Dr. Suzanne Schiller, DC
17000 Ventura Blvd., Suite 220
Encino, CA 91316
(818) 806-9662 ~ drsuzanneschiller@gmail.com

CONFIDENTIAL INTAKE FORM

Full Name: Date:

Mailing Address:

Home Phone: Work Phone:

Cell Phone: Email Address:

Preferred Method to Contact you: ❑Home ❑ Cell ❑Email ❑Text

May we email you with periodic newsletters? (Unsubscribe at any time.) ❑YES ❑NO

Occupation: Employer:

Referred By:

Date of Birth: Birth Time: am/pm City/State/Country of Birth:

Age: Height: Weight: Sex: ❑Female ❑Male

Relationship Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Domestic Partner

Name of Spouse/Partner: Name(s)/age(s) of children:

<u>In case of emergency please notify</u>:

Name: Relationship:

Emergency Contact Phone numbers:

Primary Care Provider: PCP Phone:

PCP City: PCP State/Zip Code:

Date of last Physical Exam: May we contact your PCP? ❑ Yes ❑ No

Other Healthcare Providers or Specialists:

REASON FOR YOUR VISIT

What awareness, concern or challenge brings you here today?

When and how did this begin?

What do you feel or sense is going on with your current condition?

What measures have you tried to improve your condition?

How have you responded to your attempts to improve your condition?

What are your main sources of stress right now?

What is the desired outcome for your visit?

Describe in 3 words how you would most like to feel in your body:

CONFIDENTIAL HEALTH & STRESS HISTORY

Please check all that apply to your past or present health:

❑ Alcoholism	❑ Anxiety	❑ Obesity
❑ Allergies	❑ Arthritis	❑ Mental Illness
❑ Autoimmune Illness	❑ Cancer: explain type	❑ Tobacco Use
❑ Addiction	❑ Heart Disease	❑ Other: please explain
❑ Depression	❑ Diabetes	
❑ Digestive Problems	❑ Thyroid Disease	

Please list ALL surgeries, hospitalizations, accidents, injuries, illnesses, or abuse with dates:

List medical diagnoses here:

List current medications with dosage and length of use:

List current supplements with dosage and length of use:

Please check all stressors, current or recent, which apply:

❑ Personal relationship	❑ Work
❑ Family dynamics	❑ Financial
❑ Parenting/Fertility	❑ Moving/Relocating/Remodeling
❑ Chronic pain or illness	❑ Loss of loved one
❑ Changes in diet/lifestyle	❑ Extended Sitting
❑ Addiction	❑ Death or Loss
❑ Chemical Sensitivity/Exposure	❑ Spiritual or Creative Crisis
❑ Job or Career Change	❑ Exhaustion or Burnout
❑ Physical Exertion/Overtraining	❑ Feeling Lack of Support or Connection

ABDOMINO-PELVIC HEALTH HISTORY

PLEASE CHECK ALL THAT APPLY (PAST OR PRESENT) AND INCLUDE DATES:

❑ low back/hip pain

❑ PMS/menstrual pain

❑ pain with sex

❑ low/high libido

❑ fibroids/cysts

❑ hemorrhoids

❑ childbirth complications

❑ sexual abuse

❑ drug/alcohol abuse

❑ eating disorder

❑ incontinence/urinary

❑ abdomino-pelvic surgeries

❑ cancer

❑ organ prolapse

❑ weight gain/loss

❑ pelvic/abdominal pain

❑ irregular/prolonged bleeding

❑ sexually transmitted disease

❑ menopausal issues

❑ bladder infections/UTI

❑ constipation/irritable bowel

❑ tearing with birth

❑ physical/emotional abuse

❑ depression/mood swings

❑ smoking habit

❑ incontinence/ bowel

❑ sexual dysfunction

❑ trauma

❑ digestive complaints

❑ other: _____

Date of last Physical Exam:

Date of last PAP:

Dates of positive PAP tests:

Past gynecological treatments:

Age menses began: Age menses stopped: Birth control history:

Number of pregnancies: Date/Type (vaginal or C-sect) of deliveries:

INFORMED CONSENT FOR CHIROPRACTIC CARE, ATMAT & HOLISTIC PELVIC CARE

PRIVACY PRACTICES AND RELEASE OF INFORMATION. I understand that Suzanne Schiller, DC will honor my confidentiality and abide by all HIPAA regulations for my protected health information. If I request submission of my health records to any third party I understand I will need to authorize this with a signed release form prior to the transmission of health records or any discussion between Suzanne Schiller, DC and any third party about my treatment. It is my right to receive a written Notice of Privacy Practices should I request it.

CHIROPRACTIC TREATMENT: The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to correct motion in your joints.

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: • Spinal manipulative therapy • Range of motion testing • Muscle strength testing • Ortho/neuro testing • Palpation • Postural Analysis • Myofascial & Muscle Therapy

As with any healthcare procedure, there are complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costo-vertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients feel stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Complications from chiropractic care are rare.

Other treatment options for your condition may include: • Self-administered, over-the-counter analgesics and rest • Medical care and prescription drugs • Hospitalization• Surgery

If you chose to use one of the above treatment options, you should be aware that there are risks and benefits you may wish to discuss these with your primary medical physician.

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction and further reduce mobility.

ATMAT: This powerful bodywork treatment of the abdomen, lower back and tail, promotes circulation of lymph, blood, hormones, nerve and energy flow through the whole body. I will be placing my hands on your abdomen, your lower back, sacrum, coccyx. These areas are often guarded and protected. Please alert me if any areas are too sensitive or if you do not feel comfortable at any time.

As with any bodywork, you may experience soreness, physical or emotional detoxification as a result. If you choose this treatment I will give you self-care practices to do at home.

HOLISTIC PELVIC CARE ~ PELVIC FLOOR ASSESSMENT AND HEALING: HPC does not replace the regular health screening or care of a gynecologist, urologist or medical doctor/specialist. Dr. Schiller does not handle medical emergencies, diagnose illnesses, nor discuss the use or discontinuation of medications. Holistic Pelvic Care can supplement traditional medical care by offering self-care education and strategies for life-long pelvic wellness.

Your HPC pelvic floor assessment includes an internal, manual vaginal and/or rectal exam to determine pelvic muscle health and balance. Your treatment session may include internal vaginal myofascial release bodywork (sustained manual pressure and gentle stretching), instruction in pelvic muscle, awareness and breathing exercises, rectal assessment, and other physical or energetic healing techniques as needed.

I understand and consent to these services, and I also understand that there can be no guaranteed outcome or result. Patients may experience a wide range of positive, beneficial effects; although rare, uncomfortable effects are also possible, including soreness, bleeding or emotional release. I understand and agree that if at any time I experience symptoms that concern me or if I have difficulty integrating a pelvic session, I will promptly consult with Dr. Schiller, my primary care physician, or my therapist for additional support, as needed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I agree to take full responsibility for my wellbeing as a collaborator with my entire health care team, and I certify that I have read, fully understand, and agree to the terms of this consent form.

> By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment with Dr. Suzanne Schiller, DC.

Typing my name below constitutes an electronic signature, which is the legal equivalent of my manual signature on this agreement.

Patient Signature: Date:
Printed Name:

If client is a minor: I, as the ❑ parent or ❑ guardian, authorize Suzanne Schiller, DC, to provide treatment to .

OUR FINANCIAL POLICY

Thank you for choosing Dr. Suzanne Schiller, D.C. as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you read and sign prior to any treatment.

Full payment for your office visit, phone consultation, lab tests or supplements is expected at time of service. Credit card payments will be processed the same day of your appointment. If test kits or supplements are ordered for pick-up or drop-ship, you will be charged the day they are ordered.

We do not accept insurance; however, you can submit your patient statement to your insurance carrier. Upon request, we will give you a Superbill with all codes and instructions necessary for insurance filing. It is your responsibility to communicate with your insurance company; we do not assist with insurance claim resolution or respond to insurance carrier requests for additional information.

Fees

Chiropractic Initial Visit (60 min./90 min.)	$150/ $195
Chiropractic Follow-up Visit (25 min./45 min./60 min.)	$85/ $125/$150
Functional Medicine Intake Consultation (75 min.)	$295
Ongoing Care Consult (Office Visit or Phone Appointment) (15 min.)	$50
ATMAT or Women's Wellness Initial Visit (75-90 min.)	$195
ATMAT or Women's Wellness Follow-up Single Visit (60 min.)	$150
AMAT or Women's Wellness Series Visit (Bundled Visits in Series of 3 +)	$130
ATMAT or Women's Wellness Initial Series (Initial + 3 Follow-up Appointments)	$585

Lab Test Fees (CA sales tax included)

201 FUNCTIONAL ADRENAL STRESS	$195
205 FUNCTIONAL ADRENAL STRESS + 5 HORMONE	$280
207 PREMENOPAUSE PROFILE (<24 Day Cycle)	$295
208 EXPANDED PREMENOPAUSE PROFILE (>24 Day Cycle)	$360
209 FEMALE HORMONE BASELINE CHECK	$180
401-H GI PATHOGEN + H. PYLORI	$375
0091 ORGANIX COMPREHENSIVE	$395

Service Charge and Rebilling Fees

Any account not paid in full will be subject to a 2% service fee per month on any portion of the month thereof. If the account is not paid in full within 30 days of the initiation of treatment, it may also be subject to a $10.00 rebilling charge.

Missed Appointments and Fees

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments, barring emergencies (i.e. illness, earthquake, fire, flood, etc.); at a rate that directly reflects the amount of time reserved for treatment.

In the event of a default of payment, you will be held responsible for collection costs and/or reasonable attorney fees.
Thank you for understanding our Financial Policy. Please let us know if you have any further questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.
Typing my name below constitutes an electronic signature, which is the legal equivalent of my manual signature on this agreement.

X_____ DATE_____
Signature of Patient/Responsible Party

