Chiropractic
FUNCTIONAL MEDICINE
Restore your health & wellness, naturally!

Patrick Krupka, DC, PA

10330 Lake Rd, Suite T
Houston, TX 77070

www.DrKrupka.com KrupkaOffice@DrKrupka.com
Office: 281-664-6464 Fax: 281-664-6466

GENERAL INFORMATION

Name _____ Preferred Name_____ Date _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Age _____ Date of Birth _____ Place of Birth_____Gender: female ○ male ○

Married ○ Separated ○ Divorced ○ Widowed ○ Single ○ Partnership ○ Do you have any children? Yes ☐ No ☐

If so, how many? _____ Age(s)_____ Gender(s)_____ Name(s)_____

Occupation _____ Nature of Business_____

How did you hear about our clinic? Website ☐ Media ☐ Friend/ family member_____

Has any other family member already been a patient at the clinic? _____

Who is your primary medical physician?_____

Have you ever lived or travelled outside the United States? Yes ☐ No ☐ If yes, when and where?

Have you or your family recently experienced any major life changes? Yes ☐ No ☐ If yes, please comment:

Have you experienced any major losses in life? Yes ☐ No ☐ If yes, please comment:

Do you have any allergies? Yes ☐ No ☐ If yes, what are you allergic to and what is your reaction?

Functional Assesment Questionnaire

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present. (Use the back of the page if necessary.)

PROBLEM	ONSET	FREQUENCY	SEVERITY

What diagnosis or explanation have been given to you?_____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Please list all physicians you have seen for the above health conditions:

1._____ 4._____

2._____ 5._____

3._____ 6._____

PAST MEDICAL & SURGICAL HISTORY

ILLNESSES	Date	Date	Date	Comments
Chicken Pox		X	X	
German Measles		X	X	
Measles		X	X	
Mumps		X	X	
Whooping cough		X	X	
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic Fatigue				
Crohn's Disease/ Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				
Gout				
Heart attack/Angina				
Heart failure				
Hepatitis				
High blood pressure				
Irritable bowel				
Kidney stones				
Mononucleosis				
Pneumonia				
Rheumatic fever				
Sinusitis				
Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				

DIAGNOSTIC STUDIES	Date	Date	Date	Comments
Chest X-ray				
Mammogram				
EKG				
Sigmoidoscopy/Colonoscopy				
Upper GI Series				
Barium Enema				
CAT scan/MRI/X-rays				
Bone scan				
Bone Density Test				
Carotid Artery Ultrasound				
Other (describe)				
OPERATIONS	**Date**	**Date**	**Date**	**Comments**
Tonsillectomy		X	X	
Tubes in Ears				
Appendectomy		X	X	
Gall Bladder		X	X	
Hernia				
Hysterectomy		X	X	
Other (describe)				

MEDICATIONS & SUPPLEMENTS

MEDICATION LOG

Please indicate the type of medications you are taking now. Please include non-prescription drugs.

Medication Name	Date started	Dated Stopped	Dosage	# per day

SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name and Brand	Dose	Frequency	Dated Started	Reason for use

HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

CHILDHOOD HEALTH HISTORY

As a child, were there any foods that you had to avoid because they gave you symptoms? Yes ☐ No ☐

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

FEMALE MEDICAL HISTORY (for women only)

OBSTETRICS HISTORY *Check box if yes and provide number of*

❑ Pregnancies _____ ❑ Caesarean _____ ❑ Vaginal deliveries _____

❑ Miscarriage _____ ❑ Abortion _____ ❑ Living Children _____

❑ Post partum depression ❑ Toxemia ❑ Gestational diabetes

❑ Baby over 8 pounds ❑ Breast feeding? Yes ☐ No ☐ For how long?_____

GYNECOLOGICAL HISTORY

Age at 1st period:_____ Menses Frequency: _____ Length: _____ Pain: Yes ☐ No ☐ Clotting: Yes ☐ No ☐

Has your period skipped? _____ For how long? _____ Do you currently use contraception? Yes ☐ No ☐ If yes, what type?

❑ Condom ❑ Diaphragm ❑ IUD ❑ Partner vasectomy

❑ Patch ❑ Birth control pills If yes, does it agree with you? Yes ☐ No ☐ ❑ Nuva Ring How long?_____

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes ☐ No ☐

Last Mammogram/Thermogram _____ Breast Biopsy/Date _____ Last PAP Test: _____ Normal ☐ Abnormal ☐

Date of last Bone Density: _____ Results: ❑ High ❑ Low ❑ Within normal range

Are you in menopause? Yes ☐ No ☐ Age at Menopause _____

Do you take: ❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone

❑ Provera Other _____ How long have you been on hormone replacement? _____

Have your medications or supplements ever caused you unusual side effects or problems? Yes ☐ No ☐ If yes, please describe:

FAMILY MEDICAL HISTORY

(Please mark any health problem(s) your family has suffered with either now or in the past)

Check Family Members that Apply	Father	Mother	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)												
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer (Specify Type)												
ADD/ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALS	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis (Specify Type)												
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Diseases	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bladder disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood clotting problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes (Specify I or II)												
Eczema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bowel Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pneumonia/Bronchitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Smoking addiction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Any other family history we should know about? Yes ☐ No ☐

If yes, please comment:

NUTRITION & LIFESTYLE HISTORY

Have you made any changes in your eating habits because of your health? Yes ☐ No ☐

Do you currently follow a special diet or nutritional program? Yes ☐ No ☐

Check all that apply:

- ❑ Low Fat
- ❑ Low Starch/Carbohydrate
- ❑ Mixed Food Diet(Animal and Vegetable Sources)
- ❑ The Blood Type Diet
- ❑ High Protein
- ❑ Metabolic Typing Diet
- ❑ Vegetarian
- ❑ Specific Program for Weight Loss/Maintenance Type:_____
- ❑ Total Calorie Restriction
- ❑ Vegan
- ❑ Diabetic
- ❑ Gluten Free
- ❑ No Dairy
- ❑ Low Sodium
- ❑ No Wheat

Height (feet/inches)_____ Current Weight_____

Usual weight range +/- 5 lbs_____ Desired Weight range +/- 5 lbs_____

Highest adult weight _____ Lowest adult weight _____

Are there any foods that you avoid because they give you symptoms? Yes ☐ No ☐

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

Do you have symptoms **immediately after** eating, such as belching, bloating, sneezing, hives, etc.? Yes ☐ No ☐ If yes, please explain:

EXERCISE

Current Exercise program: *Activity (list type, number of sessions/week, and duration of activity)*

Activity	Type	Frequency per week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength Training			
Other (Pilates, yoga, etc.)			
Sports or Leisure Activities			

List problems that limit activity: _____

Do you feel fatigued after exercise? Yes ☐ No ☐ Do you usually sweat when exercising? Yes ☐ No ☐

SOCIAL HISTORY

SLEEP/REST

Average number of hours you sleep ❑ >10 ❑ 8 – 10 ❑ 6 – 8 ❑ <6

Do you have trouble staying asleep? Yes ☐ No ☐

Do you have trouble falling asleep? Yes ☐ No ☐

Do you feel rested upon awakening? Yes ☐ No ☐

Do you snore? Yes ☐ No ☐

TOBACCO HISTORY

Currently using tobacco? Yes ☐ No ☐ How Long ? _____ What type? Cigarette _____ Packs per day: _____

Smokeless _____ Cigar _____ Pipe _____ Patch/Gum _____ **Previous** smoking: How many years? _____ Packs per day:_____

ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits

None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 ☐ If none skip to "Other Substances"

Previous alcohol intake? Yes ☐ (Mild ◯ Moderate ◯ High ◯)

ESTABLISHING HEALTH GOALS

Personal Message

Before we begin our journey together, I would like to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated and failed in their attempt to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms – it's about living a life of vibrant health.

I've discovered that any discussion of the correct way to achieve health and stay healthy is, in actuality; a discussion of how you have lived your life up to this point and how you will live it in the future.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

What do you hope to achieve in your visit with us?

If you had a magic wand and could erase three problems, what would they be?

1. _____

2. _____

3. _____

Have you made the decision to change? To do what it takes to get well? Yes ☐ No ☐

I have read something interesting: ***"The definition of insanity is to keep doing the same thing and expecting different results".*** If you keep following the same course of treatment you have been following will your results really change? Have you ever wondered if you are on the right path to achieving optimal health? Sometimes it requires taking a new and improved road to reach your destination.

Most people I ask tell me they've made the decision to change. But how many people have truly decided to change? Very few! Why?

Because there is a big difference between deciding something and having “reasons” to actually do it.

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask:

List up to 5 things that you have ***been unable* to do as a result of your present symptoms. Please be specific.**

List up to 5 things that you plan to do once you are feeling better. Please be specific. (Use extra pages if necessary)

Are there any other health goals you want to achieve?

READINESS ASSESMENT

Rate on a scale of: 5 (very willing) to 1(not willing)

In order to improve your health, how willing are you to:

Significantly modify your diet:	5 ○	4 ○	3 ○	2 ○	1 ○
Take several nutritional supplements each day:	5 ○	4 ○	3 ○	2 ○	1 ○
Modify your lifestyle:	5 ○	4 ○	3 ○	2 ○	1 ○
Practice relaxation techniques:	5 ○	4 ○	3 ○	2 ○	1 ○
Engage in regular exercise:	5 ○	4 ○	3 ○	2 ○	1 ○
Have periodic lab tests to assess progress:	5 ○	4 ○	3 ○	2 ○	1 ○

Comments:

Thank you for taking the time to complete this health history medical questionnaire.

The information derived from all of these medical forms will provide invaluable data.

Each section builds upon the other, allowing me and other physicians the opportunity to discover the **“missing key”** that will solve your health problem.

Once all the sections of this form and the questionnaires have been filled out please return them to our office and we’ll make an appointment for our initial consultation.

I thank you once again and look forward to helping you achieve a **“return to health and well being.”**

Sincerely,

Patrick Krupka, DC

Chiropractic
FUNCTIONAL MEDICINE
Restore your health & wellness, naturally!
10330 Lake Rd, Suite T, Houston, TX 77070
281-664-6464 www.DrKrupka.com

NUTRITIONAL INFORMED CONSENT

1. **SERVICES**: My health care provider has recommended functional, nutritional, and lifestyle evaluation, testing, consulting, and care, including dietary supplements. I understand and am informed that products and services are not provided by medical physicians and do not include prescription of legend drugs, surgery, or other conventional allopathic medical treatments. I further understand that consultations, evaluations, supplementation, lifestyle consultation, testing, recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients pertain to the functional health/whole body concept.

2. **NO GUARANTEE**: I have been informed that the methods of nutritional evaluation or testing made available to me are not intended to diagnose disease from an allopathic model of medicine. Rather, they are intended as a guide to developing an appropriate overall health-supportive program for me, and to monitor progress in achieving goals. I further understand that any recommendations are supportive in nature allowing the body to return to improved health. Like all other health care, results are not guaranteed and there is no promise to cure. Accordingly, I understand that payment(s) for services are not conditional on my response to care. Prorated fees for unused, prepaid services, however, will be refunded if I wish to cancel. No refunds will be available for any products purchased.

3. **RISKS**: I understand the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that may be recommended are generally considered safe, however, some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be toxic in large doses. I also understand that nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may interact with some legend drugs. Accordingly, I agree to consult with my prescribing physician about any legend drugs I am taking and the impact of supplements, vitamins, minerals, food grade herbs, and other nutrients on such drugs. I will inform my health practitioner if I experience gastrointestinal upset (nausea, gas, stomachache, vomiting), allergic reactions (hives, rashes, itching, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients.

4. **PREGNANCY**: I understand that some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be inappropriate during pregnancy, and I will notify the health practitioner if I am or become pregnant.

5. **ALTERNATIVES**: I understand that the alternatives to the recommendations include doing nothing and/or seeking additional allopathic medical care.

6. **QUESTIONS AND ANSWERS**: I have read and fully understand this consent form, and understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND THIS FORM!

I have read and fully understand this consent. All items have been explained, I have had sufficient time to evaluate the information, and my questions have been answered. Knowing the alternatives and risks, I consent to the services.

Signature _____ Date _____

Name (printed)_____

Chiropractic Functional Medicine

Patrick Krupka, DC, PA
10330 Lake Rd, Suite T Houston, TX 77070
(281) 664-6464

Informed Consent to Chiropractic Treatment

Medical doctors, Chiropractic doctors, Osteopaths, and Physical Therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations / adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with procedures as follows.

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures / Joint injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million, to once in ten million treatments. Once in one million is about the same chance as being struck by lightning, and once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Treatment results:
I also understand that there are beneficial effects associated with treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However I appreciate that there is no certainty that I will receive these benefits.

Alternative treatments available:
Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over the counter medications, exercises, and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, or prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar / adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction prior to my signing this consent form. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature:_____ Date: _____

Chiropractic
FUNCTIONAL MEDICINE
Restore your health & wellness, naturally!

Financial Agreement

Cash Payment

We would like to take a moment to welcome you to our office and assure you that you will be receiving the very best care available. In order to familiarize you with the financial policies of our office, I would first like to explain how your bills will be handled.

It is our policy in this office to maintain your account on a current basis. Charges for treatment are DUE AND PAYABLE at the time the service is provided. We accept cash, check, or credit card (Visa, MC, American Express & Discover). We ask that you make payments on a PER VISIT BASIS. If you accrue a balance, it is also understood that you are responsible for any collection costs incurred. If you need to make alternate payment arrangements please let us know, often times we can reach an appropriate solution.

Once again, we would like to welcome you to our office. If you have any questions at any time, please feel free to ask.

I have read and agree to the above.

_____ _____

Patient Signature Date

*Please be kind enough to give us a 24 hour notice if you must change or cancel you appointment. Our office policy requires a $20.00 cancellation fee if adequate notice is not given. (Legitimate emergencies accepted.)