HOPE FAMILY WELLNESS & CHIROPRACTIC

PROVIDER OF HOPE
AND ADVANCED CARE
WHEN ALL ELSE FAILS

3336 E. CHANDLER HEIGHTS RD
SUITE 123, GILBERT, AZ 85298
WWW.ASKDRKAN.COM
TEL (480)988-6269

NEW CLIENT APPLICATION

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ Date Of Birth _____ Gender M F

Email _____ Cell Phone _____

Facebook Name _____ May we contact you via FB and text Y N

Currently Pregnant? _____ Marital Status: S__ M__ D__ W__ Number of Children: _____

Occupation:_____ How did you hear about us?_____

List Symptoms in Order of Priority (worst first):
1. _____
2. _____
3. _____
4. _____
5. _____

List all previous hospitalizations, surgeries, accidents, fractures, and illnesses. (Use additional pages if necessary)
1. Type: _____ When:_____ Hospitalized? Y___ N___
2. Type: _____ When:_____ Hospitalized? Y___ N___
3. Type: _____ When:_____ Hospitalized? Y___ N___
4. Type: _____ When:_____ Hospitalized? Y___ N___

Females Only:
Have you ever had an abnormal Pap Test? Yes No Reason?_____
Have you a history of ovarian cysts? Yes No Uterine fibroids? Yes No
Cervical Dysplasia? Yes No Endometriosis? Yes No

Please rate the following from 1-10, 10 being the best

energy____ sleep ____ digestion ____ bowel movement ____ mood ____ mental clarity ___

pain ____ circulation ____ libido ____

Height: _____ Current weight: _____ Weight you feel best: _____

Your Health Story

To us, this is the most important part of this packet. We would like you to share with us your health story. This is in your own words, please tell us what you have been going through and how it has affected your life. Please be very specific as this information is crucial to help Dr. Kan manage your case accordingly. If more space is needed, feel free to add additional pages.

When did you first notice your symptoms? Have you received a diagnosis? If so, when?

What type of treatment have you tried? Include medical as well as alternative.

What type of results (or side effects) have you experienced from the treatments?

Share a brief list of family health history. This should include grandparents, parents, and siblings.

Tell me your story. Include your physical story (symptoms, health timeline, etc) along with how it has affected you emotionally (homelife, work, relationships, etc).

Please tell me your frustrations or concerns regarding your experience with doctors so far on your journey.

What are you most concerned about with your condition? Where do you see yourself in 5 years if this is not taken care of?

How would your body look and feel if you didn't have your chronic condition? What types of activities would you do that you are unable to do now?

What are your hopes and expectations of us? What are your expectations of yourself?

Which symptom is your top priority to improve?

Is there anything you back from beginning our natural program? If there is something, how do you foresee yourself overcoming it?

Do you have a good support system to help you through a program which will change your life?

Metabolic Assessment Form

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

PART I

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

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

PART II **Please circle the appropriate number 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 relieved 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 or "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

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

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 movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or 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 VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 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

Category VI (continued)

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

Category VII

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
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	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 VIII

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category IX

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have 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 X

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 and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

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

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under 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

Category XIII

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

Category XIV

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

Category XV

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 XVI

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 XVII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3

Category XVIII *(Males Only)*

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

Category XIX *(Males Only)*

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

Category XX *(Menstruating Females Only)*

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

Category XXI *(Menopausal Females Only)*

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? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

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

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

How many times do you eat fish per week? _____

How many times do you work out 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:

Hope Integrative Wellness Center Client Agreement

This Agreement is made between Hope Integrative Wellness Center (HIW) and the undersigned client, ("You.") HIW and You hereby agree to the following:

- You fully understand and agree that the services provided by HIW IS NOT insurance/medically recognized and may be considered new/experimental/not medically necessary/not reimbursable/not proven. In this understanding, you fully understand that you cannot expect any insurance payment for services rendered and will not seek reimbursement for any care received. You agree that you will not ask us to file or complete any insurance or disability paperworks on your behalf.
- While HIW have confidence that you will derive great benefits from our services, we of course cannot guarantee any cure, relief, or result. Individual results may vary depending on age, pre-existing condition, severity and duration of of your condition, and other uncontrollable factors. Results are also dependent on controllable factors such as personal motivation, time commitment and how closely and effectively you implement the strategies taught. We can guarantee, however that you will learn lots of usable and translatable health and wellness strategies that, when followed by others, have achieved life changing results.
- Having a consultation with Dr. Kan does not mean he can help you or will take you on as a client. You hereby agree to pay for HIW services when they are rendered to you. Payments for services rendered are not refundable for any reason. Please let us know if you need to reschedule or cancel your appointment with 48 hours notice, or you will be charged for the full amount of the appointment.
- Consultations with HIW do not include lab fees or nutritional supplements. The client pays the lab directly. Nutritional supplements estimated monthly investment is $200-$300 per month.
- Non-Cancelable and Non-Refundable: If you are offered and you choose to enroll in one of our coaching programs, you agree that the coaching program is non-cancelable by you and is non refundable. You may not terminate the agreement without expressed written consent by HIW. Our business is registered in Arizona and you agree that our relationship will fall under the jurisdiction of Arizona law.
- Should you fail to remit any of the required payments on time, and have not corrected the situation in a prompt manner, HIW may terminate further services, and you will be responsible for any remaining balance, which is due immediately. We may also terminate services if, in our sole discretion, You are conducting yourself in a manner which is disparaging or disruptive to HIW or infringes upon HIW.
- You understand that services provided by HIW are nutrition and lifestyle coaching. Our services do NOT promote or practice medicine. We do not diagnose, treat, or cure any disease. Nothing we do or imply should be construed as such. We do not attempt to interfere with medical advice in any way. We cannot advise you on your medication given to you by your prescribing physician. Please always ask your prescribing physician about your medication.
- Dr. Peter Kan, D.C. is not a medical doctor and does not practice medicine, nor does he portray himself as such. Dr. Kan does not treat or care for medical emergencies. Dr. Kan and our Certified Holistic Nutritionists serve you in the capacity of nutritional and wellness consultants. You understand that if you are in great pain or discomfort, you should seek MEDICAL TREATMENT.
- Our approach to helping you is to identify deficiencies, toxicities and imbalances in your physiology that may interfere with optimal function, and to recommend lifestyle changes and solutions to restore balance, and thus allowing the body to heal itself. Our methods complement and support your primary medical treatment.

By entering into this Client Agreement, You agree to have read and understand the foregoing provisions and agree to be bound hereby:

Print Name: _____ Email: _____

Signature: _____ Date: _____

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NOTICE OF PRIVACY POLICY and PROTOCOL FOR SECURE STORAGE AND ACCESS OF RECORDS

This notice Describes how Chiropractic and Medical information about you may be used and disclosed and how you can get access to this information. Please review carefully and keep this copy for your record and sign the accompanied Acknowledgement of Receipt.

Use and Disclosures
Here are some examples of how we might have to use or disclose your health care information:

1. Your chiropractor or staff member may have to disclose your health information, including all of your clinical records, to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are potentially responsible for the payment of your service.
3. Your chiropractor and members of the staff may need to use your health information, examination and treatment records and billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your chiropractor and members of the practice staff may need to use your name, address, phone number, email and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you, such as email newsletter, health tip, and upcoming educational workshops. 164.520(b)(I)(iii)(A). If you are not at home to receive the appointment reminder, a message will be left on your machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Right to Use Personal Information From Biographies, Letters, Notes, Pictures, Videos and Other Sources for Promotional Purposes: Any pictures, stories, videos, testimonials, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of Hope Family Wellness & Chiropractic. We reserve the right to use this information about our patients (those who receive services or goods from or through us) for promotional purposes that are directly related to our mission.

By signing the Acknowledgement of Receipt of Privacy Notice, you release to Hope Family Wellness & Chiropractic Center, its agents and employees, all rights to exhibit this work in print and electronic form publicly. You wave any rights, claims, or interests you may have to control the use of your identity or likeness in the photographs or video and agree that any uses described herein may be made without compensation or additional consideration of me.
You hereby grant Hope Family Wellness & Chiropractic Center and its agents and employees the right and license to and consents to the use, reproduction, identification, and showing in any manner of the undersigned, by live telecast, picture or film, and the quoting and publishing of any and all testimonials, comments,

statements, and endorsements made by you for the purpose of supporting or promoting chiropractic care and this office.
I am only waiving my privacy rights under HIPAA, insofar as the picture or accompanying endorsement imply or reveal that I am a patient or a former patient of Dr Peter Kan, DC. All other privacy rights under HIPAA are reserved, unless specifically released by me.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Our Privacy Pledge
We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted Uses and Disclosures Without Your Consent or Authorization
Under Federal Law, we are also permitted or required to disclose your health information without your consent or authorization in the following circumstances:
1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services as an inmate.
3. If we provide health care services to you in an emergency
4. If we are required by law to treat your and were unable to obtain your consent after attempting to do so.
5. If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care,

Other than the circumstances described in the preceding five examples and noted in the uses and disclosures section above, other use of disclosure of your health information will only be made with your written authorization.

Your Right to Revoke Your Authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we received request to revoke your authorization 164.508(b)(5)(i)
2. IF you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to consent any of your claims. If you with to revoke your authorization, please write to us at our office address, c/o Billing Department.

Your Right to Limit Uses or Disclosures
If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know in writing to what individuals or organizations you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with you restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care form another health care provider.

Your Right to Receive Confidential Communication Regarding Your Health Information
We normally provide information about your health to you in person at the time you receive service. We may also mail and/or email you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information in a different form. To help us respond to your needs, please make any request in writing.

Your Right to Inspect and Copy Your Health Information
You have the right to request that we give you an account of the disclosures we have make of your health information for the last six years before the date you request. The accounting will include all disclosures except these disclosures:

6. Required for your treatment, to obtain payment for your services, or to run our practice
7. Make to you or to individuals involved in your care
8. Necessary to maintain a director of the individuals in our facility
9. For national security of intelligence purposes, as required by law
10. That were made prior to the effective date of the HIPPA privacy law

We will provide the first accounting within 12 months period without charge. There is a fee for any additional requests during the next 12 months. When you make your request, we will tell you the amount of the fee, and you will have the opportunity to withdraw of modify your request.

PROTOCOL FOR THE SECURE STORAGE, TRANSPORT AND ACCESS OF YOUR MEDICAL RECORDS
If the doctor terminates or sells the practice and the your medical record will not remain in the same physical location, the doctor will notify you in writing to your last known physical address at least 30 days before the doctor terminates or sells the practice to inform you regarding the future location of your medical records. The doctor will also include information at that time on how you may access your medical records once the doctor terminates or sells his practice.

State law requires the doctor to maintain your medical records for at least 5 years after your last treatment date. For minors under age of 18, their medical records must be kept for at least 5 years after their 18th birthday. Any unclaimed medical records after that period will be shredded and disposed of to protect your identity and privacy. This will only be done after the doctor has made a good faith attempt to reach you in writing to your last known physical address 30 days prior to document disposal.

The doctor will respond only to written request for copies of your medical record. This will be done within 14 days of the written request with your authorized signature.

In compliance to recently passed House Bill 2786, which added Arizona Revised Statute 32-3210.

Your Right to Obtain a Paper Copy of This Notice
If you have agreed to the privacy notice by email, you may request a paper copy of this notice at any time.

Our Duties
We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.
We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notice. If we make a change to the terms of our privacy terms, the change will apply for all your health information in our files.

Re-Disclosure
Information that we use or disclose may be subject to re-disclosure by the person to whim we provide the information and may not longer be protected by federal privacy rules.

Your Right to Complain
You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint, and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to Dr. Peter Kan, Clinical Director, at our office address shown at the top of the opposite page.

To Contact Us
If you would like further information about our privacy policies and practices, please contact Hope Family Wellness & Chiropractic Center at our office address or by phone at (480)988-6269. This notice is effective as of May 14, 2010 or the date of your signed acknowledgement of receipts of this notice. This notice will expire six years after the date upon which the record was created.

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Acknowledgement of Receipt of Notice of Privacy Policy and Protocol for the Secure Storage, Transport and Access of Your Medical Records

I acknowledge that I have read and received a copy of this notice. By my signature, I hereby agree to the release and use of protected health information and testimonials to Hope Family Wellness & Chiropractic as outlined in the Privacy Notice. I choose to opt-in to receive emails from Hope Family Wellness & Chiropractic to my email on file for purposes of office communication and educational purposes such as health tips and patient newsletter.

_____
Print Patient Name

_____ _____
Patient Signature Date

_____
Guardian of Minor - Print Name

_____ _____
Guardian of Minor - Signature Date