Weitz/Dembeck Nutrition Consultation

New Member Packet

Congratulations on your decision to move further on the path to optimal health! We're here to educate and support you as part of our commitment partnering with you in managing your health. The following information is necessary in order for us to optimize your care. Please fill out this form as completely and as accurately as possible.

GENERAL INFORMATION

DATE: _____

Name: _____

Street Address: _____ Apt. No.: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ SS #: _____

Age: _____ Gender: ☐ Female ☐ Male Marital Status: _____

Ethnicity:

- ☐ Caucasian
- ☐ African American
- ☐ Hispanic
- ☐ Asian
- ☐ Native American
- ☐ Other_____

Home Phone: _____ Preferred Language: _____

Work Phone: _____ Cell Phone: _____

E---Mail Address: _____

How did you hear about the practice?

- ☐ Patient referral? _____
- ☐ Dr. Weitz/Dembeck website
- ☐ Referral from MD
- ☐ Yelp
- ☐ Google
- ☐ Social Media
- ☐ Other _____

Occupation: _____ Employer: _____

Emergency Contact

Name: _____ Phone: _____

Relationship: _____

Address: _____ Apt. No.: _____

City: _____ State/Zip: _____

Current Primary Care Physician

Name: _____ Phone #: _____

City: _____

MEDICAL CARE HISTORY

PREVENTIVE TESTS	DATE	SURGICAL HISTORY	DATE
Check box if yes and provide date		*Check box if yes and provide date*	
☐ Full Physical Exam	_____	☐ Appendectomy	_____
☐ Bone Density	_____	☐ Hysterectomy	_____
☐ Colonoscopy	_____	_____ Ovaries Removed:	
☐ Cardiac Stress Test	_____	Right (R) / Left (L) / Both(B)	
☐ EKG	_____	☐ Gall Bladder	_____
☐ Endoscopy	_____	☐ Hernia	_____
☐ Hemoccult (stool test for blood)	_____	☐ Joint Replacement --- Knee/Hip	
☐ Lab work (blood/urine/saliva/stool)	_____	☐ Heart Surgery *(type)*	_____
☐ Mammogram		☐ Angioplasty or Stent	
☐ PAP Smear	_____	☐ Tonsillectomy/Adenoidectomy	_____
☐ PSA	_____	☐ Shingles Vaccine _____	_____
☐ Pacemaker		☐	
	_____		_____
Other _____	_____	Other _____	_____

HOSPITALIZATIONS

Date	Reason for Hospitalization

SPECIALIST CARE ***Please list all physicians that manage your care.***

Physician Name	Medical Specialty	Issue(s) Being Managed

MEDICAL SYMPTOM QUESTIONNAIRE

BASED ON THE PAST 30 DAYS rate each of the following symptoms based upon your typical health profile.

NAME _____ DATE _____

Please use the scale shown below to describe the severity of your symptom (please total each section)

0 ***Never* or *almost never* have the symptom**
1 ***Occasionally* have it, effect is *not severe***
2 ***Occasionally* have it, effect is *severe***
3 ***Frequently* have it, effect is *not severe***
4 ***Frequently* have it, effect is *severe***

HEAD
_____ Headaches
_____ Dizziness/Faintness
_____ Insomnia
_____ **TOTAL (this section)**

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Dark circles under eyes
_____ Vision problems (excluding near or farsighted)
_____ **TOTAL (this section)**

EARS
_____ Itchy ears
_____ Frequent ear infections
_____ Popping of ears
_____ Ringing in ears
_____ **TOTAL (this section)**

NOSE
_____ Stuffy nose/Excessive mucus formation problems
_____ Hay fever/Sneezing attacks
_____ Nose bleeding
_____ **TOTAL (this section)**

MOUTH/
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen/Discolored tongue, gums, lips
_____ Canker sores
_____ **TOTAL (this section)**

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ hair growth
_____ Excessive sweating/Body odor
_____ Flushing, hot flashes
_____ **TOTAL (this section)**

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ **TOTAL (this section)**

LUNGS
_____ Chest congestion
_____ Asthma, frequent bronchitis
_____ Difficulty breathing
_____ Frequent coughing
_____ **TOTAL (this section)**

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea, loose stools
_____ Constipation, hard/infrequent stools
_____ Bloated feeling
_____ Belching, passing gas, burping
_____ Heartburn/acid taste in mouth
_____ Intestinal/stomach pain
_____ **TOTAL (this section)**

JOINTS / MUSCLE
_____ Pain or aches in joints/Arthritis
_____ Warm, swollen joints
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Muscle weakness
_____ **TOTAL (this section)**

WEIGHT
_____ Excessive eating/drinking
_____ Strong/Excessive craving certain foods
_____ Overweight/Obese Sinus
_____ Difficulty losing weight
_____ Water retention
_____ Difficulty gaining weight
_____ **TOTAL (this section)**

ENERGY / ACTIVITY
_____ Fatigue from mental exhaustion
_____ Fatigue from emotional exhaustion
_____ Hyperactivity (mind or body)
_____ Restlessness (mind or body)
_____ **TOTAL (this section)**

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration Excessive
_____ Poor physical coordination
_____ Difficulty making decisions
_____ Speech difficulty
_____ Learning disabilities
_____ **TOTAL (this section)**

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression/Sadness
_____ Obsessive, compulsive behaviors
_____ **TOTAL (this section)**

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ **TOTAL (this section)**

SUM OF ALL SECTIONS ABOVE: _____

PERSONALIZED HEALTH STRATEGY

*Please describe your **top two (2) health goals** you seek to strategically improve.*

I would like to:

Energy-Vitality

- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be les tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ☐ Stop using laxatives and stool softeners
- ☐ Improve sex drive

Body Composition

- ☐ Loose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

Stress, Mental, Emotional

- ☐ Learn how to reduce stress
- ☐ Think more clearly and be more-focused
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less

GOAL #1:

When was the last time you felt well?

Did something trigger your change in health?

Is there anything that makes you feel worse?

Is there anything that makes you feel better?

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success: Excellent	Success: Good	Success: Fair
example: Difficulty maintaining attention		✓		**example: elimination diet**	✓		

MEDICAL HISTORY

DISEASES/DIAGNOSES/CONDITIONS

Check appropriate box and provide date of onset

pc Past Condition (pc) cc Current Condition (cc)

pc	cc	GASTROINTESTINAL	date of onset
☐	☐	Irritable Bowel Syndrome	
☐	☐	Crohn's Disease	
☐	☐	Ulcerative Colitis	
☐	☐	Gastritis or Peptic Ulcer	
☐	☐	GERD (Acid Reflux)	
☐	☐	Celiac Disease	
☐	☐	Other_____	

pc	cc	CARDIOVASCULAR	date of onset
☐	☐	Heart Attack	
☐	☐	Poor Circulation	
☐	☐	Stroke	
☐	☐	High Cholesterol Arrhythmia	
☐	☐	(irregular beat) Hypertension (high	
☐	☐	blood pressure) Heart Valve Disease	
☐	☐	Other _____	
☐	☐		

pc	c c	METABOLIC/ENDOCRINE	date of onset
☐	☐	Type 1 Diabetes	
☐	☐	Type 2 Diabetes	
☐	☐	Hypoglycemia (low blood sugar)	
☐	☐	Metabolic Syndrome	
☐	☐	Insulin Resistance or Pre---diabetes	
☐	☐	Obesity/Overweight	
☐	☐	Hypothyroidism (underactive)	
☐	☐	Hyperthyroidism (overactive)	
☐	☐	Polycystic Ovarian Syndrome (PCOS)	
☐	☐	Infertility	
☐	☐	Other _____	

pc	cc	NEUROLOGIC/PSYCHIATRIC	date of onset
☐	☐	Depression	
☐	☐	Anxiety	
☐	☐	Bipolar Disorder	
☐	☐	Headaches	
☐	☐	Migraines	
☐	☐	ADD/ADHD	
☐	☐	Autism	
☐	☐	Multiple Sclerosis	
☐	☐	Seizures	
☐	☐	Eating Disorder (Anorexia/Bulimia)	
☐	☐	Other _____	

pc	cc	GENITAL AND URINARY SYSTEMS	date of onset
☐	☐	Kidney Stones	
☐	☐	Interstitial Cystitis	
☐	☐	Frequent Urinary Tract Infections	
☐	☐	Frequent Yeast Infections	
☐	☐	Erectile or Sexual Dysfunction	
☐	☐	Urinary Incontinence	
☐	☐	Other _____	

pc	cc	MUSCULOSKELETAL/PAIN	date of onset
☐	☐	Osteoarthritis	
☐	☐	Fibromyalgia	
☐	☐	Gout	
☐	☐	Chronic Pain Syndrome	
☐	☐	Other _____	

pc	cc	INFLAMMATORY/AUTOIMMUNE	date of onset
☐	☐	Chronic Fatigue Syndrome	
☐	☐	Autoimmune Disease	
☐	☐	Rheumatoid Arthritis	
☐	☐	Hashimoto's Thyroiditis	
☐	☐	Psoriasis	
☐	☐	Food Allergies Environmental	
☐	☐	Allergies Multiple Chemical	
☐	☐	Sensitivities	
☐	☐	Other _____	

pc	oc	RESPIRATORY DISEASES	date of onset
☐	☐	Asthma	
☐	☐	Chronic Sinusitis	
☐	☐	Bronchitis	
☐	☐	COPD or Emphysema	
☐	☐	Pneumonia	
☐	☐	Sleep Apnea	
☐	☐	Other _____	

pc	cc	SKIN DISEASES	date of onset
☐	☐	Eczema	
☐	☐	Vitiligo	
☐	☐	Acne	
☐	☐	Other _____	

pc	cc	CANCER	date of onset
☐	☐	Lung Cancer	
☐	☐	Breast Cancer	
☐	☐	Colon Cancer	
☐	☐	Ovarian Cancer	
☐	☐	Prostate Cancer	
☐	☐	Skin Cancer	
☐	☐	Other _____	

FEMALE HISTORY

OBSTETRIC HISTORY *(Check box if yes and provide number of times)*

☐ Pregnancies _____ ☐ Cesarean _____ ☐ Vaginal Deliveries _____

☐ Miscarriage _____ ☐ Abortion _____ ☐ Living Children _____

☐ Postpartum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby over 8 lbs

☐ Breastfeeding For How Long? _____

MENSTRUAL HISTORY

Age at first period _____ Menses Frequency: every _____ days Menses Length: _____ days long

Describe your **current** menstrual cycle ☐ Regular ☐ Irregular ☐ Absent

Details: _____

Last Menstrual Period: _____ Date of Last PAP:

History of Abnormal PAP? ☐ Yes ☐ No If yes, date of abnormal PAP: _____

Current contraception? ☐ Birth Control Pill ☐ Condom ☐ Vasectomy ☐ IUD ☐ Hysterectomy ☐ None

Total years of hormonal contraception use? _____

WOMEN'S DISORDERS/HORMONAL IMBALANCES (check all that apply)

☐ Fibrocystic Breasts ☐ Endometriosis Fibroids ☐ Infertility

☐ Painful Periods | Heavy Periods | PMS | Menstrual Migraines

Are you in Menopause (no menses in last 12 months)? ☐ No ☐ Yes (if yes, What age? _____)

If yes, ☐ Natural ☐ Surgical removal of ovaries reason for removal _____

Current use of hormone replacement therapy?

☐ None

(How Long? _____) ☐ Traditional Prescription

(How Long? _____) ☐ Bioidentical Hormone Replacement Therapy

Previous use of hormone replacement therapy?

☐ None

(How Long? _____) ☐ Traditional Prescription

(How Long? _____) ☐ Bioidentical Hormone Replacement Therapy

Menopausal Symptoms: *Check all that apply*

☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems ☐ Vaginal Dryness

☐ Night Sweats ☐ Sleep problems ☐ Postmenopausal bleeding ☐ Loss of Control of Urine

☐ Headaches ☐ Palpitations ☐ Weight Gain ☐ Depression or Anxiety

MALE HISTORY

Have you had a PSA done? ☐ No ☐ Yes (Date of last PSA? _____)

PSA Level: ☐ 0---1 ☐ 2---4 ☐ 5---10 ☐ >10 Managing Urologist: _____

Check all that apply

☐ Fatigue ☐ Nocturia (urination at night) How many times per night? _____

☐ Irritability ☐ Urgency/Hesitancy/Change in Urinary Stream

☐ Decreased libido ☐ Enlarged Prostate

☐ Erectile Dysfunction

DIGESTIVE/DIETARY HISTORY

TYPICAL DIET: List the most common meal you eat or drink in each category---

Breakfast: _____ Beverage: _____

Lunch: _____ Beverage: _____

Dinner: _____ Beverage: _____

Snack: _____ Beverage: _____

How many cups of water do you drink a day? _____ Cups

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

If yes, ☐ within 30 min after eating ☐ after 1---2 hours of eating

Were there years where you took more than 3 courses of antibiotics per year? ☐ Yes ☐ No

Do you experience frequent yeast infections or toe fungal infections/athlete's foot? ☐ Yes ☐ No

Do you get sick from strong smells, chemicals or medications easier than most people? ☐ Yes ☐ No

Are there some foods to which you are allergic, intolerant or just seem to bother you?

Explain:

Do you suffer from allergies? ☐ Environmental ☐ Food

If environmental, are they. . . ☐ Seasonal ☐ All Year Long

Do you ever find blood in your stool? ☐ Yes ☐ No ☐

How many bowel movements do you have in a typical day? ☐ <1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 _____

If you answered <1, how often do you have a bowel movement? Every _____ days Since When? _____

Describe your typical bowel movement *(check all that apply)*

☐ Hard	☐ Soft	☐ Alternating Diarrhea/constipation	☐ Complete evacuation
☐ Pellet---like	☐ Loose	☐ Mucus in stool	☐ Incomplete evacuation
☐ Requires straining	☐ Watery	☐ Undigested food in stool	
☐ Large	☐ Floating	☐ Strange color/odor	

If you experience any digestive issues, when did they begin?

☐ Last 3---6 months ☐ Since childhood

☐ Last 6---12 months ☐ Can't remember

☐ _____ years ago

Have you ever been referred to a Gastroenterologist? ☐ Yes ☐ No Name:_____

Explain:

LIFESTYLE INFORMATION

SMOKING

Currently Smoking? ☐ Yes ☐ No How many years? _____ Packs per day: _____

Attempts to quit: _____ Using what methods: _____

Previous Smoking? ☐ Yes ☐ No How many years? _____ Packs per day: _____

Quit Date: _____

2nd Hand smoke exposure? ☐ None ☐ Low ☐ Medium ☐ High

☐ Current ☐ Past

ALCOHOL INTAKE

How many drinks currently per week? *(1 drink = 5oz wine, 12 oz beer, 1.5 oz liquor)*

☐ None ☐ 1---3 ☐ 4---6 ☐ 7---10 ☐ >10 ☐ throughout the week ☐ weekends mostly

Do you frequently (more than 2x/week) take:

☐ >1 drink per day for females

☐ >2 drinks per day for males

Previous alcohol intake? ☐ None ☐ Mild ☐ Moderate ☐ High

Do you ever feel guilty about your alcohol consumption? ☐ Yes ☐ No

Do you notice a tolerance to alcohol (you can "hold" more than others)? ☐ Yes ☐ No

Do you notice you 'feel' your alcohol at very low amounts? ☐ Yes ☐ No

OTHER SUBSTANCES

Caffeine intake

Cups per day: Coffee: _____ Tea: _____ (☐ Herbal ☐ Non---Herbal)

Caffeinated or Diet Beverages per day ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ ≥4

List favorite type (e.g. Diet Coke, Pepsi, Red Bull, Monster, etc) _____

Do you often take caffeine to avoid fatigue? ☐ Yes ☐ No

EXERCISE

Current Exercise Program: *Activity (list type, number of sessions/week, and duration of activity)*

Activity	Type	Frequency/week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Yoga/Pilates			
Sports/Leisure Activities *(golf, tennis, rollerblading, etc)*			

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

If yes, please describe: _____

Do you usually sweat when exercising? ☐ Yes ☐ No

Obstacles or challenges with exercise: (check all that apply) ☐ Time ☐ Pain ☐ Energy ☐ Other _____

LIFESTYLE INFORMATION

STRESS/COPING

1. Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No
2. Do you feel you can manage the stress in a healthy way? ☐ Yes ☐ No
3. Do you feel you make unhealthy choices due to high stress? ☐ Yes ☐ No
4. What is the level of stress in you life? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
5. How well do you manage stress in your life? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
6. Would you like to improve the way you manage stress? ☐ Yes ☐ No
7. Have you ever sought counseling? ☐ Yes ☐ No

Daily Stressors ***(rate on a scale of 1---10: 1=lowest, 10=highest)***

Work _____ Family _____ Social _____ Finances _____

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

Check all that apply: ☐ Prayer ☐ Breathing ☐ Meditation ☐ Yoga ☐ Tai Chi ☐ Other _____

SLEEP/REST

How likely are you to doze off or fall asleep in the following situations using the scale below?

0 = Would never doze *2 = Moderate chance of dozing*

1 = Slight chance of dozing *3 = High chance of dozing*

Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching television	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive in a public place (ex, a theater or meeting)	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after a lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3
As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3

Average number of hours you sleep per night? ☐ >10 ☐ 8---10 ☐ 6---8 ☐ <6

Do you have trouble falling asleep at night? ☐ Yes ☐ No

If yes, how long does it usually take to fall sleep? _____

Do you have trouble staying asleep at night? ☐ Yes ☐ No

If yes, how long are you awake throughout the night? _____

How many times do you awaken throughout the night? _____

Please list any sleep aids (prescription or natural) or other methods tried:

READINESS ASSESSMENT

In order to improve your health, how willing are you to ***(Rate on a scale of 5---very willing to 1---not willing)***:

Educate yourself on your condition	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Significantly modify your diet	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Modify your lifestyle (work demands, sleep, etc)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Practice a relaxation technique	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Take several nutritional supplements each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Engage in regular exercise	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Have periodic lab tests to assess your progress	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Comments:

Family History

Please place age at diagnosis where appropriate.	Mother	Father	Brother(s)	Brother(s)	Sister(s)	Sister(s)	Child(ren)	Child(ren)	Child(ren)	Child(ren)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still alive)														
Age at death														
Colon Cancer														
Breast Cancer														
Other Cancers --- List Type _____														
Heart Disease														
Stroke														
Hypertension														
Obesity/Overweight														
Diabetes														
High Cholesterol														
Arthritis (<60 years old)														
Multiple Sclerosis														
Rheumatoid Arthritis / Lupus / Psoriasis														
Ulcerative Colitis / Crohn's Disease														
Irritable Bowel Syndrome (IBS)														
Celiac Disease														
Asthma / Chronic Bronchitis														
Eczema/Hives														
Food Allergies or Sensitivities														
Environmental Sensitivities														
Multiple Chemical Sensitivities														
Dementia or Parkinson's														
Substance Abuse (alcoholism, drugs)														
Depression														
Anxiety														
ADHD														
Autism														
Thyroid Disorders														
Other _____														
Other _____														
Other _____														

MEDICATION HISTORY

Attach separate page as needed

CURRENT MEDICATIONS

Medication	Strength	Dosing Schedule	Start Date (month/year)	Reason for Use?

PREVIOUS MEDICATIONS (*Last 10 years)*

Medication	Strength	Dosing Schedule	Start Date (month/year)	Reason for Stopping?

CURRENT NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement (Name & Brand)	Strength (mg/iu)	Amount/frequency	Start Date (month/year)	Reason for Use

ALLERGIES (ENVIRONMENTAL, FOOD & DRUGS)

Allergen	Associated Symptoms	Treatment needed, if applicable

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, the office of Ben Weitz, DC, originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment.

I understand a Notice of Privacy Practices is available for my review. It provides a complete description of information use and disclosure (a copy can be provided upon my request). I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or health care operations.

I understand that the office of Ben Weitz, DC, is not required to agree to the restrictions requested below. I understand that I may revoke this consent in writing, expect to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the office of Ben Weitz, DC, reserves the right to change their notice and practices prior to implementation in accordance with Section 164.520 of the Code of Federal Regulation. Should the office of Ben Weitz, DC change their notice, they will send a copy of any revised notice to the address I have provided, (US mail or e-mail).

I wish to have the following restrictions for the use and disclosure of my health information

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient/Guardian Signature Date

_____

Patient Name

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I _____give permission to Weitz Sports Chiropractic and Nutrition to release any information, verbally or written, on my behalf to the following persons.

PLEASE PRINT

Name: _____

Phone: (___) _____ Relationship to Patient: _____

Name: _____

Phone: (___) _____ Relationship to Patient: _____

Name: _____

Phone: (___) _____ Relationship to Patient: _____

This notice will expire upon written notice as provided by patient to Weitz Sports Chiropractic and Nutrition.

_____ _____

Patient/Guardian Signature Date

_____

Printed Patient's Name

_____ _____

Witness Signature Date