# DR. PHYLLIS B. BOOKS
# INTAKE QUESTIONNAIRE

(Please fill in all the information – Please print)

Name ______________ Date ______________ File ______________

Address ______________ City ______________ State ______ Zip ______________

Phone (H) ______________ (O) ______________ Referred by ______________

Cell Phone ______________ Fax ______________ Email ______________

Date of birth ______________ Age ______ ❒ Female ❒ Male SS# ______________ Marital Status M S D W

Occupation ______________ Employer ______________ Years Employed ______

Employer's Address ______________ City ______________ State ______ Zip ______

Spouse's Name ______________ Occupation ______________ Employer ______________

Person Responsible for this Account: ______________

In case of Emergency, call: ______________ *Relationship to patient:* ______________

## HEALTH REPORT:

Describe the chief symptoms that brought you to this office: ______________

______________

______________

______________

List other doctors seen for this and their diagnosis and treatment: ______________

______________

List names of relatives that have or have had similar problems ______________

Have you been treated for any health condition by a physician in the last year? ❒ Yes ❒ No If yes, please explain:

______________

Have you had any x-rays taken in the past year? ❒ Yes ❒ No Females: are you now pregnant? ❒ Yes ❒ No

What diagnostic tests have you had; what were the results? ______________

______________

______________

List dates of operations or serious diseases you have had: ______________

______________

______________

______________

Please relate any childhood accidents, injuries (especially to the head or tail bone), illness and medications. Include diagnosis' rendered: ______________

______________

______________

______________

Check any of the following conditions experienced during the past six months:

| | | | | |
|---|---|---|---|---|
| ❒ Ear Infections | ❒ Digestive Problems | ❒ ADHD | ❒ Recurring Fevers | ❒ Other: |
| ❒ Asthma/Allergies | ❒ Urination Problems | ❒ Car Accident | ❒ Temper Tantrums | ❒ ______ |
| ❒ Scoliosis | ❒ Seizures | ❒ Chronic Colds | ❒ Fitful Sleep | ❒ ______ |

## MUSCULO-SKELETAL

| | Past | Present | Mild | Mod. | Severe | | Past | Present | Mild | Mod. | Severe |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Low back pain | ❒ | ❒ | ❒ | ❒ | ❒ | Leg pain/numbness/weakness | ❒ | ❒ | ❒ | ❒ | ❒ |
| Pain between shoulders | ❒ | ❒ | ❒ | ❒ | ❒ | General stiffness | ❒ | ❒ | ❒ | ❒ | ❒ |
| Neck problems | ❒ | ❒ | ❒ | ❒ | ❒ | Fractures | ❒ | ❒ | ❒ | ❒ | ❒ |
| Arm pain/weakness/numbness | ❒ | ❒ | ❒ | ❒ | ❒ | Foot/ankle problems | ❒ | ❒ | ❒ | ❒ | ❒ |
| Joint pain/stiffness | ❒ | ❒ | ❒ | ❒ | ❒ | Difficult chewing/clicking jaw | ❒ | ❒ | ❒ | ❒ | ❒ |
| Walking problems | ❒ | ❒ | ❒ | ❒ | ❒ | Shoulder problems | ❒ | ❒ | ❒ | ❒ | ❒ |
| Muscle cramps | ❒ | ❒ | ❒ | ❒ | ❒ | Knee problems | ❒ | ❒ | ❒ | ❒ | ❒ |
| | | | | | | Hip problems | ❒ | ❒ | ❒ | ❒ | ❒ |

Please grade the following stresses in order of increasing intensity:

0 = NO AWARENESS OF STRESS 1 = SLIGHTLY STRESSFUL 2 = MODERATELY STRESSFUL 3 = EXTREMELY STRESSFUL

| | | | | |
|---|---|---|---|---|
| Physical stress, trauma, abuse, including: falls, accidents, injuries, and impacts | 0 | 1 | 2 | 3 |
| Emotional/mental stress; includes: loss of loved ones, rapid change in life situation, trauma, abuse | 0 | 1 | 2 | 3 |
| Chemical stress; includes: drugs, smoke, fumes, food additives | 0 | 1 | 2 | 3 |

*Describe*: ______________________________

## BIRTH AND FAMILY HISTORY:

Birth Place: ❒ Home ❒ Hospital ❒ Birth Center

Type of Delivery: ❒ Vaginal ❒ C-Section Length of labor? ____________

Procedures: ❒ Forceps ❒ Vacuum extraction

Complications: ______________________________

How many children in the family? ______________ What number child are you? ___________

Pre-natal experiences:

During pregnancy, mother:

❒ smoked ❒ under physical stress ❒ drank ❒ under emotional stress ❒ on meds ❒ under financial stress

## EMOTIONAL/CHEMICAL FAMILY HISTORY:

| | | *Siblings* | *Mother's side* | *Father's side* | *Comments* |
|---|---|---|---|---|---|
| Depression | ❒ | ❒ | ❒ | ❒ | ______________ |
| Bipolar/manic dep. | ❒ | ❒ | ❒ | ❒ | ______________ |
| ADD | ❒ | ❒ | ❒ | ❒ | ______________ |
| Addictive personality | ❒ | ❒ | ❒ | ❒ | ______________ |

Other significant emotional or chemical history of parents or relatives: ______________________________

Home life

| | | | |
|---|---|---|---|
| Role of mother: | ❒ Available | ❒ Supportive | ❒ Good role model |
| Role of father: | ❒ Available | ❒ Supportive | ❒ Good role model |

## SOCIAL/SCHOOL HISTORY:

Physical activities you enjoy: ❒ Soccer ❒ Football ❒ Gymnastics ❒ Karate ❒ Hockey ❒ Basketball

❒ Volleyball ❒ Dance ❒ Golf ❒ Other ______________________________

How would you describe your personality? ______________________________

Interests and Hobbies? ______________________________

What things do you do well? ______________________________

What things are difficult for you? ______________________________

What is your present reading skill grade level? 1 2 3 4 5 6 7 8 9 10 11 12 12+

If any of your difficulties (academic, social, athletic, etc.) were noticeable to others in school, how were they handled or responded to by your friends, parents, teachers, etc. ______________________________

Discuss any difficulties with mathematics, coordination, concentration, reading, memory, spelling, etc.

At what age did you crawl? Walk? Talk?

## GOALS FOR TREATMENT

It is important that you and the doctor have a clear understanding about what you want and need. Please let us know what your goals are for seeking care in this office:

How will you know when each goal is achieved? ______________________________

I fully understand and agree that all services rendered me are charged directly to me and that I am directly responsible for payment unless other arrangements have been made in writing.

**Patient's or Responsible Party's Signature** ______________________________ **Date** __________

If the patient is a minor, I, being the parent or guardian of the above, a minor, the age of ____ , do hereby consent, authorize and request the above office to administer such treatment deemed advisable, necessary or requested on the above minor. I agree to hold the office harmless from any claims, suits, or damages or complications which may result from such treatment.

Parent's or Guardian's Signature ______________________________ Date __________

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Phyllis Books, D.C. or anyone authorized by Phyllis Books, D.C. of any and all photographs which you have taken of me, negative or positive, and video tapes and audio tapes, for any purpose whatsoever without further compensation to me. All negatives and positives, together with their prints, and all video tapes and audio tapes, shall constitute the property of Phyllis Books, D.C. solely and completely. I hereby consent to the use of my name in any written material for private or public use. I affirm that I am 18 years of age or older and have read this release completely.

Name ______________________________ Date __________

I am the legal guardian of the above-named minor and hereby approve the foregoing and consent to the terms mentioned above. I affirm I have the legal right to issue such consent.

Name ______________________________ Date __________

Signature ______________________________ Witness __________

## Allergy Symptoms Survey Form

Today's Date:_______________________________

Name: ____________________________________ Date of Birth: __________________

Chief Complaint: ____________________________________________________________

________________________________________________________________________

| Symptoms | Please mark your level of discomfort<br>0= No Discomfort 10= Maximum Discomfort |
|---|---|
| Blurred Vision | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Dizziness | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Excessive Gas | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Fainting Spells | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Headaches | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Heartburn | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Indigestion | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Labored Breathing | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Loose Stool | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Morning Fatigue | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Night Sweats | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Poor Memory | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Sexual Impotency | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Swelling in the Joints | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Constipation | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Dry Skin | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Excessive Perspiration | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| General Fatigue | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Heart Palpitations | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Hot Flashes | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Insomnia | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Light Headaches | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Lump in Throat | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Nerves | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Numbness | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Poor/Excessive Appetite | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Shortness of Breath | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Throat Constriction | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Other (list) | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |
| Other (list) | ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ |

## Books Neural Therapy ™ Learning Survey

Client: ________________________________________ Date: ________________

This general survey will provide us with an overview. Please use the side of this form to provide additional information.

In the left hand column, simply put a check mark if you have difficulty with the symptom. In the second column, please note the degree of difficulty from 1-10 (e.g. 1= tiny problem, 10= big problem)

Do you have difficulty with: (please check all that apply, either now or ever in your life)

| Date: | 1-10 | |
|---|---|---|
| | | Reading (e.g. slow, eye wanders, eyes get tired quickly, etc) |
| | | Remembering what you read |
| | | Spelling |
| | | Vision |
| | | Seeing Colors (color blindness, seeing colors more vividly in one eye) |
| | | Concentration |
| | | Hyperactivity |
| | | Sports/motor coordination (e.g. running, throwing a ball) |
| | | Clumsy or accident prone |
| | | Being rebellious/class clown/withdrawn |
| | | Following instructions |
| | | Following multiple instructions at one time |
| | | Reversing numbers or letters |
| | | Memory |
| | | Self-esteem |
| | | Remembering to turn in assignments |
| | | Completing assignments/tasks |
| | | Saying what you really mean |
| | | Getting lost easily |
| | | Confusing left and right |
| | | Getting along with other children |
| | | Getting along with other adults |
| | | Getting along with authority figures (teachers, bosses, etc) |
| | | Bed wetting |
| | | Stuttering (now or in the past) |
| | | Consistency in academic tests and achievements |
| | | Frequently ask someone to repeat what they just said |
| | | Have you ever fallen on your head or tail bone? |
| | | Allergies (please list, if you know) |

## HIPAA NOTICE OF PRIVACY PRACTICE
**Effective Date: May 1, 2008**

**THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

We respect patient confidentiality and only release personal health information about you in accordance with State and Federal law. This notice describes our policies related to the use of the records of your care generated by Books Family Health Center.

### USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond Books Family Health Center. This includes:

**Treatment**

With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside of Books Family Health Center that we are consulting with or referring you to.

**Payment**

Information will be used to obtain payment for the treatment and services provided. This will include providing you with insurance forms for you to complete and submit.

**Healthcare Operations**

We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff. We may also call you by name in the waiting room when your Books Family Health Center staff is ready to see you. We may use or disclose your protected health information, as necessary, to contact you for your appointment.

**Information Disclosed Without Your Consent.**

Under State and Federal law, information about you may be disclosed without your consent in the following circumstances:

**Emergencies**

Sufficient information may be shared to address the immediate emergency you are facing.

**Follow up Appointments**

We will be contacting you to remind you of future appointments, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

**As Required by Law**

This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases, or suspected abuse and neglect such as child, elder or institutional abuse.

**Coroners, Funeral Directors**

We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purpose of carrying out their duties.

**Governmental Requirements**

We may disclose information to a health oversight agency for the activities authorized by law, such as audits, investigations, inspections, and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

**Criminal Activity or Danger to Others**

If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

## PATIENT RIGHTS

**You have the following rights under State and Federal law:**

### Copy of Record

You are entitled to inspect the personal health record Books Family Health Center has generated about you. However, under Federal Law, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. We may charge you a reasonable fee for copying and mailing your record.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You have the right to use another healthcare professional.

### Release of Records

You may consent in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or others whom you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

### Restriction on Record

You may ask us not to use or disclose part of the personal health information. This request must be in writing. Books Family Health Center is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to Books Family Health Center who will consult with the staff involved in your care to determine if the request can be granted.

### Contacting

You may request that we send information to another address or by alternative means. We will honor such requests as long as it is reasonable, and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.

### Amending Record

If you believe that something in your record is incorrect or incomplete, you may request we amend it. In certain cases, we may deny your request. If we deny your request for an amendment, you have a right to file a statement that you disagree with us. We will then file our response, and your statement and our response will be added to your record.

### Accounting for Disclosures

You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operation's purposes, or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release.

### Questions and Complaints

If you have any questions or complaints you may contact Books Family Health Center in writing at our office. You also may complain to the Secretary of Health and Human Services if you believe Books Family Health Center has violated your privacy rights. We will not retaliate against you for filing a complaint.

### Changes in Policy

Books Family Health Center reserves the right to change its privacy policy at any time based on the needs of Books Family Health Center and changes in State and Federal law. You then have the right to object or withdraw the use provided in this notice. A current copy of our Privacy Policy will be posted in the lobby.

We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number.

**Signature below is only acknowledgement that you have received this Notice of Privacy Practices.**

Print Name: ________________________________________ Signature: ___________________________________

Date: _______________________________