



Dr. Janice M. Piro, DC, DABCI, 801 2nd Street N. Suite E, Safety Harbor, FL 34695
P: 727-789-4020 F: 727-712-1028

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.

Please check the type of care desired:
Preventative Short-term Long-term Second opinion

Today's Date: ____/____/____
Social Security #: ____-____-____

Name: _____ DOB: ____/____/____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____)____-____ Permission to leave a 'medical message'? Yes No

Cell Phone: (____)____-____ Permission to leave a 'medical message'? Yes No

Work Phone: (____)____-____ Ext. _____ Permission to leave a 'medical message'? Yes No

Email for medical/health correspondence: _____

Occupation: _____ Spouse's Occupation: _____

Emergency Contact: _____
Name Relationship Phone Number

Gender: Male Female Ethnicity: Caucasian Black/African American Hispanic Native American Arab/Middle Eastern
Asian/Pacific Islander Jewish Ancestry Other _____

Marital Status: Single Married Widowed Divorced Separated Name of Spouse or Significant Other: _____

WILL YOU BE FILING FOR INSURANCE REIMBURSEMENT? Yes No
Are you on Medicare? Yes No Are you on Medicaid? Yes No

How did you hear of the Piro Clinic? Check all that apply: Newsletter Magazine Article Billboard Radio Website Word-of-Mouth
Search Engine Whom may we thank for referring you? _____

Please describe your current problem/concern: List them in the order of importance, #1 being the most important and #5 being the least important. (If your concern is of pain, please also use the diagram on the following page.)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

How long have you had the above condition(s)? _____ Is it getting worse? Yes No

Does it affect your: Work, Sleep, Other: _____

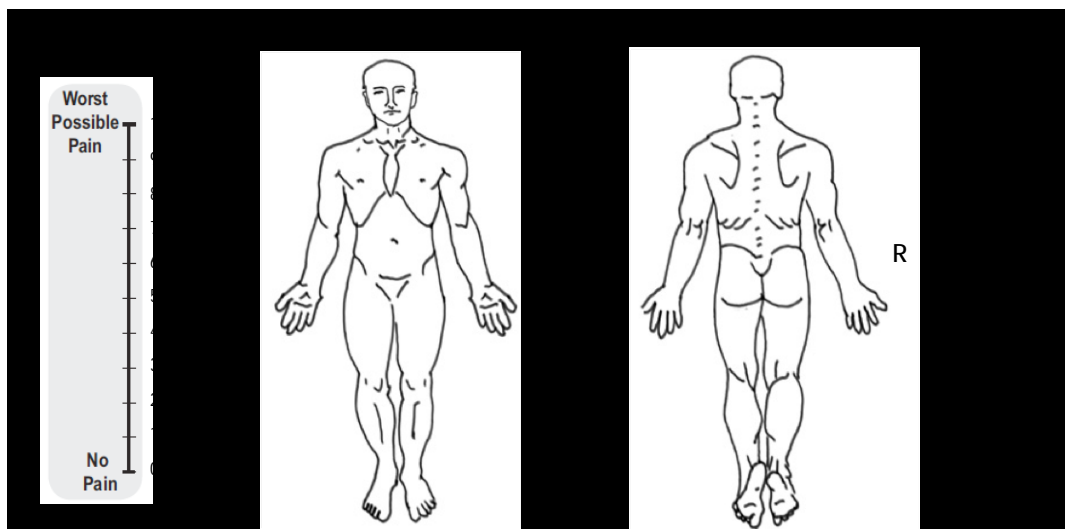
Initial cause of concern: _____

Major goals for your health: Let us know what you would like to accomplish as a patient: _____

Have you been treated for this condition in the past/present? Yes No; If YES, by whom? _____

Have you been diagnosed for this condition? Yes No; Diagnosis? _____

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



PAST HISTORY

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

... ever been hospitalized? _____

... had any surgeries? _____

... 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 been diagnosed with MRSA? **yes**, **no**

Have you had any other infections? **yes**, **no** : _____

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

FAMILY HISTORY

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

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Epilepsy _____
<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Osteoporosis _____
<input type="checkbox"/> Anemia _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Bleed easily _____
<input type="checkbox"/> High cholesterol _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Arteriosclerosis _____	<input type="checkbox"/> Thyroid disease _____
<input type="checkbox"/> Emphysema _____	<input type="checkbox"/> Dementia/Alzheimer's/Parkinson's _____
<input type="checkbox"/> Multiple sclerosis _____	<input type="checkbox"/> OTHER: _____

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	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Fatigue, lack of energy, lack of stamina	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Tired even after "good" sleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Lack of desire to get out of bed	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Undesired weight gain, difficulty losing weight	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Undesired weight loss	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Hard time falling asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Hard time staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Faint/dizzy/nauseous if a meal is skipped	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Decreased appetite	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Food or environmental allergies	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sensitive to perfumes, chemical smells, exhaust, etc.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Cold sores and blisters	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Morning stiffness/muscle cramps	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain at night/Night sweats	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Past or present diagnosis of serious conditions such as : cancer, systemic infection, kidneys disease, heart disease or other	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		

HAIR, SKIN, and NAILS	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Oily or dry skin (please circle	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Eczema	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Psoriasis	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
White spots on finer nails	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Small bumps on the back of the arms	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Skin rash or fungal infection	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Increased body or facial hair	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Decrease in body or facial hair	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Acne	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Discoloration or depigmentation of skin	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other problems or concerns in this area	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		

HEAD and MIND	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Lack of desire to get out of bed	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Headaches or Migraines (please circle)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Loss of consciousness or feeling faint, dizzy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Hard time remembering (long or short term)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Difficulty speaking or "finding" words	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Difficulty concentrating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Dyslexia or word confusion	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other problems or concerns in this area	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		
Feelings of sadness or depression	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Anxiety and stress	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Inability to cope with stressful situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Lack of interest or concern	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Mental sluggishness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Use of alcohol, drugs, vitamins/minerals/ herbals to deal with stress	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Recent or current thoughts of suicide	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Difficulty speaking or "finding" words	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other problems or concerns in this area	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		
Diagnoses of any mental disorder- depression, bipolar, schizophrenia or other	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		

CARDIOVASCULAR and PULMONARY	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Pain in the chest, left arm, and/or left side of neck	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Shortness of breath upon relaxation or exertion	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Swelling in upper or lower extremities	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Irregular heart beat	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pounded heart beat heard when resting your head on a pillow	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Rapid heart beat	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Irregular breathing or discomfort	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
"Blushed" or red faced	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Tightness of the chest	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other problems or concerns in this area	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		

EYES, EARS, NOSE, THROAT	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Watery, red, or itchy eyes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Dark circles under eyes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Loss of vision/Blurry vision	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Hard to see at night	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain in, near, or behind the eye	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Earache or pain in the ears	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Tinnitus/ Ringing in the ears	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Reoccurring ear infections	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Decrease or loss of hearing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Enlarged lymph nodes under the chin/jaw/ on the neck	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Bleeding/ sore gums	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Tongue has a white coating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Dry mouth, eyes, and/or nose	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Halitosis/ bad breath	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sore throat	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Excessive mucous formation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other problems or concerns in this area	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		

GENITO-URINARY	Never- Very rare	Occasional- Mild	Intermittent -Moderate	Frequent- Severe
Pain in the mid to lower back	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Kidney stones	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Cloudy, bloody, or dark urine	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Urinary tract infections	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Frequent urination	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Painful urination	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Difficulty controlling urination, incontinence	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Low sex drive/ libido	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
HIV test	<input type="checkbox"/> NOT	<input type="checkbox"/> YES →	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
Sexually transmitted disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		
Other problems or concerns in this area	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		

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

MALE ONLY	Never- Very rare	Occasional- Mild	Intermittent -Moderate	Frequent - Severe
Difficulty or painful erections	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Cloudy, bloody, or dark urine	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Painful or difficulty with ejaculation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Waking to urinate at night	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Decreased sexual function	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Difficulty controlling urination, incontinence	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Family history of prostate cancer	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		
Painful/tender testis	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		
Undescended testis, testis in abdomen or pelvis	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		
Other problems or concerns in this area	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		

FEMALE ONLY	Never- Very rare	Occasional- Mild	Intermittent -Moderate	Frequent- Severe
Irregular or painful menses	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain between cycles	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Heavy clotting	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Painful, swollen, fibrocystic breasts	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Excessive bleeding	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Painful intercourse	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Hot flashes or fluctuations in temperature	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Yeast infections/ vaginal itching	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Mood fluctuations that follow your cycle	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
The use of birth control pill	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Menopausal symptoms or concerns	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		
Infertility	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		
Poly cystic ovarian syndrome (PCOS)	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		
Family history of breast, uterine, or ovarian cancer?	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		
Annual female exam: breast, pap smear, etc.?	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
Other problems or concerns in this area	<input type="checkbox"/> NO	<input type="checkbox"/> YES →		

Informed Consent and Mutual Understanding

TO THE PATIENT: Please read this document 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. Janice M. Piro, D.C., DABCI at anytime 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. Janice M. Piro, D.C., DABCI holds a Doctor of Chiropractic Degree Specializing in Internal Medicine (Diplomate American Board of Chiropractic Internists) and is currently licensed in the state of Florida. 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. Janice M. Piro, D.C., DABCI for.* Because 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. Janice M. Piro, DC, DABCI, or in case of emergency, go to your local urgent care facility/Hospital. Many 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 “Herxheimer” 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. Janice M. Piro, D.C., DABCI 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 _____

Piro Clinic of Natural Medicine Financial Agreement

Dr. Janice M. Piro, D.C., DABCI values your time. Dr. Janice M. Piro, D.C., DABCI 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. Janice M. Piro, D.C., DABCI 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 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 80% of the value of the visit. 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:**
 - 80% of new patient appointment cost
 - Credit card may be necessary to re-schedule your appointment or future appointments and charged at full cost if the appointment is cancelled/rescheduled.
- **-Established patients- allowed 1 missed appointment in 12-month period**
 - 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.
 - \$25 fee for second offense
 - \$50 fee for third offense
 - Credit card will be required to schedule all future appointments and charge full cost if appointments are cancelled / rescheduled.*
- 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.

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. Piro needs to spend extra time with a patient that was not foreseen, as she 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 treatments performed at Piro Clinic of Natural Medicine regarding Medicare Benefits. Please read carefully and sign only if you understand and agree to the terms.

We will not bill Medicare insurance for you if you have coverage with Medicare or with a secondary insurance policy; **payment for the visit is due at time of service.**

For patients of Dr. Janice M. Piro, D.C., DABCI:
Medicare will not reimburse you if you submit a super bill for coverage since Dr. Janice Piro is a non-provider. You CAN NOT submit codes and charges for coverage by Medicare/Medicaid if receiving services by Dr. Janice M. Piro.

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 _____