Jana Panter | ND, CST-T

Adult Health History Form: 13 years and older

General Information: _____ Today's Date: _____

Name: _____ DOB: _____

Address: _____ City, Zip: _____

Phones: Primary: _____ Other: _____

Email: _____ Referred by: _____

Emergency contact name and phone: _____

Doctor's name and phone: _____

Whom do you live with: _____

Occupation: _____ Hobbies: _____

Allergies (topical and internal): _____

Current medications and supplements: _____

_____

Nightly amount of sleep: _____ Weekly exercise: _____

Average stress level and causes: _____

_____

Do you smoke: _____ how much: _____ Weekly alcohol consumed: _____

Other alternative therapies you have experienced: _____

Please list your primary reasons for seeking CST: _____

_____

_____

Health History:

For each system listed below please describe current concerns first and past concerns next. Be sure to include any accidents, illnesses, or chronic problems. (In parentheses are examples).

Skeletal/ bones (*broken bones, arthritis, osteoporosis, scoliosis, back pain*): _____

_____

Muscular, Connective Tissue/ muscles, joints (*sprains, bursitis, disc problems*): _____

_____

Eyes, Ears, Nose, Throat, Mouth (*TMJD, braces, hearing problems, speech, sinus, sore throats*): _____

_____

Are you wearing? ☐ contact lenses ☐ hearing aids ☐ dentures

Respiratory/ lungs (*asthma, bronchitis, frequent colds, pneumonia*): _____

_____

(please continue on other side)

Circulatory/ heart, arteries, veins, blood (*hypertension, varicose veins, bleeds or bruises easily*): _____

_____

Nervous System/ brain, nerves (*headaches, memory problems, concussions, seizures, ringing in ears, shooting pains, depression*):

_____

_____

Digestive & Elimination/stomach, intestines, bladder (*constipation, irritable bowel, urinary tract infection*): _____

_____

_____

Skin (*rashes, psoriasis, eczema, warts*): _____

_____

Birth History (*what you know about your birth*): _____

_____

Endocrine/pituitary, hypothalamus, reproductive, thyroid (*hyperthyroid, diabetes*): _____

_____

Menstrual & Fertility History (*severe PMS, pregnancy complications, hysterectomy, fibroids*): _____

_____

More details on anything described on this form or other significant factors (*family history, car accidents*): _____

_____

_____

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Your signature below signifies acceptance of the following policies:

Health Information

I have filled out the Health History form completely and accurately to the best of my knowledge. I will keep Dr. Panter informed of changes to my health or healthcare.

Scope of Practice

I understand that Dr. Panter does not provide primary medical care. She recommends that I see my primary care doctor regularly and contact them for health care concerns. In case of emergency I will contact 911.

Client Confidentiality

Dr. Panter does not sell client information. I understand that she will not share any of my information with any persons or organizations unless 1) required by law to do so or 2) when necessary to consult with other health care professionals to provide optimal care or 3) you request the release of your medical records (see below).

Release of Medical Records

I authorize the release of all of my medical records for the purpose of claims processing, to the following: my attorney, the healthcare providers attending to this condition, and insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through my attorney.

Payment

Payment is expected at time of service. Cash, check, Venmo, or PayPal are accepted. Dr. Panter is happy to provide a Superbill. Please request it when scheduling.

Cancellation

A 48-hour notice is required for cancellation of an appointment. For less than 48-hour notice I will be charged for the full appointment.

Privacy Practices

I have read, understand and been offered a copy of Dr. Panter's Private Practices Policy Form (the HIPPA).

_____ _____

Client signature (or parent signature for children under 18) Date

Dr. Panter
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