Dr. Alexandria Calderone, DC
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The following information provided is confidential and is for medical purposes only. It is important you fill it out to the best of your ability. Even if the question seems not to apply to your current condition please fill this form out completely as many things can be connected and will help us better serve you.

Name:____ **Today's Date:**_____________(mm/dd/yr)

DOB:________ (mm/dd/yr) **Current age**:____ **Height**:____ **Weight**:______ **Gender**: □ **male** □ **female**

Address:______________________________ **City:**____________ **State:**____ **Zip Code:**___________

Home Phone:_________________________ Permission to leave a 'medical' message? □ **Yes** □ **No**

Cell Phone:___________________________ Permission to leave a 'medical' message? □ **Yes** □ **No**

Email for medical/healthcare correspondence:____

Occupation:__________________________ **Employer:**___________________________________

Emergency Contact Name:______________________________ **Phone #:**______________________

Please Describe your current problem/complaint that brought you to our office: List them in order of importance. For example #1 is most important, and #5 is least important. *(if your complaint is of pain please also use the diagram on the following page)*

DESCRIBE THE PROBLEM	Onset Date	MILD/MOD /SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	2013	Moderate	Elimination Diet	Moderate
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Do any of these issues affect your (check appropriate box): □ work, □ sleep, □ other:______________________________

Major goals for your first visit: Let us know what you would like to accomplish on your first visit.

1.______________________________

2.______________________________

3.______________________________

4.______________________________

Have you been treated for this condition in the past/present? □ yes, □ no; If YES, by whom?

____

Have you been diagnosed for any of the above conditions? □ yes, □ no;

Diagnosis:______________________________

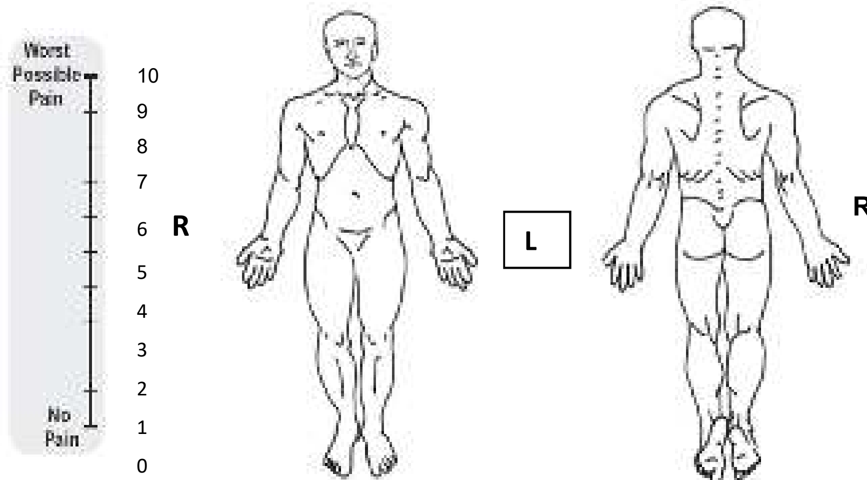
Is there anything else the Doctor should know about *you* or your *condition*?______________________________

____

____

____

Please circle a number corresponding with to your pain and use "X"'s and lines to locate your pain and describe any radiation of pain.



PAST HISTORY

Mark all that apply:

	ILLNESSES	WHEN	COMMENTS
◯	Anemia		
◯	Arthritis		
◯	Asthma		
◯	Brain Tumor		
◯	Bronchitis		
◯	Cancer		
◯	Chronic Fatigue Syndrome		
◯	Crohn's Disease or Ulcerative Colitis		
◯	Diabetes		
◯	Emphysema		
◯	Epilepsy, convulsions, or seizures		
◯	Gallstones		

◯	Gout		
	ILLNESS	**WHEN**	**COMMENTS**
◯	Heart Attack/Angina		
◯	Heart failure		
◯	Hepatitis		
◯	High blood fats (cholesterol, triglycerides)		
◯	High blood pressure (hypertension)		
◯	Irritable bowel		
◯	Kidney stones		
◯	Mononucleosis		
◯	Pneumonia		
◯	Rheumatic Fever		
◯	Sinusitis		
◯	Stroke		
◯	Thyroid Disease		
◯	Migraines		
◯	Other Tumor		
◯	Other (Describe)		
	INJURIES	**WHEN**	**COMMENTS**
◯	Back injury		
◯	Head injury		
◯	Neck injury		
◯	Other (Describe		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
◯	Barium Enema		
◯	Bone Scan		
◯	CAT Scan of Abdomen		
◯	CAT Scan of Brain		
◯	CAT Scat of Spine		
◯	Chest X-ray		
◯	Colonoscopy		
◯	EKG		
◯	Liver scan		
◯	X-rays (of what region)		
◯	NMR/MRI (of what region)		
◯	Sigmoidoscopy		
◯	Upper GI Series		
◯	Other (Describe		
	OPERATIONS	**WHEN**	**COMMENTS**
◯	Appendectomy		
◯	Dental Surgery		
◯	Breast Augmentation/Implants/Reduction		
◯	Gallbladder Removal		
◯	Hernia		
◯	Hysterectomy (**Please circle**: Full or Partial)		
◯	Tonsillectomy		
◯	Other		
◯	Other		
◯	Other		

◯	Other		
◯	Other		

Have you… **Yes** or **No** If yes, explain briefly WITH approximate date/year

... ever been hospitalized? ◻ ◻

____

____

... had any mental disorders? ◻ ◻

____

... had any broken bones? ◻ ◻

____

... had any strains or sprains? ◻

____

Have you ever been bitten by a *tick or spider* that you know of? ◻ **yes,** ◻ **no** If yes, did you have a reaction such as a rash, fever, joint pain, etc. ◻ **yes,** ◻ **no**

____

Have you ever have mono or Epstein barr virus? ◻ **yes,** ◻ **no**

Have you ever had any chronic infections?◻ **yes,** ◻ **no**

Have you ever been diagnosed with MRSA? ◻ **yes,** ◻ **no**

Have you had any other infections? ◻ **yes,** ◻ **no**

:____

Do you have any allergies to foods, medications or environment?

____

____

____

____

____

____

How often have you have taken antibiotics?

	< 5 Times	**> 5 Times**
Infancy/ Childhood		
Teen		
Adult		

How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 Times	**> 5 Times**
Infancy/ Childhood		
Teen		
Adult		

CHILDHOOD

Question	Yes	No	Don't Know	Comment
Were you a full term baby?				
Were you a preemie baby?				
Were you breast fed?				
Were you bottle fed?				
As a child, did you eat a lot of sugar and/or candy?				
As a child, did you have any type of chronic infection, rash, skin irritation, or yeast?				

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 (Example: milk – gas and diarrhea)
____
____
____

Place a check mark next to the food/drink that applies to your **curren**t diet. (List continues to next page.)

Usual Breakfast	✔	**Usual Lunch**	✔	**Usual Dinner**	✔
None		None		None	
Bacon/Sausage		Butter		Beans (legumes)	
Bagel		Coffee		Brown Rice	
Butter		Eat in a cafeteria		Butter	
Cereal		Eat in restaurant		Carrots	
Coffee		Fish sandwich		Coffee	
Donut		Juice		Fish	

Eggs		Leftovers		Green Vegetables	
Fruit		Lettuce		Juice	
Juice		Margarine		Margarine	
Margarine		Mayo		Milk	
Milk		Meat Sandwich		Pasta	
Oat bran		Milk		Potato	
Sugar		Salad		Poultry	
Usual Breakfast	✓	**Usual Lunch**	✓	**Usual Dinner**	✓
Sweet roll		Salad dressing		Red meat	
Sweetener		Soda		Rice	
Tea		Soup		Salad	
Toast		Sugar		Salad dressing	
Water		Sweetener		Soda	
Wheat bran		Tea		Sugar	
Yogurt		Tomato		Sweetener	
Tofu		Tofu		Tofu	
Other (List Below)		Yogurt		Water	
		Other (List Below)		Yellow Vegetables	
				Other (List Below)	

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of Coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet sodas	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels)	
Sodas with caffeine	
Sodas without caffeine	
Tofu	
Soy beans	
Juice	
Milk	
Cakes, Cookies, Pies, ect	

Are you on a special diet? Yes____ No____

______ ovo-lacto ______ vegetarian ______ other (describe):

______ diabetic ______ vegan ______________________________

______ dairy restricted ______ blood type diet ______________________________

_____ gluten free ______ Paleo

Is there anything special about your diet that we should know? Yes____ No____

If yes, please explain:

____

____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, headaches, etc.?

Yes____ No____

b. If yes, are these symptoms associated with any particular food or supplement(s)? Yes____ No____
c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

____
____
____

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____

.Do you feel much **WORSE** when you eat a lot of :

___high fat foods ___ refined sugar (junk food) ___high protein foods

___ fried foods ___ high carbohydrate foods (breads, pastas, potatoes) ___1 or 2 alcoholic drinks

___ other (Please list below)

____
____

Do you feel much **BETTER** when you eat a lot of :

___high fat foods ___ refined sugar (junk food) ___high protein foods

___ fried foods ___ high carbohydrate foods (breads, pastas, potatoes) ___1 or 2 alcoholic drinks

___ other (Please list below)

____
____

Does skipping a meal greatly affect your symptoms? Yes____ No____

Have you ever had a food that you craved or really "binged" on over a period of time? Food craving may be an indicator that you may be allergic to that food. Yes____ No____

If yes, what food(s)? ____
____

Do you have an aversion to certain foods? Yes____ No____

If yes, what foods?
____-
____

Please fill in the chart below with information about your bowel movements:

Frequency	✓	**Color**	✓	**Consistency**	✓
More that 3x/day		Medium brown consistently		Soft and well formed	
1-3x/day		Very dark or black		Often float	
4-6x/week		Greenish color		Difficult to pass	
2-3x/week		Blood is visible		Diarrhea	
1 or fewer x/week		Varies a lot		Thin, long, or narrow	
		Dark brown consistently		Small and hard	
		Yellow, light brown		Loose but not watery	
		Greasy, shiny appearance		Alternating between hard and loose/watery	
		Clay colored			

Describe your intestinal gas:

___Daily ___Present with pain

___Occasionally ___Foul smelling

___Excessive ___ Little odor

FAMILY HISTORY

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Cancer___________________________________
□ High blood pressure _________________________
□ Anemia _________________________________
□ Diabetes ________________________________
□ High cholesterol ____________________________
□ Arteriosclerosis _____________________________
□ Emphysema ______________________________
□ Multiple sclerosis ___________________________

□ Epilepsy___________________________________
□ Osteoporosis_______________________________
□ Stroke ____________________________________
□ Bleed easily________________________________
□ Heart disease ______________________________
□Thyroid disease ____________________________
□ Dementia/Alzheimer's/Parkinson's _____________
□ OTHER:
____
____
___________________ ____

HABITS and LIFESTYLE

What are your hobbies and leisure activities:

____
____
____

.Do you exercise regularly? Yes____ No____

If so, how many times a week?

1. ___1x
2. ___ 2x
3. ___3x
4. 4x or more

When you exercise, how long is each session?

1. ____ <15 min
2. ___ 16-30 min
3. ____31-45 min
4. ___ > 45 min

What type of exercise is it?

___ jogging/walking ___tennis ___basketball ___watersports ___home aerobics ___weight lifting

other

____
____

MOST RECENT VISIT TO A DOCTOR: *When was the last time you consulted a doctor, and for what reason?* ____ **Date of last complete physical exam**:

Date of most recent lab/blood tests: _______________

WOMEN—date of last PAP smear:______________ results:____________________

Currently pregnant? YES NO UNSURE

Do you still have your monthly period? YES NO UNSURE

How old were you when you started your first monthly period?_________

Do you have any children? YES NO **How many?**_________ **Healthy?**_______________

Name/s of your children:____ **Is there anything else the Doctor should know or you would like to elaborate on?:**

____

____

____

____

Current <u>prescription medications</u> (e.g., Prozac, lipitor, etc), **<u>non-prescription medications</u>** (e.g., aspirin, Tylenol, ibuprofen) and/or **<u>health supplements</u>** (e.g., vitamins, minerals, herbs):

NAME *of medication or supplement—drugs, vitamins, herbs, minerals*	**DOSE** *in milligrams or grams (or number of capsules, tablets)*	**FREQUENCY***:* **Times per day/ week/ month**	**DURATION***: Been* **taking for how long?**	**REASON:** Why are you taking this?

Please list the medications and/or supplements that you are currently taking. If you need more room please attached a sheet to this form. ***Please also list any drug allergies***.

REVIEW of SYSTEMS: Simply circle the most appropriate number for each attribute so we can better understand and discuss your current condition. Although this list is extensive it is important to fill out completely and as accurately as possible. If you mark "YES" to a question please provide additional info to the right or on the bottom of the page.

GENERAL HEALTH	Never-Very rare	OccasionalMild	IntermittentModerate	FrequentSevere
Fatigue, lack of energy, lack of stamina	☐0	☐1	☐2	☐3

Tired even after “good” sleep	☐0	☐1	☐2	☐3
Lack of desire to get out of bed	☐0	☐1	☐2	☐3
Undesired weight gain, difficulty losing weight	☐0	☐1	☐2	☐3
Undesired weight loss	☐0	☐1	☐2	☐3
Hard time falling asleep	☐0	☐1	☐2	☐3
Hard time staying asleep	☐0	☐1	☐2	☐3
Faint/dizzy/nauseous if a meal is skipped	☐0	☐1	☐2	☐3
Decreased appetite	☐0	☐1	☐2	☐3
Food or environmental allergies	☐0	☐1	☐2	☐3
Sensitive to perfumes, chemical smells, exhaust, etc.	☐0	☐1	☐2	☐3
Cold sores and blisters	☐0	☐1	☐2	☐3
Morning stiffness/muscle cramps	☐0	☐1	☐2	☐3
Pain at night/Night sweats	☐0	☐1	☐2	☐3
Past or present diagnosis of serious conditions such as : cancer, systemic infection, kidneys disease, heart disease or other	**☐NO**	**☐YES —>**		

HAIR, SKIN, and NAILS	Never-Very rare	OccasionalMild	IntermittentModerate	FrequentSevere
Oily or dry skin (please circle)	☐0	☐1	☐2	☐3
Eczema	☐0	☐1	☐2	☐3
Psoriasis	☐0	☐1	☐2	☐3
White spots on finger nails	☐0	☐1	☐2	☐3
Small bumps on the back of the arms	☐0	☐1	☐2	☐3
Skin rash or fungal infection	☐0	☐1	☐2	☐3
Increased body or facial hair	☐0	☐1	☐2	☐3
Decrease in body or facial hair	☐0	☐1	☐2	☐3
Acne	☐0	☐1	☐2	☐3
Discoloration or depigmentation of skin	☐0	☐1	☐2	☐3
Other problems or concerns in this area	**☐NO**	**☐YES —>**		

HEAD and MIND	Never-Very rare	OccasionalMild	IntermittentModerate	FrequentSevere

Lack of desire to get out of bed	☐0	☐1	☐2	☐3
Headaches or Migraines (please circle)	☐0	☐1	☐2	☐3
Loss of consciousness or feeling faint, dizzy	☐0	☐1	☐2	☐3
Hard time remembering (long or short term)	☐0	☐1	☐2	☐3
Difficulty speaking or "finding" words	☐0	☐1	☐2	☐3
Difficulty concentrating	☐0	☐1	☐2	☐3
Dyslexia or word confusion	☐0	☐1	☐2	☐3
Other problems or concerns in this area	**☐NO**	**☐YES —>**		
Feelings of sadness or depression	☐0	☐1	☐2	☐3
Anxiety and stress	☐0	☐1	☐2	☐3
Inability to cope with stressful situations	☐0	☐1	☐2	☐3
Lack of interest or concern	☐0	☐1	☐2	☐3
Mental sluggishness	☐0	☐1	☐2	☐3
Use of alcohol, drugs, vitamins/minerals/ herbals to deal with stress	☐0	☐1	☐2	☐3
Recent or current thoughts of suicide	☐0	☐1	☐2	☐3
Difficulty speaking or "finding" words	☐0	☐1	☐2	☐3
Other problems or concerns in this area	**☐NO**	**☐YES —>**		
Diagnoses of any mental disorder- depression, bipolar, schizophrenia or other	**☐NO**	**☐YES —>**		
CARDIOVASCULAR and PULMONARY	Never-Very rare	OccasionalMild	IntermittentModerate	FrequentSevere
Pain in the chest, left arm, and/or left side of neck	☐0	☐1	☐2	☐3
Shortness of breath upon relaxation or exertion	☐0	☐1	☐2	☐3
Swelling in upper or lower extremities	☐0	☐1	☐2	☐3
Irregular heart beat	☐0	☐1	☐2	☐3
Pounding heart beat heard when resting your head on a pillow	☐0	☐1	☐2	☐3
Rapid heart beat	☐0	☐1	☐2	☐3
Irregular breathing or discomfort	☐0	☐1	☐2	☐3
“Blushed” or red faced	☐0	☐1	☐2	☐3
Tightness of the chest	☐0	☐1	☐2	☐3

Other problems or concerns in this area	☐**NO**	☐**YES —>**	

EYES, EARS, NOSE, THROAT	Never-Very rare	OccasionalMild	IntermittentModerate	FrequentSevere
Watery, red, or itchy eyes	☐0	☐1	☐2	☐3
Dark circles under eyes	☐0	☐1	☐2	☐3
Loss of vision/Blurry vision	☐0	☐1	☐2	☐3
Hard to see at night	☐0	☐1	☐2	☐3
Pain in, near, or behind the eye	☐0	☐1	☐2	☐3
Earache or pain in the ears	☐0	☐1	☐2	☐3
Tinnitus/ Ringing in the ears	☐0	☐1	☐2	☐3
Reoccurring ear infections	☐0	☐1	☐2	☐3
Decrease or loss of hearing	☐0	☐1	☐2	☐3
Enlarged lymph nodes under the chin/jaw/ on the neck	☐0	☐1	☐2	☐3
Bleeding/ sore gums	☐0	☐1	☐2	☐3
Tongue has a white coating	☐0	☐1	☐2	☐3
Dry mouth, eyes, and/or nose	☐0	☐1	☐2	☐3
Halitosis/ bad breath	☐0	☐1	☐2	☐3
Sore throat	☐0	☐1	☐2	☐3
Excessive mucus formation	☐0	☐1	☐2	☐3
Other problems or concerns in this area	☐**NO**	☐**YES —>**		

GENITO-URINARY	Never-Very rare	OccasionalMild	Intermittent - Moderate	FrequentSevere
Pain in the mid to lower back	☐0	☐1	☐2	☐3
Kidney stones	☐0	☐1	☐2	☐3
Cloudy, bloody, or dark urine	☐0	☐1	☐2	☐3
Urinary tract infections	☐0	☐1	☐2	☐3
Frequent urination	☐0	☐1	☐2	☐3
Painful urination	☐0	☐1	☐2	☐3
Difficulty controlling urination, incontinence	☐0	☐1	☐2	☐3
Low sex drive/ libido	☐0	☐1	☐2	☐3
HIV test	☐NOT TESTED	☐YES —>	☐Positive	☐Negative
Sexually transmitted disease	☐**NO**	☐**YES —>**		

Other problems or concerns in this area	**☐NO**	**☐YES —>**	

GASTROINTESTINAL	Never-Very rare	OccasionalMild	Intermittent -Moderate	FrequentSevere
Constipation / Diarrhea (please circle)	☐0	☐1	☐2	☐3
Gas or bloating	☐0	☐1	☐2	☐3
Nausea / Vomiting (please circle)	☐0	☐1	☐2	☐3
Pains in the stomach or lower abdomen	☐0	☐1	☐2	☐3
Heartburn or “GERD”	☐0	☐1	☐2	☐3
Sense of fullness after meals	☐0	☐1	☐2	☐3
Tired after meals or feel better if you skip meals	☐0	☐1	☐2	☐3
Undigested food in stool	☐0	☐1	☐2	☐3
Food allergies	☐0	☐1	☐2	☐3
Mucous build up/ sinus congestion after meals	☐0	☐1	☐2	☐3
Greasy or fatty foods upset your stomach	☐0	☐1	☐2	☐3
Anal itching	☐0	☐1	☐2	☐3
Coated white tongue	☐0	☐1	☐2	☐3
Fungal or yeast infections	☐0	☐1	☐2	☐3
Symptoms get worse after eating sugar	☐0	☐1	☐2	☐3
Dark circles under the eyes	☐0	☐1	☐2	☐3
Hemorrhoids	☐0	☐1	☐2	☐3
Blood or mucous in the stool (please circle)	☐0	☐1	☐2	☐3
Crohn’s disease or Celiac disease (please circle)	**☐NO**	**☐YES —>**		
History of alcohol abuse	**☐NO**	**☐YES —>**		
History of hepatitis	**☐NO**	**☐YES —>**		
Long term use of prescription/recreational drugs	**☐NO**	**☐YES —>**		
Loss of bowel control, incontinence	**☐NO**	**☐YES —>**		
Other problems or concerns in this area	**☐NO**	**☐YES —>**		

MALE ONLY	Never-Very rare	OccasionalMild	Intermittent -Moderate	FrequentSevere
Difficulty or painful erections	☐0	☐1	☐2	☐3
Cloudy, bloody, or dark urine	☐0	☐1	☐2	☐3
Painful or difficulty with ejaculation	☐0	☐1	☐2	☐3
Waking to urinate at night	☐0	☐1	☐2	☐3

Decreased sexual function	☐0	☐1	☐2	☐3
Difficulty controlling urination, incontinence	☐0	☐1	☐2	☐3
Family history of prostate cancer	☐**NO**	☐**YES —>**		
Painful/tender testis	☐**NO**	☐**YES —>**		
Undescended testis, testis in abdomen or pelvis	☐**NO**	☐**YES —>**		
Other problems or concerns in this area	☐**NO**	☐**YES —>**		

FEMALE ONLY	Never-Very rare	OccasionalMild	Intermittent -Moderate	FrequentSevere
Irregular or painful menses	☐0	☐1	☐2	☐3
Pain between cycles	☐0	☐1	☐2	☐3
Heavy clotting	☐0	☐1	☐2	☐3
Painful, swollen, fibrocystic breasts	☐0	☐1	☐2	☐3
Excessive bleeding	☐0	☐1	☐2	☐3
Painful intercouse	☐0	☐1	☐2	☐3
Hot flashes or fluctuations in temperature	☐0	☐1	☐2	☐3
Yeast infections/ vaginal itching	☐0	☐1	☐2	☐3
Mood fluctuations that follow your cycle	☐0	☐1	☐2	☐3
The use of birth control (circle one)	Pill	Patch	IUD	Injection
If yes to question above, note duration	<1 year	1-4 years	5-10 years	11+
Menopausal symptoms or concerns	☐**NO**	☐**YES —>**		
What age did your mother experience menopause?				
Infertility	☐**NO**	☐**YES —>**		
Polycystic ovarian syndrome (PCOS)	☐**NO**	☐**YES —>**		
Family history of breast, uterine, or ovarian cancer?	☐**NO**	☐**YES —>**		
Annual female exam: breast, pap smear, etc.?	☐**NO**	☐**YES**		
Other problems or concerns in this area	☐**NO**	☐**YES —>**		

Informed Consent and Mutual Understanding

TO THE PATIENT: Once this document has been reviewed with you verbally, please read it in its entirety prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

It is not necessary or encouraged to discontinue treatments with other physicians or healthcare providers. If you are on any current medication or nutritional supplementation- it is your responsibility to inform changes in your condition, symptoms, contact information, or treatments between visits.
You are encouraged to contact Dr. Alexandria Calderone, D.C. at any time with health-related questions as this is a team effort and every effort will be made to keep you focused on your ultimate goal of optimal health.
Dr. Alexandria Calderone, D.C holds a Doctor of Chiropractic Degree and is currently licensed in the state of Florida and is Board Eligible for DABCI certification. Each procedure/lifestyle modification/treatment holds both risks and benefits. Your case will be thoroughly evaluated to avoid some of these negative reactions and customized to your unique health status; but no guarantees can be assured regarding the outcomes of treatment(s) or procedure(s) nor are they implied.
For distance consultations: *Due to the nature of this consult, a primary care provider is necessary and should have performed a physical exam on your current major complaint that you are seeking advice from Dr. Alexandria Calderone, D.C for. B*ecause of the nature of phone visits and internet consultations there is the inability to perform physical examination during these visits thus you need to have a complete physical exam by a local primary care physician or other healthcare provider and you need to try to provide very complete information and an accurate description of any physical ailments. For skin rashes and other visible problems, digital photos sent by email are helpful and will aid in the assessment. You must also appreciate that a full evaluation may not be possible but that in most instances we can share sufficient information to proceed with safety and effectiveness.

Nutrition Informed Consent:
According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean:
"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."
A Vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone. 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. Alexandria Calderone, D.C. or in case of emergency, go to your local urgent care facility/Hospital. May 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 last a few days to several weeks.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient’s diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body.
Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

Distance Consultations
Due to the nature, distance consultations carry their own unique risks. It is required you consult with a local physician in conjunction with any care recommended which includes but is not limited to exercises, supplementation and dietary/lifestyle changes. A physical exam is strongly recommended to be performed prior to any consultation. Should any emergency arise, call 911 immediately.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read the above explanation of the chiropractic adjustment and related treatment. Dr. Alexandria Calderone, D.C has discussed this document with me as it pertains to my specific case and has answered all my questions to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name (print) ____

Patient/Guardian Signature____

Date ______________________

Tallahassee Spine Center, Progressive Chiropractic and Wellness Financial Agreement and Cancellation Policy

Dr. Alexandria Calderone D.C. values your time. Dr. Alexandria Calderone D.C. strives to see patients in a timely manner. We respect your time and ask you to respect our time and other patients' needs by keeping your appointment. Each appointment time slot is important and cannot be recovered if a patient chooses not to keep their appointment. We collect fees to ensure that Dr. Alexandria Calderone, D.C. can continue to see patients. Please keep in mind that each skipped or missed appointment is not just time lost, but also time when other patients cannot be seen.

Please refer to the guidelines below to learn more about our Missed Appointment/Cancellation policy:

- It is your responsibility to provide us with a working telephone number to allow us to communicate important information, such as laboratory results, and provide telephone reminders of scheduled appointments. Having a valid telephone number is truly important; please help us to maintain your records.

- **New patient appointments will be subject to fees below. When a patient does not show up or does not cancel within 24 business hours the follow fees will be added to the patient's account:**

  $125 fee for New Patient Internal

  A credit card will be required to schedule all future appointments and will be charged full cost if the appointment is not cancelled/rescheduled within the 24hrs notice policy.

  Established patients

We understand that circumstances occur that do not allow you to keep your scheduled appointment. If this is the case, please call and discuss this with the office staff as soon as possible.

$65 fee for Internal Medicine
$25 fee for Chiropractic
$100 fee for Chiropractic and Internal combined

A credit card will be required to schedule all future appointments and will be charged full cost if appointments are not cancelled / rescheduled within the 24 hour notice.

- Accounts that accumulate three missed appointment fees may be dismissed from the Practice.
- Any cancellation not made at least 24 hours before the scheduled appointment is considered a missed appointment and subject to the terms above.

By signing below I agree to have my credit card automatically charged for the above mentioned fees. We realize that there are times that you may arrive for a scheduled appointment time and are not able to be seen promptly at your appointed time. Please know that we go out of our way to make certain that this does not happen, however there are times when Dr. Alexandria Calderone, D.C. needs to spend extra time with a patient that was not foreseen, as they may have done with you in the past or need to, with you, in the future.

Patient Name (print) ____

Patient/Guardian Signature______________________________Date ______________

Notice to Medicare/Medicaid Patients

The following is the office policy for internal medicine treatments performed at Tallahassee Spine Center, Progressive Chiropractic and Wellness regarding Medicare Benefits. Please read carefully and sign only if you understand and agree to the terms.

In terms of chiropractic internal medicine treatment, we will not bill Medicare insurance for you if you have coverage with Medicare or with a secondary insurance policy; Medicare does **NOT** cover chiropractic internal medicine care. **Payment for the visit is due at time of service**.

For patients of Dr. Alexandria Calderone, D.C.

Medicare will not reimburse you if you submit a super bill for coverage of chiropractic internal medicine care. You **CAN NOT** submit codes and charges for coverage by Medicare/Medicaid if receiving chiropractic internal medicine services by Dr. Alexandria Calderone, D.C.

Notice of Exclusion from Medicare/Medicaid Benefit (NEMB)

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them directly.

Please see our fee schedule for a more complete list of services offered and associated prices.

Before you make a decision, you should read this entire notice carefully.

If you have any questions, please ask us so we can clarify. By signing below you are acknowledging that you have read, understand and agree to these terms.

Patient Name (print) ____

Patient/Guardian Signature____

Date ______________________

Policy on Nutraceuticals

You have the option of picking up your nutraceuticals in office or having them shipped to you. We can hold orders for 48 hours. If they are not picked up by that time, they will be placed back into inventory.

Un-opened: May be returned within 30 days of purchase date. There will be a 10% restocking fee applied.

Opened: Pre-authorization is required from a doctor and/or office manager and may be subject to restocking fee.

If you have any questions, please ask us so we can clarify. By signing below you are acknowledging that you have read, understand and agree to these terms.

Patient Name (print) ____

Patient/Guardian Signature____

Date _____________________