7540 H Little River Turnpike
Annandale, VA 22003
703.256.2600
703.256.6566 (fax)
www.myhealthbuilders.net

Personal Profile (PLEASE PRINT): Date: _____

Name (First, MI, Last)			Prefers to be called	Date of Birth
Age	Sex	Marital Status	Home Phone	Work Phone
Home Address			Cell Phone	Email
			Emergency contact/Parent	Contact (phone)
Work Address			Employer	Job title
Personal physician			Office address/phone	
Primary Insurance:			Insurance ID & Group #	Patient SSN
Secondary Insurance:			Insurance ID & Group #	
Pharmacy Name/Phone				Referred by

Health History

What are your health concerns?

_____
_____
_____

Are you currently under the care of a physician or health professional for a medical condition?
If yes, please list providers and condition:

_____
_____
_____
_____
_____

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Past Medical History

Please check any medical conditions that you currently have (x) or have had in the past (•):

Seasonal allergies			Recurrent sinus infections		
Headaches (migraines, etc)			Dizziness		
Seizures			Psychiatric or emotional illness		
Depression			Anxiety		
Asthma			Lung problems		
Chronic bronchitis			Chest pain		
Irregular heart beat			High blood pressure		
Heart disease			Bleeding/clotting disorder		
Stroke			Circulation issues		
Indigestion			Heartburn/stomach ulcers		
Dental problems			Constipation/diarrhea		
Kidney disease			Hepatitis/liver disease		
Skin problems (acne, etc)			Back pain/sciatica		
Herniated Disc			TMJ		
Chronic muscle, tendon or joint pain			Chronic pain syndrome		
Diabetes			Thyroid disease		
Osteoporosis/Osteopenia			Rheumatoid Arthritis		
Cancer			Eye problems (glaucoma, etc)		
Artificial joints/implants			Psoriasis/eczema		
Hives			Vertigo		
Menstrual disorders			Reproductive disorders		
Prostate problems			Sexual/libido problems		
MS			Neurologic problems		

List any additional health problems not listed above:

_____
_____
_____

Past surgeries/traumas/accidents/scars with approximate dates:

_____
_____
_____
_____

Allergies (Medications, Foods, Environmental):

_____
_____
_____
_____

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Current Medications and Supplements:

_____
_____
_____
_____

Family history (relationship/disease):

_____
_____
_____
_____

Preventive Health Testing:

Test	Month/Year	Results
Cholesterol		
Bone Density (DEXA)		
Colonoscopy		
Exercise stress test		
Lifeline (if applicable)		
Coronary CT (heart scan)		
Thermography/Mammography		
PSA/Prostate Exam		

Vaccine History:

□ DTaP/Td □ MMR □ Shingles □ Pneumonia □ Flu □ Gardasil □ Hepatitis A/B
□ Meningococcal □ Other _____

Dental History (see Chart)

□ Amalgams/silver fillings □ Crowns □ Root canals □ Bridges/partial/full dentures
□ Metal retainers □ Implants □ TMJ problems

Women:

At what age did you start menstruating? _____First day of last menstrual cycle_____
Average cycle (days) _____ Cycles are generally □regular □irregular □nonexistent
Date of last pap _____ breast exam _____mammogram _____
Any abnormal paps or mammogram? If so, when and what outcome?

_____
_____

Pregnancy #: _____ Living children #: _____ Miscarriages #: _____ Abortions #:_____
Vaginal deliveries #: _____ C/S #: _____ Any complications?_____

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Hysterectomy? □yes □no With ovaries removed? □yes □no
Did you breastfeed? □yes □no Family history of breast/uterine/ovarian CA? □yes □no
Have you ever been on hormone replacement therapy? □yes □no How many years? _____
Contraceptive method: _____ Number of years on birth control pills: _____

HORMONES:

Symptom survey: (check all that applies)	MILD	MODERATE	SEVERE
Thinning of hair/baldness			
Disturbed sleep/insomnia			
Prostate enlargement/CA			
Fatigue			
Poor concentration/memory loss			
Night sweats			
Slow wound healing			
Reduced libido			
Depression			
Muscle weakness			
Impotence			
Abdominal weight gain			
Palpitations			
Anxiety			
Fibrocystic Breasts/Breast tenderness			
Heavy/irregular menses			
Hot flashes			
Dry skin/hair			
Vaginal Dryness			
Headaches			
Irritability/Mood Swings			
Arthritis			
Cramps			
Fluid retention			
Bladder symptoms			
Harder to reach climax			

Social History:

My health is □excellent □good □fair □poor
My physical fitness level is □excellent □good □fair □poor
My level of stress is □high □moderate □low □manageable
My energy level is □high □moderate □low
Pets: : □yes □no

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I eat (#) _____ meals/day. I eat out (#) _____ days/week.
I drink (#) _____ cups of water daily, _____ sodas per day/wk _____coffee/tea per day/wk
I have (#) _____ bowel movements per day/per week

Time in front of computer____hour(s); on cell phone _____hour(s); watching TV _____hour(s)
Tobacco: □yes □no □quit How many years_____ Quit date _____
Alcohol: □yes □no Type _____ Number of drinks/day/wk _____
Recreational Drugs: : □yes □no If yes, how long? _____
Exercise: □yes □no Type _____ Frequency _____

Office Policies:

A 24 hours in advance notice for cancellation/rescheduling for appointments are required so as not to incur a fee. For medical appointments with Dr. Kim, $ 100; chiropractic/acupuncture treatments with Dr. Fuller, $50; massage therapy with our massage therapists, $50. Visits to our office will be paid when services are rendered. We accept cash, checks and major credit cards.

Many of the services provided at Health Builders PC are covered under standard insurance policies. However, with the diverse selection of insurance plans, levels of coverage and frequent changes, it is not always possible for our office to keep abreast of all plan requirements. While we do our best to inform you of the requirements, you are ultimately responsible for understanding your insurance policy. Dr. Kim is an out-of-network provider, so out-of-network benefits apply once the applicable deductible has been met.

For visits that require written authorization from your primary care physician (PCP) to see a specialist, it is your responsibility to obtain a valid authorization from your PCP for each visit. Authorization cannot be issued retroactively. Without authorization, you may not be seen. If you choose to be seen without proper insurance authorization, you agree to waive your health plan benefits and agree to be personally and fully responsible for payment for any services rendered.

We welcome Medicare patients. However, we do not accept Medicare assignment. Payment will be due at the time of service. We will file your charges and any reimbursements will be mailed to you. Medicare provides reimbursement for qualified charges of manipulation. There is no reimbursement for acupuncture, massage or other physiotherapy. For charges that may not be covered by Medicare, we may ask you to sign an ABN (Advanced Beneficiary Notice).

Health Builders PC employs diagnostic and treatment methods that are traditional and nontraditional. Because we look for imbalances in the body and for trends that may result in illness if not addressed (a preventive approach), we may order tests not considered by insurance to be 'necessary' or standard of care. We employ diagnostic tools and treatment modalities that include but are not limited to chiropractic, massage, acupuncture, physiotherapy, x-rays, electrodermal testing (Asyra), applied kinesiology (NRT), Neuroemotional Technique (NET), Neural therapy, Emotional Freedom Technique (EFT), intravenous vitamin therapy, nutritional supplements, homeopathy and herbal therapies. By signing this, consent is given for the above

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modalities as it pertains to my office visits. If any dispute arises surrounding my treatments at Health Builders, I agree to resolve it through arbitration.

I have completed the above information as accurate as possible and to the best of my knowledge. I have read the Privacy Policy as mandated by HIPAA and have received a copy. I authorize treatment by Drs. Fuller and Kim with the understanding that there are no guarantees or claims that I will be helped by undergoing treatment here. I understand the collaborative nature of entering into a health agreement with my providers whose goal is to assist me in optimizing my health.

Patient Signature _____ Date _____

Parent/Responsible Party Signature _____ Relationship _____

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AUTHORIZATION FORM for NUTRITION RESPONSE TESTING/ASYRA

I specifically authorize Dr. Kim and Dr. Fuller at Health Builders PC to perform Nutrition Response Testing (NRT) and/or Asyra electrodermal health screening to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, homeopathy, etc. in order to assist me in improving my health, and not for the treatment or 'cure' of any disease.

I understand that the above assessment tools are a safe and non-invasive method of analyzing the body's physical and nutritional needs and potential imbalances discovered could cause or contribute to various health problems.

I understand that these assessment tools are not a method for 'diagnosing' or 'treating' any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing and/or Asyra electrodermal testing or any natural health, nutritional or dietary programs recommended. It is understood that by implementing the recommended program of dietary changes and nutritional supplementation, the purpose is to assist the body in achieving a more optimal state of health.

I have read and authorize NRT/Asyra electrodermal screening.

This permission form applies to subsequent visits and consultations.

Name: _____ Date:_____

Address: _____

City: _____ State_____ Zip_____

Phone (home):_____ (cell or work):_____

Signed (if minor, parent/guardian signature required):_____

Witness: _____