p>Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/Diverticulitis, or Leaky Gut Syndrome? Yes No</p> <p><b>Category VIII</b></p> <p>Greasy or high-fat foods cause distress 0 1 2 3</p> <p>Lower bowel gas and/or bloating several hours after eating 0 1 2 3</p> <p>Bitter metallic taste in mouth, especially in the morning 0 1 2 3</p> <p>Burpy, fishy taste after consuming fish oils 0 1 2 3</p> <p>Difficulty losing weight 0 1 2 3</p> <p>Unexplained itchy skin 0 1 2 3</p> <p>Yellowish cast to eyes 0 1 2 3</p> <p>Stool color alternates from clay colored to normal brown 0 1 2 3</p> <p>Reddened skin, especially palms 0 1 2 3</p> <p>Dry or flaky skin and/or hair 0 1 2 3</p> <p>History of gallbladder attacks or stones 0 1 2 3</p> <p>Have you had your gallbladder removed? Yes No</p> <p><b>Category IX</b></p> <p>Acne and unhealthy skin 0 1 2 3</p> <p>Excessive hair loss 0 1 2 3</p> <p>Overall sense of bloating 0 1 2 3</p> <p>Bodily swelling for no reason 0 1 2 3</p> <p>Hormone imbalances 0 1 2 3</p> <p>Weight gain 0 1 2 3</p> <p>Poor bowel function 0 1 2 3</p> <p>Excessively foul-smelling sweat 0 1 2 3</p> <p><b>Category X</b></p> <p>Crave sweets during the day 0 1 2 3</p> <p>Irritable if meals are missed 0 1 2 3</p> <p>Depend on coffee to keep going/get started 0 1 2 3</p> <p>Get light-headed if meals are missed 0 1 2 3</p> <p>Eating relieves fatigue 0 1 2 3</p> <p>Feel shaky, jittery, or have tremors 0 1 2 3</p> <p>Agitated, easily upset, nervous 0 1 2 3</p> <p>Poor memory/forgetful 0 1 2 3</p> <p>Blurred vision 0 1 2 3</p> <p><b>Category XI</b></p> <p>Fatigue after meals 0 1 2 3</p> <p>Crave sweets during the day 0 1 2 3</p> <p>Eating sweets does not relieve cravings for sugar 0 1 2 3</p> <p>Must have sweets after meals 0 1 2 3</p> <p>Waist girth is equal or larger than hip girth 0 1 2 3</p> <p>Frequent urination 0 1 2 3</p> <p>Increased thirst and appetite 0 1 2 3</p> <p>Difficulty losing weight 0 1 2 3</p>
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<b>Category XII</b>				
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
<b>Category XIII</b>				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount 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
<b>Category XIV</b>				
Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3
<b>Category XV</b>				
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 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 hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3
<b>Category XVI</b>				
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

<b>Category XVI (Cont.)</b>				
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3
<b>Category XVII (Males Only)</b>				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3
<b>Category XVIII (Males Only)</b>				
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining 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
Decreased 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
<b>Category XIX (Menstruating Females Only)</b>				
Perimenopausal		Yes	No	
Alternating menstrual cycle lengths		Yes	No	
Extended menstrual cycle (greater than 32 days)		Yes	No	
Shortened menstrual cycle (less than 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	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3
<b>Category XX (Menopausal Females Only)</b>				
How many years have you been menopausal?				_____ years
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 alcoholic beverages do you consume per week? \_\_\_\_\_

Rate your stress level on a scale of 1-10 during the average week: \_\_\_\_\_

How many caffeinated beverages do you consume per day? \_\_\_\_\_

How many times do you eat fish per week? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

How many times do you work out per week? \_\_\_\_\_

How many times do you eat raw nuts or seeds per week? \_\_\_\_\_

List the three worst foods you eat during the average week: \_\_\_\_\_

List the three healthiest foods you eat during the average week: \_\_\_\_\_

### PART IV

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

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



## Osborne Family Chiropractic

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Corey A. Osborne DC, DCBCN, DCCN, BCIM • Brandon M. Daniels DC

### New Patient Information

- NO returns on supplements. Supplements are considered food items, and once they are purchased, they cannot be returned.
- Within one calendar year: two missed appointments without a 24-hour notice will result in a \$45.00 missed appointment charge. Every subsequent missed visit after this charge, will result in a \$45.00 fee. If a Saturday appointment is missed, it will be a \$50 fee.
  - This fee must be paid before you can be seen again.
  - Disclaimer: this policy does not apply to circumstances outside of your control.
  - If you call to cancel after business hours, please leave a message.
- Please take off belts, jewelry, shoes, etc. before laying down on the treatment beds.
- Dr. Osborne's schedule does fill up very quickly (usually about 2 weeks out), so please consider scheduling your appointments in advance.  
We do have a cancellation list available if an appointment is needed short-notice.
- We will not submit claims for Out-of-Network insurance companies. We will gladly print out a Super Bill for you to turn in to your insurance companies for reimbursement.  
We are only In-Network with Blue Cross Blue Shield and Medicare.
- Be sure to visit our Facebook page for more information!

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