



BREATH
OF LIFE
wellness center

Welcome!

I want to personally congratulate you on your first step toward better health. It is my privilege to provide southwest Missouri with alternatives in natural health care.

I, like many of you, grew up in a medicine cabinet. If there was a problem, I wanted an immediate solution. Throughout my education, I have learned that there are many ways to care for the body and I choose preventative care. We never know what future problems we avoid by taking preventative action. We are proud to care for your family from womb to tomb!

Thank you for trusting us,

Dr. Nicole McCauley
Breath of Life Wellness Center



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TERMS OF ACCEPTANCE

Please Read Carefully

Wellness Care enables each individual to maximize his or her health. Health can only be maximized when the major cause of interference is removed and balance is obtained.

Health: A state of optimal physical, mental, social, and spiritual well-being, not merely the absence of disease or infirmity. Health will be maximized if all obstructions to it are removed.

Subluxation: An imbalance of health due to nervous system interference in the spinal column, cranium and/or contiguous structures of the body. The result is a lessening of the body's inborn "innate" ability to express life at maximum potential.

Adjustment: An adjustment is the special application of forces to facilitate the body's correction of subluxation. Our method of correction is by specific adjustments of the spine, contiguous structures and soft tissues.

Regardless of what a disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. We believe any named condition is merely a physical manifestation and not necessarily indicative of the underlying cause. Our only objective is to remove interference to the expression of your body's infinite wisdom, thus returning your body to balance.

We do not offer to diagnose or treat any disease or condition. However, if during the course of examination, we encounter unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we give you the option to seek the service of a health care provider who specializes in symptom based care.

The CSA System provides a completely non-invasive method for gaining valuable information about your body's vital functions. The primary objective of the procedure is to disclose patterns of stress and to provide feedback to help in recommending a program to restore each system and meridian (energy pattern) to balance.

I understand that the Electrodermal Stress Analysis Survey does not provide a medical diagnosis, and that my testing technician may recommend further medical testing. If you suspect that you need further medical intervention, you should consult your physician.

I give my permission for the testing technician to evaluate me on the CSA System. I understand that by doing so THE TESTING TECHNICIAN IS **NOT** BECOMING MY PRIMARY CARE PHYSICIAN.

I understand that the testing technician will give me information about myself based on the evaluation and the testing technician will make recommendations to improve my health based on what is found. Any decision to follow through with the program will be my own decision, and I will not hold the testing technician or Breath of Life Wellness Center responsible.

I _____ have read and fully understand the above statements.

(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept care on this basis _____ [Signature] _____ [Date]

NOTICE OF PRIVACY PRACTICES

Please Read Carefully

In the course of your care as a practice member at Breath of Life Wellness Center, your personal information may be used or disclosed in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital, should you choose concurrent care.
- Your health care and billing records may be disclosed to another party, such as an insurance carrier or your employer, with your expressed written consent.



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- Your name, address, phone number, and health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have the right to obtain a copy of the information we will use for these purposes. You also have the right to refuse authorization for this office to contact you regarding these matters. Your decision to refuse authorization will not affect the care you receive in any way.

Under Federal Law, we are permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but we believe, in our professional judgment, that you intend for us to provide care.
- If we are ordered to do so by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made with your express written authorization.

We normally provide information about your health to you in person at the time of your appointment. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or in a different format, please advise us in writing of your preferences.

You have the right to inspect and copy your health information for seven years from the date the record was created, or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in writing.

State and Federal Laws require us to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

Furthermore, we are required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy practices, we will notify you in writing as soon as possible following the changes. Any change in our privacy practices will apply to all your health information on file.

Information used or disclosed based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected the Federal Privacy Rule.



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This notice is effective as of **September 1, 2007**. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name Signature Date

PATIENT AUTHORIZATION FOR CONTACT REGARDING WELLNESS CARE, RELATED HEALTH SERVICES, AND/OR RELATED HEALTH PRODUCTS

Under Federal Law we are required to ask for your permission to leave a message regarding confirming your appointment times and meetings and informing of products. The purpose of this use is to make a more pleasant, personable, efficient, and productive Wellness Center as well as further enhancing your access to quality health care.

If you choose not to authorize this information use, your decision will have **not** effect your care in this office or your relationship with our staff.

Your signature indicates your authorization of this activity.

____Please check here if there is an alternate number where a message may be left.
Please enter the phone number here: (____) _____-_____.

Name Signature Date

You may revoke this authorization at any time in writing. Please allow 2 weeks for this change to be completed.



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Personal Health Appraisal (PHA)

Name _____ Home Phone _____
 Address _____ Work Phone _____
 _____ Occupation _____
 DOB _____ Referred By _____

General Health Enhancement

WHAT WOULD YOU LIKE TO SEE BETTER OR IMPROVED IN YOUR HEALTH?

Healthy Women

Yes	No		Please Describe
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a miscarriage or are you prone to miscarry?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Is intercourse painful to you?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have diminished sexual desire?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulty controlling your sexual desire?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a hysterectomy?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent yeast infections?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have problems with fertility?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you experience morning sickness with pregnancy?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Are you through or have symptoms of menopause?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pre-menstrual syndrome?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you retain fluid during your period?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have menstrual pain, cramps, or irregularities?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have feminine discharge?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have vaginal pain or discomfort?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed with endometriosis?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have breast cysts or lumps?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have mastitis?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have tender or sore nipples?	_____



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- Do you frequently feel hot or perspire? _____
- Do you have any other female disorders? _____

Healthy Skin

Yes No

- Do/did you have teenage or middle age acne? _____
- Is your skin generally healthy? _____
- Do you have premature aging and wrinkles? _____
- Do you have any abnormal skin growths or discolorations? _____
- Do you have athlete's foot? _____
- Do you have insect bite reactions or allergies? _____
- Are insects attracted to you? _____
- Do you scar easily? _____
- Do you have pain or discomfort in or around any scars? _____
- Do you have adhesions? _____
- Do you have excess body perspiration? _____
- Do you have excess body odor? _____
- Do you have reactions to poison ivy, oak or sumac? _____
- Do you have oily, dry, or itchy skin? _____
- Do you have eczema? _____
- Do you have psoriasis or cracking skin? _____
- Do you have cysts, warts, moles, liver spots, or fungal growths? _____
- Do you have rashes or vesicles (small blisters)? _____
- Do you have herpes or shingles? _____
- Do you have cold sores, fever blisters or canker sores? _____
- Are you troubled with boils? _____
- Do you get sores that are slow to heal? _____
- Are you troubled with corns? _____
- Do you have any other skin disorders? _____

Healthy Eyes

Yes No

- Do you wear glasses or contacts? _____
- Do you experience dry itchy, watery, or red eyes? _____



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- Do you have eye discomfort associated with allergies? _____
- Do you or have you had pink eye? _____
- Do you have styes? _____
- Do you have cataracts? _____
- Do you have eye stress? _____
- Do you have macular degeneration? _____
- Do you have any other eye conditions? _____

Healthy Pain and Injuries

Yes No

- Have you been diagnosed with Rheumatoid Arthritis? _____
- Have you been diagnosed with osteoarthritis? _____
- Does any part of your body experience numbness or tingling? _____
- Do you have back problems? _____
- Do you have a spinal curvature? _____
- Do you suffer from muscle cramps? _____
- Do you suffer from muscle spasms? _____
- Are your muscles frequently sore? _____
- Do you have muscle weakness? _____
- Are your joints stiff in the morning? _____
- Do you suffer from foot pain? _____
- Have you been diagnosed with gout? _____
- Do you have headaches? _____
- Do you have migraine headaches? _____
- Do you have sciatica? _____
- Do you have teeth or gum problems? _____
- Do you have metal fillings? _____
- Do you have jaw problems? _____
- Do you bruise easily? _____
- Have you been diagnosed with neurological disease? _____
- Do you have any other pain or injuries? _____



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Healthy Weight

Yes No

- Are you overweight? _____
- Are you underweight? _____
- How often do you exercise? _____
- What type of exercise do you do? _____
- How many cups of water do you drink per day? _____
- Do you crave sweets? _____
- Do you have an excessive appetite? _____
- Do you have a poor appetite? _____
- Do you desire to vomit after eating? _____
- Do you have any obsessive diet habits? _____
- Do you have eating disorder? _____
- Do you eat when you are nervous? _____
- Do you have edema or retain water? _____
- Do you have any other weight disorders? _____

Healthy Mind and Emotions

Yes No

- Do you or have you suffered from any emotional trauma? _____
- Do you have a fear of crowds or of going out of your house? _____
- Are you usually jumpy? _____
- Do you suffer from nervousness? _____
- Are you claustrophobic? _____
- Do you have signs of depression? _____
- Do you portray signs of manic depression or personality shifts? _____
- Do you have feelings of grief or guilt? _____
- Do you have recurring fears or nightmares? _____
- Do you have any other phobias? _____
- Do you feel you are under considerable emotional stress? _____
- Do you have any obsessive behaviors? _____
- Have you been diagnosed with epilepsy? _____
- Do you suffer from poor concentration? _____



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- Do you suffer from loss of memory? _____
- Do you suffer from confusion? _____
- Do you have any other mental or emotional disorders? _____

Healthy Control

Yes No

- Do you smoke tobacco? _____
- Do you chew tobacco? _____
- Do you use recreational drugs? _____
- Do you drink alcoholic beverages? _____
- Do you crave stimulants? _____
- Do you have any other addictions? _____
- Do you wish to quit your addiction? _____
- Do you drink caffeinated beverages? _____

Healthy Immune System

Yes No

- Are you bothered with viruses at various times during the year? _____
- Do you have food allergies? _____
- Are you sensitive to chemicals? _____
- Are you oversensitive to the environment? _____
- Do you have recurring infections (viral, bacterial, or fungal)? _____
- Do you have colds or influenza often? _____
- Do you cough frequently? _____
- Do you have frequent earaches or discharge? _____
- Do you have ringing in the ears or a loss of hearing? _____
- Have you been diagnosed with Lyme disease? _____
- Do you have frequent laryngitis or hoarseness? _____
- Do you have fevers frequently? _____
- Do you have frequent sinus infections? _____
- Do you have frequent sore throats? _____
- Are your glands often swollen? _____
- Are your tonsils often swollen? _____
- Do you have sinus headaches? _____



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- Do you have yeast or fungal overgrowths? _____
- Do you or have you had thrush (*Candida albicans*)? _____
- Do you have any other immune disorders? _____

Healthy Digestion

Yes No

- Do you have problems with constipation? _____
- Do you use laxatives? _____
- Do you have diarrhea? _____
- Do you have colitis? _____
- Have you been diagnosed with a gall bladder condition? _____
- Do you have gallstones? _____
- Do you have black stools? _____
- Do you have red or bloody stools? _____
- Do you have problems with heartburn? _____
- Do you have problems with hemorrhoids? _____
- Do you have problems with rectal fissures or polyps? _____
- Do you have indigestion? _____
- Do you have problems with gas? _____
- Do you have problems with bloating? _____
- Do you experience pain or tenderness in your abdomen? _____
- Have you ever had intestinal worms? _____
- Have you ever had an itchy nose or rectum? _____
- Are you frequently nauseated? _____
- Do you vomit frequently? _____
- Do you suffer from motion sickness? _____
- Have you been diagnosed with stomach ulcers? _____
- Do you have any other digestive disorders? _____

Healthy Urinary Tract

Yes No

- Do you have frequent urination? _____
- Do you ever lose control of your bladder? _____
- Do you ever dribble urine when sneezing or laughing? _____



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- Do you have painful urination? _____
- Do you have difficulty starting your stream of urine? _____
- Do you have frequent kidney or bladder infections? _____
- Do you or have you ever had kidney stones? _____
- Do you have any other urinary tract disorders? _____

Healthy Circulation

Yes No

- Do you have slurred speech? _____
- Do you have confusion? _____
- Have you been diagnosed with a heart condition? _____
- Do you have low blood pressure? _____
- Do you have high blood pressure? _____
- Do you have circulatory problems? _____
- Are you often dizzy? _____
- Do you get light headed when standing quickly? _____
- Do you have cold hands or feet? _____
- Do you experience spells of rapid hear beats? _____
- Are you aware of your heart skipping beats? _____
- Do you have nosebleeds? _____
- Do you have varicose or spider veins? _____
- Have you been diagnosed with phlebitis? _____
- Do you have any other circulatory disorders? _____

Healthy Respiration

Yes No

- Do you have hay fever or other allergies? _____
- Is your nose frequently stuffy? _____
- Have you been diagnosed with asthma? _____
- Have you been diagnosed with emphysema? _____
- Have you been diagnosed with bronchitis or pneumonia? _____
- Do you have chest pain or discomfort? _____
- Do you have post-nasal drip? _____
- Do you spit up phlegm? _____



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- Do you snore frequently or loudly? _____
- Do you have any other respiratory disorders? _____

Healthy Detoxification

Yes No

- Do you have acid accumulations in your body? _____
- Have you been diagnosed with any forms of cancer? _____
- Do you have any tumors or abnormal growths? _____
- Have you been diagnosed with a liver condition? _____
- Have you ever had chemotherapy or radiation treatment? _____
- Do you have pain in the lower right portion of your abdomen? _____
- Have you worked or lived in any toxic environments? _____
- Do you have any other toxic conditions? _____
- Do you have any tooth fillings? _____
- Do you have old plumbing or paint in your home? _____
- Do you frequently consume seafood? _____
- Do you live in an area with heavy outdoor pollution? _____
- Does breathing the air at work/home worsen your symptoms? _____
- Are you frequently in contact with household chemicals? _____
- Are you frequently in contact with topical cosmetics? _____
- Do you have acid accumulations in your body? _____

Healthy Sports Enhancement

Yes No

- Are you interested in increasing muscular strength? _____
- Do you have any sports injuries? _____
- Are you sore or stiff after sports activities? _____
- Are you interested in any sports enhancements? _____

Healthy Allergy Correction

Yes No

- Do you have allergies? _____
- Do you live or work in a moldy environment? _____
- Are you sensitive to fragrances or other odors? _____



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Healthy Cancer Support

Yes No

Do/did any of your immediate family have cancer? _____

Supplements and Medications

Please list nutritional supplements you have tried with their results. Please specify if you are currently taking them.

Please list any prescription drugs you have taken in the past:

Please list any prescription drugs you are currently taking, how long you have been taking them, and the conditions for which you are taking them:

Please list any prescription drugs you have taken in the past:

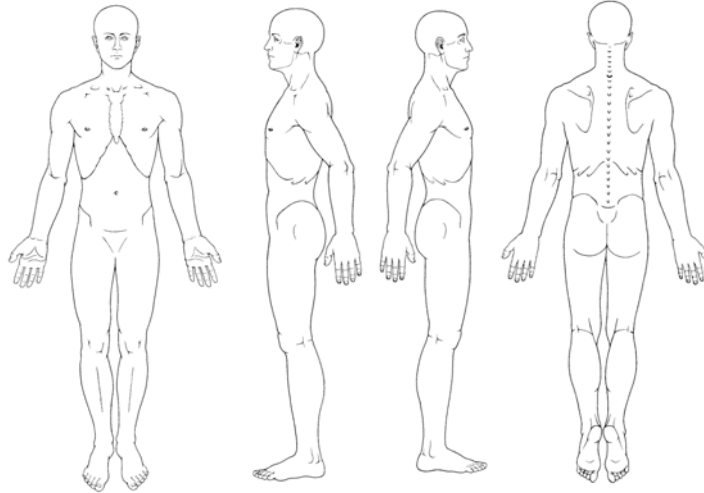
Please list any over the counter drugs you are currently taking, how long you have been taking them, and the conditions for which you are taking them:

Please list any over the counter drugs you have taken in the past:



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Pain Locations and Descriptions:



Legend:

PP = Pain
NN = Numbness
TT = Tightness
BB = Burning
CC = Cramping

The information I have provided is accurate and true to the best of my knowledge.

Signature

Date

Thank you for completing this questionnaire. We look forward to serving you!