Harmony Healing Center, P.C.

Brandon M. Lundell, DC, APC, DABCI, Dipl. Ac., NE
714 Kimbark St. • Longmont, Co 80501
303-651 1502 • Fax: 303-651-9383

Extremely Important. Please read.

Welcome to our office! We look forward to becoming your partner in evaluating and improving your health. Please take the time prior to your first visit to fill out all the forms included in the new patient packet. Give yourself plenty of time to fill in everything as accurately and thoughtfully as possible. This may be the most important step in your health and recovery. Knowing the history and underlying aspects of your case ensures a more accurate assessment and efficient treatment recommendations. It is often the smallest, most seemingly insignificant detail that turns out to be an important factor in how you got to where you are now. **It is extremely important to return all the forms completely filled out at least 2 weeks prior to your scheduled first visit so that Dr. Lundell will have time to review your case before you meet with him.** Please send by email, regular mail or fax.

In your first visit Dr. Lundell will obtain a complete medical history and interview. The key to functional medicine is treating each person as an individual and getting to the root cause of health problems. That generally entails a detailed conversation about your current state of health, health history, family history, diet, lifestyle habits, etc. At that point, Dr. Lundell will discuss with you potential approaches and recommended laboratory workups. This visit will last approximately 60 minutes and is primarily an **information gathering and sharing session, as well as a sort of two-way interview**. You are about to embark on a whole new health journey. Both you and Dr. Lundell will decide if a respectful, healing relationship is possible and if this is a good fit for success and growth. Dr. Lundell may make some simple recommendations at this time, but most advice and treatments will be given after laboratory and physical exam results are obtained and there has been time to thoughtfully consider your case.

The second visit is generally scheduled a week or two later. It is at that time that Dr. Lundell will discuss your "review of findings" which may include reviewing your laboratory results if any were performed, as well as what treatment options are most appropriate for your case. You and Dr. Lundell will then decide on what treatments to begin, which may include supplementation (vitamins, herbs, etc.), diet recommendations, lifestyle modifications, chiropractic, acupuncture, specific exercise instruction etc. Dr. Lundell believes firmly that a key component in healing is for you to understand what is really happening in your body, on as many levels as possible – biochemical, physical, molecular, nutritional, energetic etc. Expect to learn a lot about what is really going on and why you are feeling the way you are!

How often you see Dr. Lundell will depend on the severity and response of your condition and the motivation you have for learning and healing. There is usually much information to gather, prioritize and review in order for you to fully understand all the factors contributing to your current state of health or disease. The healing process takes time, patience consistency and perseverance. Dr. Lundell encourages each person must take responsibility for his/her own health, and he will help educate, guide, elucidate and support you along the way. The initial few months require the greatest amount of investment of time, energy, finances, etc. And you are worth it; there is no better time than now. The degree you see improvement is equal to the degree of commitment you are willing to put forth. Dr. Lundell can't do it for you. He will show you how and support you along the way. So, it is up to you, and you can do it!

If you have any further questions after reading the enclosed information, please feel free to call or email our office. We will be happy to assist you. Please be sure to complete all forms and send them to us before your scheduled visit. We look forward to working with you!

In health,

Dr. Lundell and Staff

Harmony Healing Center, P.C.

Dr. Brandon M. Lundell, DC, DABCI, APC, IFMCP, Dipl. Ac.
714 Kimbark St., Longmont, CO 80501 - 303.651.1502 - Fax: 303.651.9383

Date: _____

GENERAL INFORMATION *(If more space is needed when filling in certain sections, please feel free to provide separate sheet)*

Name: *First*_____ *Middle*_____ *Last*_____
Preferred Name:_____
Date of Birth: _____/_____/_____ Age: _____ Gender: □ Male □ Female

Primary Address: _____ Apt. No.: _____
City: _____ State: _____ Zip: _____
Alternate Address: _____ Apt. No.: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Best Phone and Times to Reach You: _____
Email: _____ Fax: _____
Emergency Contact: Name _____ Phone_____
Relationship to you_____ Address: _____
City: _____ State: _____ Zip: _____

Your Genetic Background: □ African □ Asian □ European □ Ashkenazi □ Native American
□ Middle Eastern □ Mediterranean □ Other _____
Highest Education Level: □ High School or Equivalent □ Graduate □ Post-Graduate
Job Title: _____
Nature of Business: _____
Primary Pharmacy: Name_____ Phone_____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____ Fax: _____

Whom may we thank for referring you? _____
□ Book □ Website □ Media □ Other _____

Insurance Information

Dr. Lundell is not in network with any insurance company. We do not bill directly to any insurance carrier. If you would like a superbill to submit to insurance, note that there will be a fee associated with this service. ***Please carefully read the additional insurance forms you will need to fill out separately from this intake.***

Payment Information *Payment is due at time of service, no exceptions. If you would like to submit a claim for payment of services to your insurance company, we will provide you with a statement for a small setup and statement fee. Please see our insurance policy handouts for more information. Knowledge and awareness of insurance coverage is the sole responsibility of the patient.*

Health Concerns & Goals

Please list current and/or ongoing areas of concern you would like to address in order of priority.

Health Concern or Goal #1 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #2 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #3 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

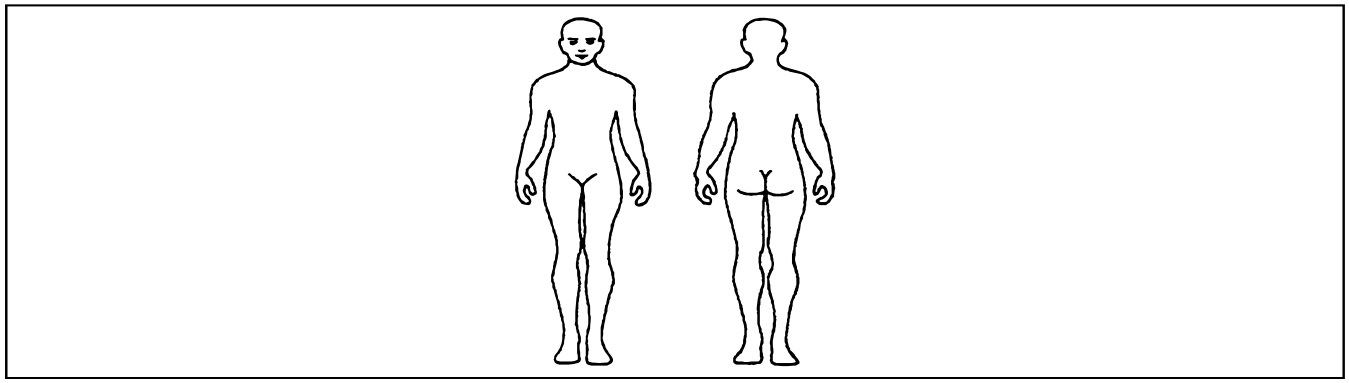
In general, what do you hope to achieve with your visits here? _____

_____

_____

When was the last time you felt exceptionally well? _____

Please mark any areas of concern with as much detail as you can. Please write anywhere in the box



Other comments you think are important _____

_____

Medical History

Please list all other healthcare providers with whom you have received treatment within the last 10 years:

□ Doctor of Chiropractic *Name:* _____ *City:*_____

Treatment Focus: _____

□ M.D. / D.O. *Name:* _____ *City:*_____

Treatment Focus: _____

□ Physical Therapist *Name:* _____ *City:*_____

Treatment Focus: _____

□ Acupuncture *Name:* _____ *City:*_____

Treatment Focus: _____

□ *Other:* _____

Name: _____ *City:*_____

Treatment Focus: _____

Medical History *continued*

Hospitalizations □ None

*Date*_____ - *Reason* _____

_____ - _____

_____ - _____

_____ - _____

Allergies

Medication/Supplement/Food	*Reaction*
_____	_____
_____	_____
_____	_____
_____	_____

Diseases/Diagnosis/Conditions: *Check appropriate box and provide Month/Year of onset* □ *Past Condition* □ *Ongoing Condition*

Gastrointestinal
- □ □ Irritable Bowel Syndrome ___/____
- □ □ Inflammatory Bowel Disease ___/____
- □ □ Crohn's ___/____
- □ □ Ulcerative Colitis ___/____
- □ □ Gastritis or Peptic Ulcer Disease ___/____
- □ □ GERD *(reflux)* ___/____
- □ □ Celiac Disease ___/____
- □ □ Hemorrhoids ___/____
- □ □ Other ___/____ _____

Cardiovascular
- □ □ Heart Attack ___/____
- □ □ Other Heart Disease ___/____
- □ □ Stroke ___/____
- □ □ Elevated Cholesterol ___/____
- □ □ Arrhythmia *(irregular heart rate)* ___/____
- □ □ Hypertension *(high blood pressure)* ___/____
- □ □ Rheumatic Fever ___/____
- □ □ Mitral Valve Fever ___/____
- □ □ Other ___/____ _____

Cancer
- □ □ Lung Cancer ___/____
- □ □ Breast Cancer ___/____
- □ □ Colon Cancer ___/____
- □ □ Ovarian Cancer ___/____
- □ □ Prostate Cancer ___/____
- □ □ Skin Cancer ___/____
- □ □ Other ___/____ _____

Genital & Urinary Systems
- □ □ Kidney Stones ___/____
- □ □ Gout ___/____
- □ □ Interstitial Cystitis ___/____
- □ □ Frequent Urinary Tract Infections ___/____
- □ □ Frequent Yeast Infections ___/____
- □ □ Erectile or Sexual Dysfunctions ___/____
- □ □ Other ___/____ _____

Metabolic/Endocrine
- □ □ Type 1 Diabetes ___/____
- □ □ Type 2 Diabetes ___/____
- □ □ Hypoglycemia ___/____
- □ □ Metabolic Syndrome *(Insulin Resistance/ Pre-Diabetes)*___/____
- □ □ Hypothyroidism *(low thyroid)* ___/____
- □ □ Hyperthyroidism *(overactive thyroid)* ___/____
- □ □ Endocrine Problems ___/____
- □ □ Polycystic Ovarian Syndrome *(PCOS)* ___/____
- □ □ Infertility ___/____
- □ □ Weight Gain ___/____
- □ □ Weight Loss ___/____
- □ □ Frequent Weight Fluctuations ___/____
- □ □ Bulimia ___/____
- □ □ Anorexia ___/____
- □ □ Binge Eating Disorder ___/____
- □ □ Night Eating Syndrome ___/____
- □ □ Eating Disorder *(non-specific)* ___/____
- □ □ Other ___/____ _____

Musculoskeletal/Pain
- □ □ Osteoarthritis ___/____
- □ □ Fibromyalgia ___/____
- □ □ Chronic Pain ___/____
- □ □ Tendonitis ___/____
- □ □ Tension Headaches ___/____
- □ □ TMJ Problems ___/____
- □ □ Foot Cramps ___/____
- □ □ Joint Deformity ___/____
- □ □ Joint Pain ___/____
- □ □ Other ___/____ _____

Diseases/Diagnosis/Conditions: *continued*

Inflammatory/Autoimmune
- □ □ Chronic Fatigue Syndrome ___/____
- □ □ Autoimmune Disease ___/____
- □ □ Rheumatoid Arthritis ___/____
- □ □ Lupus SLE ___/____
- □ □ Immune Deficiency Disease ___/____
- □ □ Herpes-Genital ___/____
- □ □ Cold Sores ___/____
- □ □ Severe Infectious Disease ___/____
- □ □ Poor Immune Function *(frequent infections* ___/____
- □ □ Food Allergies ___/____
- □ □ Environmental Allergies ___/____
- □ □ Multiple Chemical Sensitivities ___/____
- □ □ Latex Allergy ___/____
- □ □ Other ___/____ _____

Respiratory Diseases
- □ □ Asthma ___/____
- □ □ Chronic Sinusitis ___/____
- □ □ Bronchitis ___/____
- □ □ Emphysema ___/____
- □ □ Pneumonia ___/____
- □ □ Tuberculosis ___/____
- □ □ Sleep Apnea ___/____
- □ □ Other ___/____ _____

Head, Eyes, & Ears
- □ □ Conjunctivitis ___/____
- □ □ Distorted Sense of Smell ___/____
- □ □ Distorted Taste ___/____
- □ □ Ear Fullness ___/____
- □ □ Ear Pain ___/____
- □ □ Hearing Loss ___/____
- □ □ Hearing Problems ___/____
- □ □ Headache ___/____
- □ □ Migraine ___/____
- □ □ Sensitivity to Loud Noises ___/____
- □ □ Vision Problems *(other than glasses)* ___/____
- □ □ Macular Degeneration ___/____
- □ □ Vitreous Detachment ___/____
- □ □ Retinal Detachment ___/____
- □ □ Other ___/____ _____

Nails
- □ □ Bitten ___/____
- □ □ Brittle ___/____
- □ □ Curve Up ___/____
- □ □ Frayed ___/____
- □ □ Fungus-Fingers ___/____
- □ □ Fungus-Toes ___/____
- □ □ Pitting ___/____
- □ □ Ragged Cuticles ___/____
- □ □ Ridges ___/____
- □ □ Soft ___/____
- □ □ Thickening of Finger Nails ___/____
- □ □ Thickening of Toenails ___/____
- □ □ White Spots/Lines ___/____
- □ □ Other ___/____ _____

Skin Diseases
- □ □ Acne on Back ___/____
- □ □ Acne on Chest ___/____
- □ □ Acne on Face ___/____
- □ □ Acne on Shoulders ___/____
- □ □ Athlete's Foot ___/____
- □ □ Bumps on Back of Upper Arms ___/____
- □ □ Cellulite ___/____
- □ □ Dark Circles Under Eyes ___/____
- □ □ Ears Get Red ___/____
- □ □ Easy Bruising ___/____
- □ □ Lack of Sweating ___/____
- □ □ Hives ___/____
- □ □ Jock Itch ___/____
- □ □ Lackluster Skin ___/____
- □ □ Moles w/ Color/Size Change ___/____
- □ □ Oily Skin ___/____
- □ □ Pale Skin ___/____
- □ □ Patchy Dullness ___/____
- □ □ Rash ___/____
- □ □ Red Face ___/____
- □ □ Sensitive to Poison Ivy/Oak ___/____
- □ □ Shingles ___/____
- □ □ Skin Darkening ___/____
- □ □ Strong Body Odor ___/____
- □ □ Hair Loss ___/____
- □ □ Vitiligo ___/____
- □ □ Eczema ___/____
- □ □ Psoriasis ___/____
- □ □ Melanoma ___/____
- □ □ Skin Cancer ___/____
- □ □ Other ___/____ _____

Neurologic/Mood
- □ □ Depression ___/____
- □ □ Anxiety ___/____
- □ □ Bipolar Disorder ___/____
- □ □ Schizophrenia ___/____
- □ □ Headaches ___/____
- □ □ Migraines ___/____
- □ □ ADD/ADHD ___/____
- □ □ Autism ___/____
- □ □ Mild Cognitive Impairment ___/____
- □ □ Memory Problems ___/____
- □ □ Parkinson's Disease ___/____
- □ □ Multiple Sclerosis ___/____
- □ □ ALS ___/____
- □ □ Seizures ___/____
- □ □ Other Neurological Problems _____

Blood Type

□ A □ B □ AB □ O □ Rh+ □ unknown

Injuries

Check box if yes and provide date/description
- □ Back Injury ___/____ _____
- □ Head Injury ___/____ _____
- □ Neck Injury ___/____ _____
- □ Broken Bones ___/____ _____
- □ Other ___/____ _____

Diseases/Diagnosis/Conditions: *continued*

Female Reproductive
□ □ Breast Cysts ___/____
□ □ Breast Lumps ___/____
□ □ Breast Tenderness ___/____
□ □ Ovarian Cysts ___/____
□ □ Poor Libido ___/____
□ □ Vaginal Discharge ___/____
□ □ Vaginal Odor ___/____
□ □ Vaginal Itch ___/____
□ □ Vaginal Pain with Sex ___/____
□ □ Other ___/____ _____

Surgeries
Check box if yes and provide date of surgery
□ None
□ Appendectomy ___/____
□ Hysterectomy +/- Ovaries ___/____
□ Gall Bladder ___/____
□ Hernia ___/____
□ Tonsillectomy ___/____
□ Dental Surgery ___/____
□ Joint Replacement: Knee/Hip ___/____
□ Heart Surgery: Bypass Valve ___/____
□ Angioplasty or Stent ___/____
□ Pacemaker ___/____
□ Other ___/____ _____

Male Reproductive
□ □ Discharge from penis ___/____
□ □ Ejaculation Problem ___/____
□ □ Genital Pain ___/____
□ □ Impotence ___/____
□ □ Prostate or Urinary Infection ___/____
□ □ Lumps in Testicles ___/____
□ □ Poor Libido *(Sex Drive)* ___/____
□ □ Other ___/____ _____

Preventive Tests
Check box if yes and provide date of most recent test
□ Blood Tests ___/____
□ Full Physical Exam ___/____
□ X-Ray ___/____ *Body Part?*_____
□ Dental X-Ray ___/____
□ Bone Density ___/____
□ Colonoscopy ___/____
□ Cardiac Stress Test ___/____
□ EKG ___/____
□ Hemoccult Test (stool test for blood) ___/____
□ MRI ___/____
□ CT Scan ___/____
□ Upper Endoscopy ___/____
□ Upper GI Series ___/____
□ Ultrasound ___/____
□ Other ___/____ _____

Gynecologic History *(for women only)*

Obstetric History *Check box if yes and provide relevant quantity*
□ Pregnancy_____ □ Vaginal Delivery_____ □ Caesarean Delivery_____ □ Miscarriage_____ □ Abortion_____
□ Living Children_____ □ Post-Partum Depression_____ □ Toxemia_____ □ Gestational Diabetes_____
□ Baby over 8 lbs. _____ □ Premature_____ □ Low Birth Weight (< 6lbs) _____
□ Breast Feeding Your Child *How long?* _____ □ Oral Contraceptives_____ *How long?* _____

Menstrual History
Age at first period: _____ Menses Frequency: _____ Length between menses: _____ Pain: □ Yes □ No
Clotting: □ Yes □ No Has your period ever skipped? □ Yes □ No How long? _____
Last Menstrual Period: _____
Do you use contraception? □ Yes □ No *If yes:* □ Condom □ Diaphragm □ IUD □ Partner Vasectomy

Women's Disorders/Hormonal Imbalances
□ Fibrocystic Breasts □ Breast Cancer ___/___ □ Endometriosis □ Fibroids □ Infertility
□ Painful Periods □ Heavy Periods □ PMS
Last Mammogram ____/____ Anything Abnormal? _____ □ Breast Biopsy ____/_____
□ Thermogram ____/____/____ Last PAP Test ___/___/___ □ Normal □ Abnormal
Date of Last Bone Density: ___/___/____ Results: □ High □ Low □ Within Normal Range
Are you in menopause? □ Yes □ No Age of onset of menopause: _____
Check box if you are experiencing
□ Hot Flashes □ Mood Swings □ Concentration/Memory Problems □ Vaginal Dryness
□ Decreased Libido □ Heavy Bleeding □ Joint Pains □ Headaches □ Weight Gain
□ Loss of Control of Urine □ Palpitations □ Painful Intercourse
□ Use of hormone replacement therapy *How Long?* _____ *What hormones and dosage?* _____

_____

Men's History *(for men only)*

Have you had a PSA done? □ Yes □ No Date of last test? ___ /___ /____ Highest PSA Level: □ 0-2 □ 2-4 □ 4-10 □ >10

Check all that apply:

Do you regularly have morning erections? □ Yes □ No □ Increased fat accumulation □ Headaches
□ Emotional reactions □ Prostate enlargement □ Prostate infection □ Change in libido □ Impotence
□ Difficulty obtaining an Erection □ Difficulty maintaining an erection □ Prostate Cancer
□ Nocturia *(urination at night)* How many times a night? _____ □ Urgency/Hesitancy/Change in Urinary Stream
□ Loss of Control of Urine □ Testicular injury □ Testosterone replacement □ More fatigue and/or muscle soreness

Medications

Current Medications *(Both prescription and over-the-counter)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Previous Medications*: Last 10 Years*

Medication	Dose	Frequency	Start Date (month/year)	End Date (month/year)	Reason For Use

Nutritional Supplements: *(Vitamins, Minerals, Herbs, &Homeopathy)* *If more space is needed, please write on separate sheet.*

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? □ Yes □ No

Describe: _____

Have you had prolonged *(3 days or longer)* or regular use of NSAIDS *(i.e. Advil, Aleve, Motrin, Aspirin, etc.)*? □ Yes □ No
Have you had prolonged or regular use of Tylenol? □ Yes □ No
For what reason, and for how long, did you use pain relievers? _____
How much do you use NSAIDS now? Daily _____ Weekly _____ Monthly _____
Have you had prolonged or regular use of Acid Blocking Drugs *(i.e. Tagamet, Zantac, Prilosec, etc.)*? □ Yes □ No
Have you taken antibiotics **more than** 1 x per year? □ Yes □ No
Have you had long-term use of antibiotics? *(More than 10 days.)* □ Yes □ No
How many times have you taken antibiotics throughout your lifetime? _____
Have you ever used steroids *(i.e. prednisone, nasal allergy inhalers, skin/joint creams, etc.)*? □ Yes □ No

GI History

Foreign travel? □ Yes □ No *Where?* _____
Wilderness Camping □ Yes □ No *Where?* _____
Have you had severe: □ Gastroenteritis □ Diarrhea □ Crohn's/Ulcerative colitis □ Parasites
Do you feel like you digest your food well? □ Yes □ No Do you feel bloated after meals? □ Yes □ No

Patient Birth History

□ Term □ Premature *Pregnancy Complications:* _____
Birth Complications: _____
□ Breast Fed *How long?* _____ □ Bottle-fed
Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____
Did you eat candy or sugar as a child? □ Yes □ No

Dental History

Dental Surgery? _____
□ Silver Mercury Fillings *How many?* _____ □ Gold Fillings □ Root Canals □ Implants □ Tooth Pain
□ Bleeding Gums □ Gingivitis □ Problems with Chewing
Do you floss regularly? □ Yes □ No Do you brush regularly? □ Yes □ No
What toothpaste do you use? _____ Have you had Fluoride treatments? □ Yes □ No

Diet

Do you have known adverse food reactions, allergies, or sensitivities? □ Yes □ No *If yes, describe symptoms and list all foods:*
_____
_____
Do you have an adverse reaction to caffeine? □ Yes □ No
When you drink caffeine do you feel: □ Irritable or Wired □ Aches & Pains □ Headaches
Do you adversely react to: *Check all that apply*
□ Monosodium Glutamate *(MSG)* □ Aspartame *(NutraSweet)* □ Preservatives *(ex. sodium benzoate)*
□ Cheese □ Citrus foods □ Chocolate □ Alcohol □ Red Wine □ Caffeine □ Bananas □ Garlic □ Onion
□ Sulfite containing foods *(wine, dried fruit, salad bars)* □ Other: _____

Environmental & Detoxification Assessment

Which of these significantly affect you? *Check all that apply*

□ Cigarette Smoke □ Perfumes/Colognes □ Auto Exhaust Fumes □ Other: _____
In your home or work environment, are you exposed to: □ Chemicals □ Electromagnetic Radiation □ Mold
How often do you use your cell phone? ____$^{hrs}/_{day}$ How often do you use your computer? ____$^{hrs}/_{day}$ ____$^{hrs}/_{wk}$
Have you ever turned yellow *(jaundiced)*? □ Yes □ No
Have you ever been told you have Gilbert's syndrome or a liver disorder? □ Yes □ No
If yes, explain _____
Do you have a known history of significant exposure to any harmful chemicals such as the following:
□ Herbicides □ Insecticides *(frequent visits of exterminator)* □ Pesticides □ Organic Solvents
□ Heavy Metals □ Other _____
Chemical *Name/Date/Length of Exposure (if known)* _____
Do you dry clean your clothes frequently? □ Yes □ No
Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? □ Yes □ No
Do you have any pets or farm animals? □ Yes □ No
What detergents/soaps do you use *(Brand names)*? _____
What deodorant? _____
What beauty products do you use *(Lotions, Hair products, Make-up, etc.)*? _____

Family History

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age *(if still alive)*												
Age at Death *(if deceased)*												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis *(Rheumatoid, Psoriatic, Ankylosing Spondylitis)*												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases *(such as Lupus)*												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities, or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse *(such as Alcoholism)*												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar / Mood Disorder												
Other:												

Social History

Weight Stats

Height _____*ft.* _____*in.* Current Weight _____ Usual Weight Range *(+/- 5lbs)* _____
Desired Weight Range *(+/- 5lbs)* _____ Highest Adult Weight _____ Lowest Adult Weight _____
Have you experienced weight fluctuations greater than 10 lbs? □ Yes □ No Body fat % _____
Is your weight, in the recent past, increasing, decreasing, or staying the same? *If changing describe* _____
_____

Nutrition History

Have you ever had a nutrition consultant? □ Yes □ No
Have you made any changes in your eating habits because of your health? □ Yes □ No *Describe* _____
_____
Do you currently follow a special diet or nutritional program? □ Yes □ No *Check all that apply*
□ Low Fat □ Low Carbohydrate □ High Protein □ Low Sodium □ Diabetic □ No Dairy □ No Wheat
□ Gluten Restricted □ Vegetarian □ Vegan □ Ultrametabolism □ Macrobiotic □ Paleo
□ Specific Program for Weight Loss/Maintenance Type: _____ □ Other _____
How often do you weigh yourself? □ Daily □ Weekly □ Monthly □ Rarely □ Never
Have you ever had your metabolism *(resting metabolic rate)* checked? □ Yes □ No *If Yes, what was it?* _____
Do you avoid any particular foods? □ Yes □ No If yes, types & reason _____
_____
If you could only eat a few foods a week, what would they be? _____
_____
Do you grocery shop? □ Yes □ No If no, who does the shopping? _____
Do you eat organic foods? □ Yes □ No
What percentage of your food is organic (pesticide free, non-GMO, etc.)? _____
How many meals do you eat out per week? □ 0 – 1 □ 1 – 3 □ 3 – 5 □ >5 meals per week

Check all factors that apply to your current lifestyle and eating habits

□ Fast Eater
□ Erratic eating pattern
□ Eat too much
□ Late night eating
□ Dislike healthy food
□ Time constraints
□ Eat more than 50% meals away from home
□ Travel frequency
□ Non-availability of healthy foods
□ Do not plan meals or menus
□ Reliance on convenience
□ Poor snack choices
□ Significant other or family members don't like healthy foods
□ Significant other or family members have special dietary needs or food preferences
□ Love to eat
□ Eat because I have to
□ Have a negative relationship to food
□ Struggle with eating issues
□ Emotional eater *(eat when sad, lonely, depressed, bored)*
□ Eat too much under stress
□ Eat too little under stress
□ Don't care to cook
□ Eating in the middle of the night
□ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is: _____
_____
What foods would be the hardest to reduce or eliminate? _____

Smoking

Currently smoking? □ Yes □ No *How many years?* _____ *Packs per day:* _____ *Attempts to quit:* _____
Previous smoking? *How many years?* _____ *Packs per day:* _____ *Date quit:* _____
Secondhand smoke exposure? _____ *From where?* _____

Social History *continued*

Alcohol Intake

How many drinks currently per week? *1 Drink = 5 oz. wine, 12 oz. beer, or 1 oz. spirit*
□ None □ 1 -3 □ 4 – 6 □ 7 – 10 □ > 10 If 'None' – Skip to 'Other Substances'
Most common beverage? _____
Have you ever been told you should cut down your alcohol intake? □ Yes □ No
Do you get annoyed when people ask you about your drinking? □ Yes □ No
Do you ever feel guilty about your alcohol consumption? □ Yes □ No
Do you ever take an eye-opener? □ Yes □ No
Do you notice a tolerance to alcohol? *(Can you 'hold' more than others?)* □ Yes □ No
Have you ever been unable to remember what you did during a drinking episode? □ Yes □ No
Do you get into arguments or physical fights when you have been drinking? □ Yes □ No
Have you ever been arrested or hospitalized because of drinking? □ Yes □ No
Have you ever thought about getting help to control or stop your drinking? □ Yes □ No

Other Substances

Caffeine intake: □ Yes □ No Cups/day: □ Coffee □ Tea - □ 1 □ 2 – 4 □ > 4 a day
Caffeinated sodas or diet sodas intake: □ Yes □ No
12 oz. soda per day: □ 1 □ 2 – 4 □ > 4 a day Favorite soda: _____
Are you currently using any recreational drugs? □ Yes □ No *Type* _____
Have you ever used IV or inhaled recreational drugs? □ Yes □ No

Exercise

Current exercise program

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other *(Yoga, Pilates, Gyrotonics, etc.)*			
Sports or Leisure Activities *(Golf, Tennis, Rollerblading, etc.)*			

Rate your level of motivation for including exercise in your life? □ Low □ Medium □ High
List your problems that limit activity: _____
_____
Do you feel unusually fatigued after exercise? □ Yes □ No *If yes, please describe:* _____
_____
Do you usually sweat when exercising? □ Yes □ No

Psychosocial

Do you feel significantly less vital than you did a year ago? □ Yes □ No
Are you happy? □ Yes □ No Do you feel your life has meaning and purpose? □ Yes □ No
Do you believe stress is presently reducing the quality of your life? □ Yes □ No
Do you like the work you do? □ Yes □ No Have you ever experienced major losses in your life? □ Yes □ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations? □ Yes □ No
Would you describe your experience as a child in your family as happy and secure? □ Yes □ No

Social History *continued*

Stress / Coping

Have you ever sought counseling? □ Yes □ No *Describe* _____
Are you currently in therapy? □ Yes □ No *Describe* _____
Do you feel you have an excessive amount of stress in your life? □ Yes □ No
Do you feel you can easily handle the stress in your life? □ Yes □ No
How do you deal with stress? _____
Daily Stressors: *Rate on a scale of 1 – 10* Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____
Do you practice meditation or relaxation technique? □ Yes □ No *How often?* _____
Check all that apply □ Yoga □ Meditation □ Imagery □ Breathing □ Tai Chi □ Prayer
□ Other: _____
Have you ever been abused, a victim of a crime, or experienced a significant trauma? □ Yes □ No
If yes, please explain _____
Do you regularly give gratitude for everything in your life? □ Yes □ No
How would you describe your overall attitude towards life? _____
Do you have a spiritual practice? □ Yes □ No *Describe* _____

Sleep / Rest

Average number of hours you sleep per night: □ > 10 □ 8 -10 □ 6 – 8 □ < 6
What time do you typically go to sleep? _____:_____ AM/PM Do you have trouble going to sleep? □ Yes □ No
Do you feel rested upon awakening? □ Yes □ No Do you have problems with insomnia? □ Yes □ No
Do you snore? □ Yes □ No Do you use sleeping aids? □ Yes □ No *Explain:* _____

Roles / Relationship

Marital status: □ Single □ Married □ Divorced □ Gay/Lesbian □ Long Term Partnership □ Widow

Spouses name: _____

Child's Name	Age	Gender

Who is living in your Household? *Number* _____ *Names* _____
Their Employment/Occupation: _____
Resources for emotional support? *Check all that apply*
□ Spouse □ Family □ Friends □ Religious/Spiritual □ Pets □ Other: _____

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At School				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your spouse/boyfriend/girlfriend				
With your children				
With your parents				

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)*

Significantly improve your diet _____ □ 5 □ 4 □ 3 □ 2 □ 1
Take several nutritional supplements each day _____ □ 5 □ 4 □ 3 □ 2 □ 1
Start preparing your own meals _____ □ 5 □ 4 □ 3 □ 2 □ 1
Modify your lifestyle _____ □ 5 □ 4 □ 3 □ 2 □ 1
Practice a relaxation technique _____ □ 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
Get regular bodywork such as chiropractic or massage _____ □ 5 □ 4 □ 3 □ 2 □ 1
Setting regular appointments _____ □ 5 □ 4 □ 3 □ 2 □ 1
Read books or articles to learn about your health and solutions _____ □ 5 □ 4 □ 3 □ 2 □ 1
Be fully responsible for your own healing _____ □ 5 □ 4 □ 3 □ 2 □ 1

Comments: _____

_____

How confident are you of your ability to organize and follow through on the above health related activities?
Rate on a scale of: 5 (very confident) to 1 (not confident at all) □ 5 □ 4 □ 3 □ 2 □ 1 *If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?* _____

_____

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? *Rate on a scale of: 5 (very supportive) to 1 (very unsupportive)* □ 5 □ 4 □ 3 □ 2 □ 1 *Comments:* _____

_____

_____

How much ongoing support and contact *(office visits)* from the Doctor would be helpful to you as you implement your personal health program? *Rate on a scale of: 5 (very frequent) to 1 (very infrequent contact)* □ 5 □ 4 □ 3 □ 2 □ 1
Please list how often you would be willing to make appointments if needed _____
Comments: _____

_____

4-Day Diet Diary Instructions

There is a 4-day diet diary at the end of this packet. It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 4 consecutive days including one weekend day. Please feel free to carry it with you as it is often easier to write down what you consume shortly after you consume it, rather than wait until the end of the day. You do not have to record it using this form. You can use any form you wish including your cell phone if you desire. As long as all the information is there.

- **Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.**
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible e.g., milk – what kind? (whole, 2%, or nonfat); toast – (whole wheat, white, buttered); chicken - (fried, baked, or breaded); coffee – (decaffeinated w/ sugar & ½ 'n' ½)
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, **including water**, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits in this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc.)
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

ASQ – Appraisal and Symptom Questionnaire – (Abbreviated)

Name: _____ *Date:* _____

The Health Appraisal and Symptom Questionnaire is designed to elucidate symptoms that help to identify the underlying causes of illness, as well as help track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days.

POINT SCALE:
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is significant
3 = Frequently have it, effect is significant
4 = Frequently have it, effect is very significant

Digestive Tract
☐ Nausea or vomiting
☐ Diarrhea (loose stools or >3x/day)
☐ Constipation (not going everyday)
☐ Bloated feeling or abdominal swelling
☐ Belching or passing gas
☐ Heartburn of GERD
☐ Intestinal/stomach pain
☐ Reactions to foods
☐ Gallstones or pain after fatty meals
☐ Bad breath
☐ Blood or mucous in stool
☐ Other_____
Total _____

Ears
☐ Itchy ears
☐ Earaches, ear infections
☐ Drainage from ear
☐ Ringing in ears, hearing loss
Total _____

Emotions
☐ Mood swings
☐ Anxiety, irritability
☐ Anger or emotional outbursts
☐ Depression
Total _____

Energy/Activity
☐ Fatigue, sluggishness
☐ Apathy, lethargy
☐ Hyperactivity
☐ Restlessness
☐ Restless legs
☐ General feeling of ill health
Total _____

Eyes
☐ Watery or itchy eyes
☐ Swollen, reddened or sticky eyelids
☐ Bags or dark circles under eyes
☐ Blurred or tunnel vision *(does not include near-or-far-sightedness)*
Total _____

Head
☐ Headaches
☐ Faintness
☐ Dizziness or vertigo
Total _____

Heart
☐ Irregular or skipped heartbeat
☐ Rapid or pounding heartbeat
☐ Chest pain
Total _____

Joints/Muscles
☐ Pain or aches in joints
☐ Arthritis
☐ Stiffness or limitation of movement
☐ Pain or aches in muscles
☐ Feeling of weakness or tiredness
☐ Muscle cramping
Total _____

Lungs
☐ Chest congestion
☐ Asthma, bronchitis
☐ Shortness of breath
☐ Difficulty breathing
☐ Inability to take deep breaths
Total _____

Mind
☐ Poor memory
☐ Confusion, poor comprehension
☐ Poor concentration
☐ Poor physical coordination
☐ Difficulty in making decisions
☐ Stuttering or stammering
☐ Stuttered speech
☐ Slurred speech
☐ Insomnia
☐ Learning disabilities
Total _____

Nose
☐ Stuffy nose
☐ Sinus problems
☐ Hay fever
☐ Sneezing attacks
☐ Excessive mucus formation
Total _____

Skin
☐ Acne
☐ Hives
☐ Hair loss/thinning
☐ Rash or reddened skin
☐ Excessive sweating
☐ Edema
☐ Dry or oily skin (circle which)
☐ Dry, cracked nails
☐ Body odor offensive or strong
Total _____

Weight
☐ Binge eating
☐ Craving certain foods
☐ Excessive weight
☐ Compulsive eating
☐ Water retention
☐ Underweight
Total _____

Mouth/Throat
☐ Chronic coughing
☐ Gagging, frequent throat clearing
☐ Sore throat, hoarseness, loss of voice
☐ Swollen/discolored tongue, gums, lips
☐ Canker sores
☐ Sticky coating on tongue
☐ Dry, cracked lips
Total _____

Immune
☐ Frequent illness
☐ Teeth infection/bleeding
☐ Frequent or urgent urination
☐ Urinary tract infections
☐ Genital itch/discharge or STD outbreak
Total _____

Hormones
☐ Awake feeling un-refreshed/tired
☐ Craving salty/sweet foods (circle which)
☐ Low or High Libido (circle)
☐ Facial or unusual hair growth
☐ Flushing or hot flashes
☐ Painful/abnormal periods (females)
☐ Cold hand/feet
☐ Frequent thirst
☐ Dizziness when standing
*Total*_____

Grand Total _____

Diet Diary: *Name* _____ *Date* _____

Day 1

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____

Day 2

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____

Day 3

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____

Day 4

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____

Harmony Healing Center, P.C.

Brandon M. Lundell, DC, APC, DABCI, IFMCP, Dipl. Ac.
714 Kimbark St. • Longmont, Co 80501
303-651 1502 • Fax: 303-651-9383

Services and Prices (abbreviated)

New Patient Initial Visit ……$375/hr.
Functional Medicine Services (labs, nutrition etc.)……350/hr.
Chiropractic services……250/hr.
Functional Medicine consulting (if not a current patient)……450/hr.
I.V. Nutrition (Price may vary based upon ingredients)……125
Sports/School Physical 40
Acupuncture (at same time as Office Visit) 65
Acupuncture (without OV) 85
Fitness/Rehab Center membership .....45/mo.
Laser Treatment (first 5 min.).....25
Whole Body Vibration (first 10 min.).....20
Traction/Inversion 15
Infrared Lamp 20
Infrared Sauna (5 min increments)..... 10
Ultrasound 25
Alpha Stim. (10-20 min.) 30
Personal Training .....1/2 hr.-$75; 1 hr -$150
Blood Chemistry Analysis (Price varies with level of investigation)
Hormone Panels (Price varies with level of investigation)
Gastrointestinal Panels (Price varies with level of investigation)
Neurotransmitter Testing (Price varies with level of investigation)
Food and Environmental Testing (Price varies with level of investigation)

Missed Appointment Fee (if cancelled less than 48 hours and we are unable to fill, patient is responsible for full price of appointment)

Time-based fees are calculated using a therapeutic hour of 55 minutes, which is standard in the health field.

Please keep in mind, your office visit charge may include the time given to your case outside of the office visit, such as laboratory test interpretation, review of history, etc.

We do not accept returns on any products once they are purchased. No exceptions. See our return policy on the consent form for more detail. If a lab test kit needs to be returned, there is a 15% return fee.

* If your office visit should require more time than was scheduled, we will be happy to reschedule you for another appointment. If we are able to extend your appointment time, your visit will be pro-rated according to the hourly fee.

Fees are subject to change without notice. A copy of current fees is always posted in waiting room or available upon request.

Harmony Healing Center, P.C.

PATIENT CONSENT FOR TREATMENT

(PLEASE READ CAREFULLY BEFORE SIGNING)

INFORMED CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending practitioner(s) and it is the responsibility of the staff of the Harmony Healing Center (HHC) to carry out the instructions of such practitioner(s). I understand the risks associated with chiropractic, acupuncture and adjunctive procedures used in this office and agree to the rendering of such care. Procedures used in this office include but are not limited to laboratory diagnostics, chiropractic manipulation, soft tissue therapy, acupuncture, nutritional counseling, herbal medicine, injectable nutrients, physical therapy physiology, etc. By signing this, I agree to allow HHC employees to administer the care that is deemed necessary and prudent.

There are certain "side-effects" associated with all medical care, chiropractic and acupuncture which may include, but are not limited to: stiffness, aches or discomfort for several hours or days after the treatment (it is natural for the body to have a period of "re-adjusting" to a new alignment of joints), dizziness, headaches, bruising, infection, aggravation of symptoms, fainting, hematoma, excess energy, sleepiness, tiredness and increased thirst. All treatments carry some risk or complications. Please inform the doctor if any symptoms you may experience are severe or worsen.

I have been made aware that certain procedures used in this office are considered "experimental" and "unproven" by the Colorado State Board of Chiropractic and Medical Examiners. One example is cold-laser therapy. However, all means of diagnosis and treatment used in this office has validation and general acceptance within the alternative health community.

I understand that as with all health-related treatments, there is no guarantee of relief or cure of any disease or condition. I understand that I am free to seek other forms of treatment and that I may withdraw from any treatment at any time.

PROTECTED HEALTH INFORMATION:

By signing this form, I am granting consent to Harmony Healing Center P.C. (HHC) to use and disclose my protected health information (PHI) for the purposes of treatment, payment and healthcare operations. HHC's **Notice of Privacy Practices** provides more detailed information about the use and disclosure of this protected health information. I understand that I have a legal right to review the Notice of Privacy Practices before I sign this consent and HHC encourages me to read it in full. (Please ask the front desk for a copy if you would like). I acknowledge that a copy of the Notice of Privacy Practices was given to me to keep on the initial visit. HHC's Notice of Privacy Practices is subject to change. If it is changed, I may obtain a copy of the revised notice by telephoning the office at 303-651-1502 or asking in person or in writing for a revised copy. I understand that I have a right to request HHC to restrict how to use and disclose my protected health information for the purposes of treatment, payment or health care operations. HHC is not required by law to grant my request. However, if HHC does decide to grant my request, HHC is bound by the agreement.

I further understand that this consent is valid for ten years and that I have the right to revoke this consent in writing, except to the extent HHC has already used and disclosed my protected health information in reliance to my consent. I also understand that if I choose not to sign this consent, HHC and its affiliates will not treat me.

MEDICARE AND MEDICAID CONSENT TO RELEASE OF INFORMATION:

I certify that the information given by me in applying for payment under title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period (if applicable) _____.

I have read, understand and have had all my questions answered and I wish to have HHC and its employees treat me at this time.

X_____ **Date:** _____

Print Patient's Name

X_____ **X** _____

Patient's Signature **Witness Signature**

Harmony Healing Center, P.C.

Brandon M. Lundell, DC, APC, DABCI, IFMCP, Dipl. Ac., NE

714 Kimbark St. • Longmont, Co 80501

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CONSENT AGREEMENT AND WAIVER OF LIABILITY FOR LABORATORY ASSESSMENT, FUNCTIONAL MEDICINE AND NUTRITIONAL THERAPY

PLEASE READ THOROUGHLY!

Dr. Lundell and the Harmony Healing Center offer laboratory testing for the purpose of assessing the complete metabolic and biochemical terrain of the patient. He also offers nutritional support as part of his individualized treatment plans.

This office does not treat symptoms or diagnose diseases. Our focus is to uncover the underlying causes of imbalance. Since a nutritional deficiency may be associated with a specific symptom, or it may be the cause of the symptom, or it may occur as a result of that symptom. It is important for you to understand fully that Dr. Lundell uses laboratory analysis and other exam findings to uncover deficiencies and their causes, and not for the diagnosis of a medical condition or illness. Dr. Lundell prescribes vitamins, minerals, bioidentical hormones and therapeutic agents for the sole purpose to aid and support the body to restore proper function and optimal wellness. Instead of focusing on disease and illness, Dr. Lundell uses many modalities to support the body nutritionally, energetically and spiritually, in addition to educating the patient on how to be responsible caregivers to their own bodies. A fully functioning body will by nature, be less likely to manifest disease or illness. This office also uses laboratory assessment and nutritional therapy for the **prevention** of symptoms. Functional laboratory evaluations and scientific nutritional therapy are powerful tools for healing imbalances, as well as for prevention of illness. One must be pro-active in their health in order to preserve that health and avoid illness.

The laboratory tests and subsequent nutrient recommendations are not intended to diagnose, treat or cure any specific disease. The nutritional recommendations we make based on laboratory tests, physical and clinical findings, history and symptoms, do not constitute treatment for any specific disease.

In the nutritional management of a case, we routinely prescribe numerous vitamins, minerals, enzymes, homeopathics, nutraceuticals, bioidentical hormones and other nutritional substances. We do not want you to have any misconceptions about their use in this clinic. In the event that any vitamin, mineral, food or other nutritional substance mentioned above is prescribed or administered in your case, we want you to understand explicitly that its purpose will be for:

1) Improvement of your overall nutritional status
2) Improvement of your metabolism; including absorption, proper utilization and detoxification
3) Improvement of the sense of well-being
4) Possible remission or reduction of pain where present.

You may or may not receive any/all of these benefits, because they do not occur predictably with every patient. Also, it is up to you to follow the dietary and/or lifestyle instructions given to you, as this allows the prescribed nutraceuticals to be utilized properly and be supportive for your healing. Nutritional supplements are an important part of the healing process in that they provide missing or lacking nutrients and can affect metabolic changes in the body which need support. However, it is vital to understand that nutritional supplements do not "fix" problems or treat symptoms. They are part of a holistic treatment plan which is offered here and may include dietary and lifestyle modifications.

Dr. Lundell uses only the highest quality nutritional products available. Most of what he prescribes is only available through licensed qualified healthcare practitioners. They are of higher quality, and in many cases, of greater potency than what is available in supermarkets or health food stores. He has researched every nutritional supplement that is offered so that the patients under his care will receive only the highest quality, scientifically formulated, and clinically proven products. Supplements bought elsewhere are often not put through strict manufacturing processes and may not even contain labeled ingredients. All supplements offered through Dr. Lundell are meticulously manufactured by FDA-approved, state of the art facilities with advanced raw material testing, production processes, and are verified by third parties as to the purity and potency of each

product. Buying a cheaper supplement may only delay the healing process and in some instances may be toxic to your body and exacerbate a condition.

Dr. Lundell has also received advanced training in the administration of nutraceuticals and continues to stay current on the latest research and clinical effectiveness using natural therapeutics. It is important that you follow his instructions to the best of your ability. This office is not be responsible for any adverse reactions or absence of effectiveness. In order to improve your health outcome, please implement all suggestions given (including dietary and lifestyle changes). The individualized treatment plan given to you is dependent on all facets working synergistically together. To give a simple analogy, how well does a car move with only two or three wheels? **Healing is a partnership and you must be willing to do your part**.

There are always **risks and benefits** associated with any therapy. Supplements are prescribed in your case because there has been a clinical need or indication established. They may also be prescribed as purely preventive or supportive in nature. However, everybody reacts differently to something new. And often when the body is undergoing a shift, it may feel uncomfortable for a period of time. Please advise Dr. Lundell if any reactions appear, as they may be part of the healing process or signify that a change in dosage or product is needed. Possible unintended reactions include stomach pain/cramps, rashes, headaches, fatigue, allergy, joint pain, vomiting, sweating, increase in body odor, etc. If any severe allergic reaction is noted, please discontinue use and go to the nearest urgent care facility.

It is also important that you return to our office for scheduled appointments to review the results and interpretation of your test(s). Our office policy (not state law) requires that you see or discuss your results with Dr. Lundell **before** we can release the results of the test to you or to anyone else. These tests allow you and Dr. Lundell to better understand your unique physiology and design an effective and thorough health care plan. Follow up tests are often required as well, in order to ensure that the underlying imbalances are improving with treatment. It is also highly encouraged to acquire annual preventive laboratory exams so that the baseline tests can be compared and trends observed over time. Knowing your individual, biochemical uniqueness is of great advantage when interpreting laboratory tests. Allowing the same doctor to run your annual labs and physical exam can cut down on unnecessary tests and procedures.

Payment, Insurance, Refunds: Payment is due at time of service, no exceptions. Payment for service is not conditional on response to care. HHC does not bill insurance, nor contracted with any insurance company. You may choose to bill your insurance yourself if you choose and all reimbursements are between you and your insurance company. No refunds are given for any reason for services rendered.

Return Policy: Once a supplement is purchased, it cannot be returned for any reason, even if the bottle/package is unopened. Once the supplement leaves this office, we can no longer guarantee the potency, purity or condition of the product, how it was handled, stored, etc. (Please keep all supplements in a cool, dry place or refrigerated if indicated).

By signing below I am attesting that I HAVE READ AND UNDERSTAND THE ABOVE, and have had all my questions answered satisfactorily. I hereby place myself under Dr. Lundell's care for such advice, prescription, treatment and administration as may appear to be indicated in his professional judgment. I understand there is no guarantee of results of care. I agree to hold Dr. Lundell, Harmony Healing Center, P.C. and all of it's staff and affiliates free of any and all liability for any adverse reactions that may result from testing procedures and/or administration of nutraceuticals or other treatments.

DO NOT SIGN unless you have read and fully understand this document.

Patient (print): _____ Date: _____

Signature: _____

Witness: _____

Harmony Healing Center, P.C.

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Nutritional and Herbal Supplements
Helpful Tips, Release and Consent Form

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support overall health and well-being. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking. Adverse reactions are rare, and may include, but are not limited to: bloating, nausea, vomiting, rash, fatigue, diarrhea, constipation, headaches and dizziness. If any of these or other symptoms appear, please discontinue immediately and talk to Dr. Lundell, or in case of emergency, go to your local urgent care facility. Many times adjustments in dosages and or timing is all that is needed to alleviate these symptoms. Keep in mind also, there is often an initial "Herxhiemer" reaction. This was first described by a German physician of the same name. He observed that as patients started to fulfill a need nutritionally, or emotionally, often a "detox" would start to happen as the body adjusts to metabolic pathways becoming functional again. This is usually temporary and may only last a few days to several weeks.

As a service to you, we make nutritional supplements available in our office at a discounted rate. We never sell anything to you for retail. You are not obligated to purchase supplements at our office. However, we purchase quality products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science and research behind the ingredients used in the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process. The supplement company brands that we carry in this office are those that meet our high standards and tend to provide the most consistent benefits.

While there are many different supplement companies on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. **The chief reason we make these products available is to ensure quality to you**. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely (visit consumerlab.com for more info.)

There are ways to make your nutritional supplements work even better. The first is to understand what each supplement is and is not. Dr. Lundell makes every effort to explain what each supplement does in the body and why he is recommending it for you. This may include some laboratory result indicating lack of specific nutrients, or it may be simply for better health and well-being. It is your responsibility, ultimately to know why you are taking something. Research has shown that when two groups are given the same supplement (or drug), the individuals who *understand* what that nutrient is doing in their body get better results. It is part of aligning your mind and being with the healing properties of that nutrient. We have handouts for most of our products that explain the science behind each supplement. Please ask the front desk if you are interested in more information or have any questions.

Also, it is important to understand the supplements are just one part of a comprehensive treatment plan and if taken alone without attention to diet, exercise and lifestyle, they are limited in their effectiveness. Please follow all recommendation given by Dr. Lundell and your other health care providers to the best of your ability to ensure health and longevity.

If you have concerns about this issue, please discuss them with Dr. Lundell or the staff.

I, _____,

have read and understand the above statement on and I consent to taking nutritional supplements for my overall health. I release Dr. Lundell and the Harmony Healing Center, PC (HHC) from all liability from any adverse effects or drug-nutrient interactions experienced as a result of the nutritional supplements recommended by Dr. Lundell and HHC. I understand I may discontinue treatment at any time, and discuss any adverse reactions with Dr. Lundell.

Signature _____, _____ (date).

Harmony Healing Center, P.C.

Brandon M. Lundell, DC, APC, DABCI, IFMCP, Dipl. Ac.
714 Kimbark St. • Longmont, Co 80501
303-651 1502 • Fax: 303-651-9383

NOTICE OF PRIVACY PRACTICES

Harmony Healing Center, P.C. (HHC), a professional corporation, in accordance with the Federal Privacy Rule, 45 CFR parts 160 and 164 and applicable state laws, is **committed to maintaining the privacy of your Private Healthcare Information (PHI). PHI includes information about your health condition and the care and treatment received from HHC and is often referred to as your health care or medical record. This Notice also details your rights regarding your PHI.**

HOW HHC USES AND DISCLOSES YOUR PHI

HHC values your privacy and private health-related information. In this age of identity theft and misuse of such information, we take every precaution to safeguard your information and to use it for healthcare purposes only. HHC will only use your PHI without your express consent for the following reasons stated:

- **TREATMENT-** To provide you with the health care you require, HHC may use and disclose your PHI to other healthcare professionals, so that it may coordinate and plan your health care. For example, Dr. Brandon Lundell may require obtaining medical records from other doctors or consulting with another doctor for the best treatment possibilities. Whenever possible, your identity shall remain anonymous.
- **PAYMENT-** To get paid for services provided to you by this clinic, HHC may provide your PHI, directly or through a billing service, to a third party such as insurance companies or lawyers in a personal injury case. If necessary, HHC may use your PHI for collection purposes with respect to all persons who may be liable to HHC for bills related to your care. This may include, but not limited to, the use of a collection agency or billing service clearinghouse.
- **HEALTH CARE OPERATIONS-** To operate in accordance with applicable law and insurance requirements, and to provide quality, effective care, HHC may need to compile, use and disclose your PHI. For example, some of your basic PHI may be used for in-house statistical reporting.
- **ADVICE OF APPOINTMENT AND SERVICES-** HHC may contact you to provide appointment reminders or information about your treatment alternatives or other health related benefits and services that may be of interest to you. The following reminders or contacts may be used: mail correspondence to your address; email: telephoning you with the numbers you have provided and leaving a message on your machine or with the individual who answers. If you object this form of notification or prefer another mode of communication please inform us.
- **DIRECTORY / DAY SHEET/ APPOINTMENT BOOK-** HHC keeps a list of those who have been treated or made a payment in our office each day. There is also an appointment book that bears the names of those who have appointments at our office. These items are kept secure or hidden. However, when making appointments or entries these items may be visible to others.
- **WAITING AREA-** HHC may use your name to be called back to a treatment room when the doctor is ready for you. If you object to this manner of notification please inform us. You may also be seen by others as you walk into or out of the office.
- **BILLING-** HHC uses a family billing procedure where all bills at one address go into one envelope. If you object to this manner of billing please notify this office and arrangements may be made for alternate billing.
- **FAMILY/FRIENDS-** HHC may disclose your PHI to a family member, relative, a close personal friend, or any other person chosen by you, only what is relevant to such person's involvement with your care or for the payment for your care. HHC may also use or disclose your PHI to notify or assist in the notification to a family member, a personal representative, or another person responsible for your care, of your location, general condition, or death. However, in both cases, the following conditions will apply:

  a) If you are present at or prior to the use or disclosure of your PHI, HHC may use or disclose your PHI if you agree, or if HHC can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

  b) If you are not present, HHC will, in exercise of professional judgment, determine whether the use or disclosure is your best interest and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

OTHER USE AND DISCLOSURES WHICH MAY BE PERMITTED OR REQUIRED BY LAW

HHC may also use and disclose your PHI, with or without your consent or authorization in the following instances:

a) De-identified Information- HHC may use and disclose health information that may be related to your care but does not identify you or cannot be used to identify you.

b) Business Associate- HHC may use and disclose PHI to one or more of its business associates if HHC obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A Business Associate is an entity that assists HHC in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

c) Personal Representative- HHC may use and disclose PHI to a person who, under law, has the authority to represent you in making decisions related to your health care.

d) Emergency Situations- HHC may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that HHC attempts to obtain your consent as soon as possible; or to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

e) Public Health Activities- HHC may use and disclose PHI when required by law to provide information to a public health authority to prevent or control disease.

f) Abuse, Neglect, Domestic Violence- HHC may use and disclose PHI when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm to you or another individual.

g) Health Oversight Activities- HHC may use and disclose PHI when required by law to provide information in criminal investigations, disciplinary actions, or

other activities relating to the community's health care or public works systems.

h) Judicial and Administrative Proceeding- HHC may use and disclose PHI in response to a court order or a lawfully issued subpoena.

i) Law Enforcement Purposes- HHC may use and disclose PHI, when authorized, to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or if it is suspected that your death was the result of criminal conduct.

j) Coroner or Medical Examiner- HHC may use and disclose PHI to a coroner or medical examiner for the purpose of identifying you or the cause of death.

k) Organ, Eye or Tissue Donation- HHC may use and disclose PHI if you are an organ donor, to the entity to whom you have agreed to donate your organs.

1) Research- HHC may use and disclose PHI subject to applicable legal requirements if HHC is involved in research activities, making every attempt to conceal your identity where possible.

m) Avert a Threat to Health or Safety- HHC may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or to the public and such a disclosure is to an individual or entity who is reasonably able to prevent or lessen that threat.

n) Specialized Government Functions- HHC may use and disclose PHI when authorized by law with regard to military or veteran activities.

o) Worker's Comp.- HHC may use and disclose PHI if you are involved in a Worker's Comp. Claim, to an individual or entity that is part of the Worker's Comp. System.

p) National Security - HHC may use and disclose PHI to authorized government officials with necessary intelligence information for national security purposes only when absolutely necessary.

q) Military and Veterans- HHC may use and disclose PHI if you are a member of the armed forces, as required by the military command authorities.

r) Medical Release Authorization – If you require your PHI to be released by us, you may sign a medical release authorization. We will then copy your records to the extent you wish (there may be a nominal fee associated with copying costs). Uses and/or disclosures, other than those described above, will be made only with your written authorization.

YOUR RIGHTS

You have the right to:

- Revoke any authorization or consent you have given to HHC, at any time. To request a revocation, you must submit a written request to HHC's Privacy Officer.
- Request special restrictions on certain uses and disclosures of PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under the Privacy Rule Section 164.5228 and restrictions related to disclosures to your family and other individuals involved in your care under Section 164.5 lOb. Except in certain instances, HHC may not be obligated to agree to any restrictions. To request restrictions, you must submit a written request to HHC's privacy officer. In your written request you must inform the practice of what information you want to limit. If the practice agrees to your request it will be followed, unless the information is needed in order to provide you with emergency treatment.
- Receive confidential communications or PHI by alternate locations as provided by Privacy Rule Section *164.522b.* For instance, you may request all written communications to you marked "Confidential PHI". Your request must be made in writing to the HHC's Privacy Officer. HHC will honor all reasonable requests.
- Inspect and copy your PHI as provided by law. To do so requires a written request to the Privacy Officer. HHC can charge fees for such services. In certain situations we can by law deny these requests. However, you will be notified in written form of a denial notice.
- Amend your PHI. A written request must be sent to the Privacy Officer. You must provide a reason for your request. HHC may deny the request in written form. If you disagree with this denial you may submit a written statement of disagreement.
- Receive an accounting of disclosures of your PHI as provided by law. To do so requires a written request to the Privacy Officer. A time period of 6 years from the date of request is the limit and may not include dates before April 14, 2003. The first list is free. All subsequent requests may be subject to a fee.
- Receive a paper copy of this Privacy Notice from HHC upon request.
- Complain to HHC or to the Secretary of Health and Human Services if you believe these rights have been violated. These complaints must be written.

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To obtain more information about your Privacy Rights or, if you have questions, you may contact:
Brandon Lundell, Privacy Officer for HHC
714 Kimbark St.
Longmont, CO 80501
Tel: 303-651-1502 / Fax:303-651-9383

OUR REQUIREMENTS

Harmony Healing Center is committed to:

A) Maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the practice's legal duties and privacy practices with respect to your PHI.

B) Maintain greater restrictions on the use or release of your PHI than that which is provided by Federal law (sometimes required by State or local statutes).

C) Abide by the terms of this Privacy Notice.

Further, HHC reserves the right to change the terms of this Privacy Notice and to make the New Privacy Notice provisions effective for your entire PHI. You may ask for a copy of this form and any subsequent revisions at any time. We will be glad to provide you with such.

This notice is effective as of 7/15/2005

PATIENT ACKNOWLEDGMENT

By signing my name below, I acknowledge that I have read, fully understand and agree with the above information and terms. I also understand that it is my responsibility to understand the information and terms and to make the necessary effort to clarify any items in this document.

Name:_____ Date_____

Thank You- Harmony Healing Center