Application Form

All pages are required to be complete for Functional Medicine visits. For chiropractic care, please complete pages 2-4.

We are grateful you've chosen Valeo Health and Wellness Center to assist with your health goals. Our belief is that when the body isn't working properly, it's our job to figure out why. We see the first exam as an investigation of what is going on with your health. You'll discover that our chiropractic and functional medicine exams are both very thorough. We will not only be looking to discover what symptoms you may have, but also what is causing them. This means looking at your entire body, even if it seems like it is unrelated.

- ☐ Obtain & submit most recent blood labs (if any) along with my paperwork *(Functional Medicine appointments only)*
- ☐ Fill out all paperwork & mail, email, fax, or drop off at Valeo prior to scheduled exam
- ☐ Wear comfortable clothing appointments (no skirts/dresses, or wear shorts underneath)

☐ I agree to the above terms and understand that if paperwork is not completed and sent to Valeo before my scheduled exam, my appointment will need to be rescheduled.

☐ I agree and understand that should I receive a Consultation on my case as outlined in this paperwork, that the doctors at Valeo Health and Wellness are assessing my case on the basis of their chiropractic license alone and do not diagnose or treat any disease including cancer. I agree and understand that it is my responsibility to seek appropriate medical care in such cases.

Signature _____

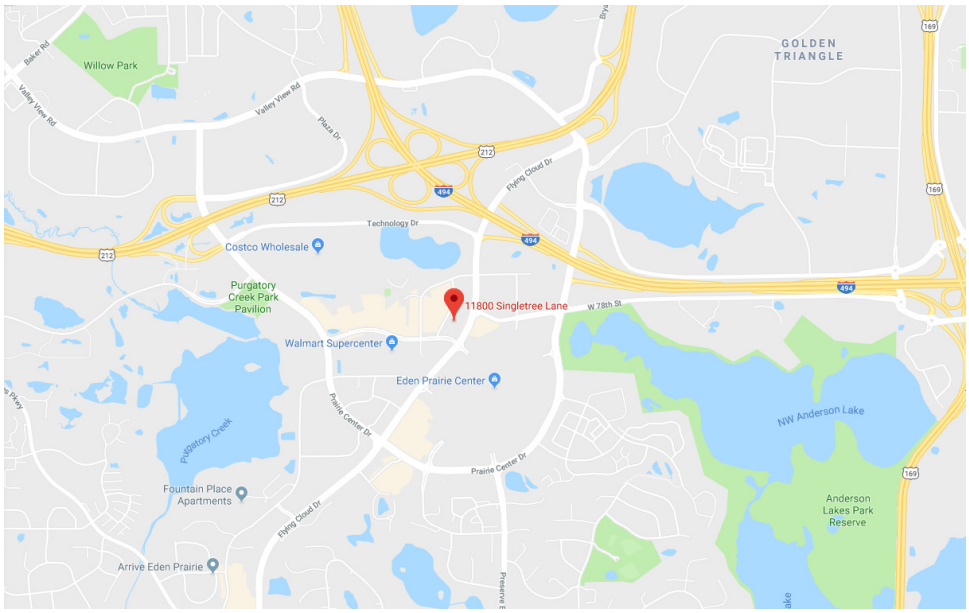
Today's Date _____

PLEASE SUBMIT PAPERWORK PRIOR TO SCHEDULED EXAM.

Email: info@valeowc.com

Fax: 952-949-0868 / Phone: 952-949-0676

Address: 11800 Singletree Lane, Ste 205, Eden Prairie 55344



VALEO
HEALTH AND WELLNESS CENTER

Office Use Only
Practitioner: AM KK RL JT
Appt Type: CHIRO FUNC
Appt Date _____ ☐ CT ☐ C ☐ Thank You

PERSONAL INFORMATION

Name:	**Guardian Name & Relationship:**		
Today's Date:	**Date of Birth:**		**Age:**
Address:	**Height:**	**Weight:**	**Gender:**
City:	**Email Address:**		
State: **Zip:**	**Primary Phone:** ◯ Home ◯ Cell		
Preferred Contact: ◯ Phone ◯ Email	**Name/Relationship of Primary Phone owner:**		
Would you like to receive our newsletter? ◯ Yes ◯ No			

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact	Relationship to Patient	Phone Number

REFERRAL INFORMATION

How were you referred to our office? (Dropdown) _____

Name of referrer or event (so that we can thank them):

GOALS FOR MY CARE

People see health care practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others to correct whatever the core malfunction may be. Your practitioner will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes.

◯ Relief Care: Symptomatic relief of pain or discomfort

◯ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

◯ Comprehensive Care: Address the entire system and bring your body to the highest state of health possible.

Any other goals you'd like to share?

THE BEGINNING YEARS

Birth to 17 years of age	NO	YES	EXPLAIN
Did you have any serious childhood illness?			
Did you have any serious falls as a child?			
Was there prolonged use of medicine such as antibiotics or an inhaler?			
Were you vaccinated?			
Do you have any scars? If yes, explain where.			

List Any Known Allergies

HEALTH CONCERNS - List according to severity. Rate from 1 (mild) to 10 (unbearable)

Health Concern	Severity	Episode Start Date?	Had this before? When?	Constant or Intermittent?

Since the problem started, is it (Please Check):

◯ Same ◯ Improving ◯ Worse

Does it travel/radiate?

◯ No ◯ Yes, where?

What makes it better?

What makes it worse?

Do you have a family history of this or similar symptoms?

◯ No ◯ Yes/explain:

Have you seen other doctors for this condition? ◯ No ◯ Yes

☐ Medical ☐ Chiropractor ☐ Other:

If yes, what Yes, diagnosis:

What was done?

Do you have allergies/sensitivities to fragrances or oils?

◯ No ◯ Yes, explain:

Do you have any known allergies?

◯ No ◯ Yes, explain:

How have you taken care of your health in the past?

☐ Medications ☐ Emergency Room ☐ Routine Medical
☐ Exercise ☐ Nutrition/Diet ☐ Holistic Care
☐ Vitamins ☐ Chiropractic ☐ Other:

How have the previous method(s) work out for you?

☐ Bad results ☐ Some results ☐ Great Results
☐ No change ☐ Still trying ☐ Other:

Are you concerned that this condition is or will negatively affect any of the following, now or in the future?

☐ Job ☐ Marriage ☐ Kids ☐ Future Ability
☐ Sleep ☐ Self-esteem ☐ Freedom ☐ Finances
☐ Time ☐ Other

Are you concerned that your helath conditions(s) might turn into any of the following?

☐ Family health problems ☐ Heart Disease ☐ Cancer
☐ Fibromyalgia ☐ Depression ☐ Chronic Fatigue
☐ Diabetes ☐ Arthritis ☐ Other

Have your health condition(s) affected your job, finances, relationships, family or other activities?

☐ No
☐ Yes, explain:

If you have health issues, what have they cost you?

☐ Time ☐ Money ☐ Hope ☐ Happiness
☐ Sleep ☐ Freedom ☐ Please explain:

PAST ACCIDENTS/SURGERIES/INJURIES/PROCEDURES: List all (auto/work), x-rays, trauma (physical/emotional)

Type	Date	Doctor/Hospitalization/x-rays/Procedure

List all prescription drugs, over-the-counter drugs, and all supplements you are currently taking

Name of drug or supplement	Taken for how long?	For what purpose?	How much?

HIPAA ACKNOWLEGEMENT OF RECEIPT OF NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Valeo Health & Wellness Center's Notice of Privacy Practices. Valeo is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. Signing below acknowledges that you have access to this notice via internet or the copy in our office for your review at any time.

Client Name: _____

Signature of patient (or parent, if minor): _____ Date _____

VALEO PAYMENT POLICY

RETURNED CHECK POLICY - If you pay with a check that is returend due to insufficient funds, we will require immediate payment in another form plus a $35.00 returned check fee and any bank charges. If there is no response from you, we must send this to collections.

SERVICE AGREEMENT - I clearly understand and agree that all services and products rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. Valeo will work with you regarding payment plans if necessary. There will be an 18% APR charged on balances over 30 days past due. Anything older than 120 days will be sent to collections. Please contact us if you have any questions regarding this policy.

CANCELLATION AND MISSED APPOINTMENT POLICY - I understand and agree that text and/or email reminders are only a courtesy of Valeo and that I am personally responsible for tracking my scheduled appointments. I also understand and agree to pay 50% of the appointment type charge if I miss my appointment or cancel my appointment with less than 24-hours notice (except in cases of emergency).

Signature: _____ Date: _____

INSURANCE PAYMENT AGREEMENT - *FOR PERSONAL INJURY, WORK COMP OR MEDICARE ONLY:*
I understand that insurance will be billed for Valeo services and I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Signature: _____ Date: _____

POLICIES AND PROCEDURES

1. The practitioners design and recommend specific health plans in order for you to get better in the shortest amount of time. It is to your benefit to maintain your visit schedule and care plan as explained to you when you start care with the practitioner. The practitioners take your health very seriously and we ask that you do the same.

2. If you need to cancel or reschedule an appointment, please provide the office with at least a 24-hour notice. Our goal is to stay on time; however, occasionally emergencies or unforseen circumstances arise where the practitioner will spend more time with a patient. We will do our best to inform you if the practitioner is running behind schedule. Appointments missed or canceled with fewer than 24-hours notice may be charged in accordance with the cancellation and missed appointment policy above.

Metabolic Assessment Form™ - *Required for Functional Medicine Patients Only.*

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3

Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome? **Yes** **No**

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3

Have you had your gallbladder removed? **Yes** **No**

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

Since menopause, do you ever have uterine bleeding?	Yes			No
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

Child Neurotransmitter and Nutrition Assessment Form™ (CNNQ)

Required for Functional Medicine Patients Only.

Child's Name:_____ **Age:** _____ **Sex:** _____ **Date:** _____

SECTION: GENERAL DIET

- Does your child have any food sensitivities or allergies? (If yes, please list)

_____

_____

- List your child's 4 healthiest foods eaten during the average week.

_____

_____

_____

_____

- List your child's 4 unhealthiest foods eaten during the average week.

_____

_____

_____

_____

- How many times does your child eat candy per week?

_____

- How many times does your child drink soda per week?

_____

- List the top 4 foods your child craves regularly.

_____

_____

_____

_____

- List the medication(s) your child is currently prescribed and any over-the-counter products used.

_____

_____

- Do you find it difficult to have your child on a special diet?

_____

_____

Please circle the appropriate number on all questions below (0 as the least/never to 3 as the most/always).

SECTION A

- Does your child eat pasta, breads, and breaded foods? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc) after eating foods containing wheat/gluten? **0 1 2 3**
- Does your child consume dairy products? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc) after consuming dairy products? **0 1 2 3**

SECTION B

- Does your child eat fried fish? **0 1 2 3**
- Does your child eat roasted nuts or seeds? **0 1 2 3**
- Is your child missing essential fatty acid-rich foods in his/her diet? (for example: avocados, flax seeds, olives) **0 1 2 3**
  (circle "0" if present, "3" if missing)
- Does your child eat fried foods? **0 1 2 3**

SECTION C

- Is your child's mental speed slow? **0 1 2 3**
- Does your child have difficulty with learning or memory? **0 1 2 3**
- Does your child have difficulty with balance and coordination? **0 1 2 3**

SECTION D

- Does your child have stress? **0 1 2 3**
- Does your child not have enough sleep and rest? **0 1 2 3**
  (circle "0" if enough, "3" if not enough)
- Does your child not have regular exercise? **0 1 2 3**
  (circle "0" if regular exercise, "3" if no exercise)
- Does your child feel overly worried and scared? **0 1 2 3**

SECTION E

- Does your child have temper tantrums? **0 1 2 3**
- Does your child exhibit wild behavior? **0 1 2 3**
- Does your child frequently yell or scream for unnecessary reasons? **0 1 2 3**
- Does your child have an inability to nap or sleep when physically exhausted? (circle "0" if able, "3" if unable) **0 1 2 3**
- Is your child overly talkative? **0 1 2 3**
- Does your child fidget and squirm when seated? **0 1 2 3**
- Does your child run and climb excessively? **0 1 2 3**
- Does your child have difficulty playing quietly or engaging in leisure activities? **0 1 2 3**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

SECTION F

- Does your child get excited easily? **0 1 2 3**
- Does your child have anxiety and panic for minor reasons? **0 1 2 3**
- Does your child feel overwhelmed for minor reasons? **0 1 2 3**
- Does your child find it difficult to relax when he/she is awake? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION G

- Does your child seem depressed? **0 1 2 3**
- Does your child have mood changes with overcast weather? **0 1 2 3**
- Does your child have symptoms of inner rage? **0 1 2 3**
- Does your child seem uninterested in games or hobbies? **0 1 2 3**
- Does your child have difficulty falling into deep, restful sleep? **0 1 2 3**
- Does your child seem uninterested in friendships? **0 1 2 3**
- Does your child have unprovoked anger? **0 1 2 3**
- Does your child seem uninterested in eating? **0 1 2 3**

SECTION H

- Does your child have difficulty handling stress? **0 1 2 3**
- Does your child have anger and aggression while being challenged? **0 1 2 3**
- Does your child feel tired even after many hours of sleep? **0 1 2 3**
- Does your child tend to isolate himself/herself from others? **0 1 2 3**
- Does your child get distracted easily? **0 1 2 3**
- Does your child have a constant need and desire for candy and sugar? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION I

- Does your child have difficulty with visual memory (shapes and images)? **0 1 2 3**
- Does your child have difficulty remembering locations? **0 1 2 3**
- Does your child have fatigue or low endurance for learning activities? **0 1 2 3**
- Does your child have difficulty with attention or a short attention span? **0 1 2 3**
- Does your child have slow or difficult speech? **0 1 2 3**
- Does your child have uncoordinated or slow movements? **0 1 2 3**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

AE267(201803291528)