John Douillard's LifeSpa
PO Box 701, Niwot, CO 80544
Phone: 303.516.4848, Fax: 720.798-1976
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 (720) 798-1976 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: _____

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
- ☐ Other: _____

- ☐ Disinterest in Sex
- ☐ Irritability
- ☐ Chest pains
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Sleeping problems

- ☐ Digestive problems
- ☐ Lightheaded
- ☐ Low back pain
- ☐ Vomiting
- ☐ Depression
- ☐ Incontinence

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