John Douillard's LifeSpa
6662 Gunpark Drive, Suite 102, Boulder, CO 80301
Phone: 303.516.4848, Fax: 303.530.4409
info@lifespa.com, lifespa.com

Welcome to our office! Please take a few moments to tell us about yourself.

Instructions (Please send completed paperwork to us 5 days prior to your scheduled appointment)

Complete on a Computer

1. Save this form to your computer.
2. Fill out form.
3. You can type your signature into the signature fields.
4. Save this completed form to your computer and **upload it securely** at the webpage: http://lifespa.com/new-patient-paperwork/.

Complete Handwritten

1. Print out this form.
2. Fill out form.
3. **Fax or scan/upload** this form back to (303) 530-4409 or **upload it securely** here: http://lifespa.com/new-patient-paperwork/.

Date: ______________________________ Referred By: ______________________________

Name: ______________________________ Parent/Guardian: ______________________________

Address: ____

____

City: ____________________________ State: ______________ Zip: ______________

Home Phone: ______________________ Work: ______________ Cell: ______________

Email Address: ______________________________ Send me your *free* health newsletter: ☐

Date of Birth: ______________________________ Age: ______________________________

Weight: ________ Height: ________ # of Children ____________ # of Siblings: ____________

Marital Status: ____ Married ____Single ____Partner ____Separated ________Divorced ____ Widow(er)

Occupation/School: ______________________ Employer: ______________________________

How did you hear about us?: ____

Why did you choose LifeSpa?: ____

Please list current complaints in order of severity:

1)______________________________ For how long?: ______________________________

2)______________________________ For how long?: ______________________________

3)______________________________ For how long?: ______________________________

4)______________________________ For how long?: ______________________________

5)______________________________ For how long?: ______________________________

Check the time of day you feel the most energy or the least symptoms:		
____7am- 9am	____3pm-5pm	____11pm-1am
____9am-11am	____5pm-7pm	____1am-3am
____11am-1pm	____7pm-9pm	____3am-5am
____1pm-3pm	____9pm-11pm	____5am-7am

Check the time of day you feel worst or when symptoms are aggravated:		
____7am – 9am	_____3pm-5pm	____11pm-1am
____9am-11am	_____5pm-7pm	____1am-3am
____11am-1pm	_____7pm-9pm	____3am-5am
____1pm-3pm	_____9pm-11pm	____5am-7am

Check symptoms that apply:

____ Headaches
____ Neck pain
____ Neck stiffness
____ Pins & needles
____ Itching/Rash
____ Numbness
___ Disinterest in Sex
___ Irritability
___ Chest pains
___ Dizziness
___ Shortness of breath
___ Sleeping problems
_____ Digestive problems
_____ Lightheaded
_____ Low back pain
_____ Vomiting
_____ Depression
_____ Incontinence
____ Other: ____

Date of last Physical Exam ______________________ Family Physician: ____________________

Do you wear:

___ Corrective lenses ___ Dentures ____Hearing Aid
___ Medical Devices/prosthetics/implants (describe):
____

Circle the level of stress you are experiencing on a scale of 1 - 10 *(1 being the low, 10 being high):*
1 2 3 4 5 6 7 8 9 10

Have you had an unintentional weight loss or gain of 10 pounds or more, in the last three months?
____Yes ____No

What medications are you currently taking?

________________________________ for: ______________________________________
________________________________ for: ______________________________________
________________________________ for: ______________________________________
________________________________ for: ______________________________________

Please list major hospitalizations, injuries, surgeries, illnesses & car accidents:

Year	Procedure/injury	Outcome

Family History	**Diabetes**	**Heart Disease**	**Cancer**	**Back Pain**	**Headaches**
Mother					
Father					
Sibling(s)					
Grandparents					

Health Habits:

_____ Tobacco: Cigarettes: #/day: ___________
Cigars: #/day: ___________
_____ Alcohol: Wine: # glasses/day or wk: ___________
Liquor: # oz/day or wk: ___________
Beer: # glasses/day or wk: ___________
_____ Caffeine: Coffee: # 6 oz cups/day: ___________
Tea: # 6 oz cups/day: ___________
Soda w/caffeine: #cans/day: ___________
_____ Water: # Glasses/day: ___________
_____ Other: ___________

Exercise

_____ 5-7 days per week
_____ 3-4 days/ week
_____ 1-2 days/ week

_____ 45+ min duration/workout
_____ 30-45 min duration/workout
_____ Less than 30 min

_____ Walk
_____ Tennis
_____ Swim
_____ Hike
_____ Run, jog, jump rope
_____ Weights
_____ Yoga
_____ Other

Nutrition & Diet

_____ Mixed food diet (animal & vegetable sources)
_____ Vegetarian (no animal products whatsoever)
_____ Salt restriction
_____ Fat restriction
_____ Starch/carbohydrate restriction
_____ Total calorie restriction
_____ Commercial diet (which one?): ___________
Other: ___________

Eating Habits

_____ 3 square meals/day
_____ Skip breakfast
_____ Two meals/day
_____ One meal/day
_____ Graze (small frequent meals)
_____ Food rotation
_____ Eat constantly whether hungry or not
_____ Generally eat on the run or while distracted
_____ Add salt to food
_____ Snacks

Specific food restriction/allergies:

_____ Dairy ____ Wheat ___ Soy ____ Eggs ___ Corn ____ All Gluten

_____ Other: ___________

Would you like to:

_____ Have more energy
_____ Be stronger
_____ Have more endurance
_____ Increase your sex drive
_____ Be thinner
_____ Be more muscular
_____ Improve your complexion
_____ Have stronger nails
_____ Have healthier hair
_____ Be less moody
_____ Be less depressed
_____ Be less indecisive
_____ Feel more motivated
_____ Be more organized
_____ Think more clearly and be more focused
_____ Improve memory
_____ Do better on tests in school
_____ Stop using laxatives or stool softeners
_____ Be free of pain
_____ Sleep better
_____ Have agreeable breath
_____ Have agreeable body odor
_____ Have stronger teeth
_____ Get fewer colds and flus
_____ Get rid of your allergies
_____ Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
_____ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

Current Supplements:

_____ Multivitamin/mineral
_____ Vitamin C
_____ Vitamin E
_____ Vitamin D
_____ EPA/DHA
_____ Evening Primrose/GLA
_____ Calcium, source: ___________
_____ Magnesium
_____ Zinc
_____ Minerals, describe: ___________
_____ Friendly flora (acidophilus)
_____ Digestive enzymes
_____ Amino acids
_____ CoQ10
_____ Antioxidants (e.g., lutein, resveritrol, etc.)
_____ Herbs – teas
_____ Herbs – extract
_____ Chinese herbs: ___________
____
_____ Ayurvedic herbs: ___________
____
_____ Homeopathy: ___________
_____ Bach flowers
_____ Protein shakes
_____ Superfoods (bee pollen, phytonutrient blends)
_____ Liquid meals (e.g., Ensure): ___________
_____ Other: ___________

Sign or Type Signature (Patient or Guardian) ___________ **Date** ___________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please contact me with protected health information (PHI) in the following manner. (This does not include appointment confirmation calls or other general administrative information):

_____Home Telephone ________________________

_____OK to leave message with detailed information

_____Leave message with call-back number only

_____Written Communication

_____OK to mail to my home address

_____OK to mail my work/office address

_____OK to fax to this number:_______________

_____Work Telephone ________________________

_____OK to leave message with detailed information

_____Leave message with call-back number only

_____Other _____________________________

____

____

____
Sign or Type Signature (Patient or Guardian)

____
Date

____
Print Client's Name

____
Print Guardian's Name

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. **Note: Uses and disclosures of information may be permitted without prior consent in an emergency.**

For office use only:

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or fax #	(1)	Description & purpose of disclosure	Disclosed by whom	Type (2)	Method (3)

(1) Check this box if disclosure is authorized by patient or legal guardian.
(2) Type key: T=Treatment Records, P=Payment Information, A=Authorization on File, O=Other
(3) Enter how disclosure was made: F=Fax, P=Phone, E=Email, M=Mail, O=Other

Dr. John Douillard D.C., Ayurvedic Consults

DISCLOSURE AND RELEASE AND WAIVER OF LIABILITY AGREEMENT

I, the undersigned (client), acknowledge that I have read and understood the contents of this agreement.

1. Dr. John Douillard, D.C. and LifeSpa Professional LLC make no representations, claims, or guarantees regarding the efficacy of his recommendations. The recommendations are based upon a combination of his clinical experience in the state of Colorado and knowledge of natural health literature. A natural health consultation as provided by Dr. John Douillard D.C. does not constitute a medical service or health care treatment.
2. I also grant permission to John Douillard D.C. to perform such examinations and therapeutic treatments as are considered necessary or advised for my diagnosis and treatment plan. I understand that I may look at my medical record at any time and may request a copy of it. I understand that the nature of the recommended treatments for my care will be explained to me and that I will have the opportunity to ask questions of those involved in my care. I am not being forced to accept treatment.
3. The title of “Dr.” is used to indicate the achievement of a Doctor of Chiropractic degree and does not imply that Dr. John Douillard is licensed to practice medicine in the state of Colorado. Dr. John Douillard D.C. maintains a license to practice chiropractic in Colorado because there is no license to recognize Ayurveda in the United States.
4. Individualized recommendations are offered and applied as an educational and informative consultation. Any action taken as a result of the consultation is done at the sole discretion of the client. Therefore, it is strongly recommended that in addition to any health consultation that you maintain a relationship with one or more physicians qualified to care for health condition(s). For example, in the case of children I advice that you seek the advice of a pediatrician; if you have cardiovascular disease, consult with a cardiologist; and if you have cancer, consult with an oncologist, etc.
5. Your signature verifies that you have not been told to discontinue treatments with any other medical specialists or other health care providers. Your signature is being given prior to rendering any service, advice, and/or recommendations whatsoever.
6. Financial Policy: Patients are fully responsible for all professional services, herbs, supplements, or equipment received. We are not contracted with insurance companies and do not bill for services. We are able to provide you with an insurance superbill with appropriate diagnosis and procedure codes and a receipt that you may submit for reimbursement. I, the undersigned, understand that I am responsible for all charges. I understand that failure to pay is illegal.
   a. We will collect full payment for any nutritional supplies, supports, and any therapeutic appliances the day they are prescribed.
   b. We will charge a $25 fee for any returned checks.
   c. Office Visit Cancellation: We require a 24-hour (business days) advance notice of an office visit cancellation. There is a 50% fee for visits not cancelled 24 hours (business days) in advance.
7. Supplements: Dr. John Douillard D.C., LifeSpa Professional LLC, and LifeSpa Products LLC make available nutritional supplements and other health products. You are in no way obligated to purchase these products from this office or any other specific location or company. You may freely choose to purchase such products from any source(s) as you wish.
8. Follow up: It is the responsibility of the client to follow up for results of all testing and laboratory procedures. It should not be assumed on the part of the client that if they are not contacted by LifeSpa Professional LLC or if the patient does not schedule or keep a consultation, that test results are normal (or without abnormalities), and may not require further medical treatments or advice. Health/medical recommendations and/or possible referral and additional follow-up may be warranted based upon laboratory testing and evaluations.

By typing or printing my name in the signature field below (which shall constitute my signature), I agree to comply with the above polices and acknowledge that I understand all terms, verbiage (language) and concepts herein. ***I understand this consent agreement and have executed it freely and willingly.***

______________________________	______________________________
Sign or Type Signature (Patient or Guardian)	Date
______________________________	______________________________
Print Patient’s Name	Print Guardian’s Name

CONFIDENTIAL PATIENT FILE DISCLOSURE AGREEMENT (OPTIONAL)

I, the undersigned (client), acknowledge that I have read and understood the contents of this agreement.

I give Dr. John Douillard D.C., LifeSpa Professional LLC, LifeSpa Products LLC, its officers and employees the right to publish my health history as a case study for educational purposes. I understand that my name will be kept anonymous and all my account information will remain confidential.

By typing or printing my name in the signature field below (which shall constitute my signature), I agree to comply with the above disclosure and acknowledge that I understand all terms, verbiage (language) and concepts herein. ***I understand this consent agreement and have executed it freely and willingly.***

______________________________	______________________________
Sign or Type Signature (Patient or Guardian)	Date
______________________________	______________________________
Print Patient's Name	Print Guardian's Name