CHATHAM
CHIROPRACTIC
A holistic wellness center
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What is Functional Medicine?

Functional Medicine determines how and why an illness occurs, and restores health by addressing the root causes of the illness. It is a science based approach that empowers the patient and their practitioner to work together to address the underlying causes of an illness. It involves gathering a detailed history and understanding of each patient's symptoms. After which, testing through bloodwork, urine or stool will be recommended. This will allow a window into each individual's genetic and biochemical makeup, and diagnose for certain underlying infectious processes. Based on the results of these tests, the doctor will develop a protocol that will encompass lifestyle modifications, dietary recommendations, vitamins and supplements designed to suit each individual patient's needs to promote their optimal health and wellness.

Patient information:

Name: _____ Date Of Birth:_____ Today's Date: _____

Address: _____

Street City State Zip code

Home Phone: ( ) _____ Cell Phone ( ) _____

Email Address _____

Social Security #: _____ □ Male □ Female

Occupation _____

□ Single □ Married □ Divorced □ Widowed

Who may we thank for referring you to us? _____

CONSENT AND DISCLAIMER

Dr. Sonal Dalal provides functional medicine to offer an individualized approach to health. The objective of an initial examination is to consider health from a holistic view, with an assessment of physical, mental and emotional condition.

When used correctly under the supervision of a qualified functional provider, this approach to health can be an integral part of preventative care and ailment management.

NOTE: Functional medicine is not intended to be a substitute for allopathic or traditional medicine. Functional medicine is complementary, and the therapy and information offered should not be construed by you, the client, to be a clinical medical diagnosis of any disease or injury. You must consult with your physician for any serious medical condition.

Please read carefully, initial each statement and sign at the bottom.

_____I confirm that I have not been advised to refrain from seeking or following conventional medical treatment. I recognize that input from my primary care physician is welcome and encouraged, and the information will be used to augment the functional medicine process.

_____While Dr. Dalal has had extensive training in the functional medicine sciences, I acknowledge that she is not a medical doctor.

_____By signing on as a client with Dr. Dalal I certify that I currently have a primary care provider and that I will notify Dr. Dalal if I withdraw as a patient of such primary care provider.

_____I confirm that any prescription medications I am taking under the care of my primary care provider will not be withdrawn without the prescribing primary care physician's supervision.

_____I understand that though Dr. Dalal may recommend supplements and nutritional plans, no such suggested product or idea should be construed as pharmaceutical prescription or medication.

_____I understand that any recommended supplements may not be FDA approved and Dr. Dalal does not make any assertions or guarantees regarding ingredients, side-effects, or effectiveness.

_____I confirm that I will provide a complete and accurate health history to Dr. Dalal.

_____I fully understand the risks, benefits, and alternatives to functional medicine including how it differs from traditional/allopathic medicine and I consent to the functional treatments offered or recommended to me by Dr. Dalal.

Signature: _____

If patient is under 18 years, parental signature is required

Date:_____

FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

I understand that a block of time has been set aside for my private appointment, and that a 24-hour notification is required if I must cancel. I understand that there is a full charge for appointments canceled less than 24 hours in advance.

I understand that Dr. Sonal Dalal's functional medicine services are cash-pay only. Insurance and health plans are not accepted. As such I am expected to pay the total cost for all services rendered at the time of my visit. I may request a billing statement after payment is remitted.

I understand it is my responsibility to know my own insurance benefits including reimbursement options, exclusions, and any pre-authorization requirements.

I understand that payment is due at the time services are rendered, unless other arrangements have been made prior to the appointment.

I understand that phone consultations will be billed at the usual hourly rate.

I understand that current fees for consultations are as follows, but that there may be changes in the fee structure in the future.

Initial Consultation	$	
Follow-Up Consultation	$	

I have read the above financial policies, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that regardless of my insurance company contributions or reimbursement, if any, I assume financial responsibility and will pay all service charges at the time service is rendered.

Signature: _____

If patient is under 18 years, parental signature is required

Date:_____

THIRD-PARTY PLATFORM CONSENT

As part of receiving functional consultations from Dr. Sonal Dalal, I understand and consent to use of third-party video or phone communication software and platforms, including but not limited to Zoom, FaceTime, etc.

I further understand that the agencies that certify health technology – the Office of the National Coordinator for Health Information Technology and the National Institute of Standards and Technology – do "not assume the task of certifying software and off-the-shelf products", nor accredit independent agencies to do HIPAA certifications. Additionally, the HITECH Act only provides for testing and certification of Electronic Health Records (EHR) programs and modules.

I understand that while these platforms affirm that they implement the controls needed to secure protected health information (PHI) according to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Security Rule, Breach Notification Rule, and the applicable parts of the Privacy, Dr. Dalal is not involved in this process and cannot guarantee its efficacy.

I hereby agree to hold Dr. Sonal Dalal harmless from all claims, liabilities, or damages resulting from a third-party platform's breach of privacy or failure to meet any of its security measures.

Signature: _____

If patient is under 18 years, parental signature is required

Date:_____

Website Privacy & Data Use Disclaimer

Dr. Sonal Dalal and her employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voicemails, and online submissions, that are either required by law or necessary for client onboarding.

Financial and/or medical information that you provide to us in writing, online, on the phone (including information left on voicemails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, sell, or disseminate any information about clients who inquire about or actually receive our services. Such information is considered personal protected information and is confidential. We understand that sharing such information is restricted by law, except as allowed by a signed Release of Information Authorization.

Personal information is only used as is reasonably necessary to provide you with health or counseling services which may require communication between Dr. Dalal and health care providers, pharmacies, insurance companies, and other providers necessary to verify your medical information is accurate and determine the type of services you need.

Dr. Sonal Dalal is compliant with HIPAA regulations. You may contact our office at (973) 635-2290 to learn more about our privacy policy and how we collect, keep, and process your private information in accordance with these laws.

Website FDA Supplement Disclaimer

The supplements, and claims made about specific products, on or through this Site have not been evaluated by the United States Food and Drug Administration and are not approved to diagnose, treat, cure or prevent disease.

This Site is not intended to provide diagnosis, treatment or medical advice. Supplements, services, information and other content provided on this Site, including information that may be provided on this Site directly or by linking to third-party websites are provided for informational purposes only. Please consult with a physician or other healthcare professional regarding any medical or health related diagnosis or treatment options.

Information on this Site including any product label or packaging should not be considered as a substitute for advice from a healthcare professional. Dr. Dalal recommends against self-management of health issues. Information on this Site is not comprehensive and does not cover all physical conditions or their treatment. Contact your healthcare professional promptly should you have any health-related questions.

Individuals may react differently to different supplements. You should consult your physician about interactions between medications you are taking and supplements. Comments made on this Site by any employee, officer, or agent of Dr. Dalal are strictly their own personal views made in their own personal capacity and based on their personal experience and should not be understood to apply to any other person.

Contact the manufacturer directly for clarification as to product labeling and packaging details and recommended use.

Dr. Sonal Dalal is not liable for any information provided on this Site with regard to recommendations regarding supplements for any health purposes. Consult with a healthcare professional before starting any diet, supplement or exercise program. Dr. Dalal makes no guarantee or warranty with respect to any supplements or services sold.

Dr. Sonal Dalal is not responsible for any damages for information or services provided.

1: What are your 3 primary complaints and why are you struggling with these complaints?

_____
_____
_____
_____
_____

2: What treatments have you tried that helped and which that did not help?

_____
_____
_____
_____
_____

3: When was the last time you saw a conventional MD for this condition? Who was it? When was the last time you saw a MD in general?

_____
_____
_____
_____
_____

4: When did this problem very first start?

_____
_____
_____
_____
_____

5: What else was going on in your life at that time in terms of stress, travel, moving, relationships, ext?

_____
_____
_____
_____
_____

6: What was the most stressful period of your life? What were your sources of stress? (Sexual abuse, physical abuse, alcoholic or mentally ill parents, food addiction, eating disorders)

_____
_____
_____
_____
_____

7: Are you under stress now or is most of your stress in the past? If so what is the current stress and how long do you think it will be going on?

_____
_____
_____
_____
_____

8: How are you doing with the lifestyle factors, diet (what do you eat for breakfast, lunch and dinner), exercise (how much, what kind), sleep patterns (get to sleep easily, stay asleep, how many hours, what time do you go to bed, when do you wake up), stress management (what you do to handle stress), relationship (sex drive ok or not)

_____
_____
_____
_____
_____

9: History of digestive problems (for women history of hormone issues)

_____
_____
_____
_____
_____

10: Any questions or concerns you have not already mentioned?

_____
_____
_____
_____
_____

11: What are your overall health goals once your complaints are resolved?

_____
_____
_____
_____
_____

12: How long has it been since you felt really good?

_____
_____
_____
_____
_____

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight:_____ Height: _____Blood pressure (if known): _____

% Body Fat (if known) _____

1: Are you presently taking any medications, nutritional supplements or vitamins? YES NO

If YES please list:

_____

_____

_____

_____

_____

2: In the past, have you used birth control pills and/or antibiotics? _____

For how long? _____

3: If you have fillings, please list material(s) used:

_____

_____

4: Do you have, or have you ever had any of the following conditions? (Circle all that apply)

Anemia	Frequent headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

5: How much sleep do you get each night on average? _____

6: Do you have any food allergies, sensitivities or restrictions?

_____

_____

_____

_____

_____

7: Do you smoke, drink alcohol or use recreations drugs? _____

How much, how often? _____

8: Please list foods you tend to overeat or crave (sweets, breads, fatty foods, meats, milk, ext.)

_____

_____

_____

_____

_____

9: Are there any foods you eat on a daily basis, almost daily basis?

_____
_____
_____
_____
_____

10: Write briefly about your weight gain/loss history:

_____
_____
_____
_____
_____

What do you feel triggered your weight fluctuation? (Circle all that apply)

Hereditary Stress Eating habits Boredom

Was your weight gain/loss: (circle)

Sudden Gradual Problem since childhood

11: Please list close relatives that have diabetes, heart disease or obesity:

_____
_____
_____
_____
_____

12: What methods have you tried to lose/gain weight?

_____
_____
_____
_____
_____

13: How is your energy level?

_____
_____
_____

Are there times in the day that you feel your best? _____ worst? _____

14: Are you happy in your life right now? _____

15: What are your main sources of stress?

_____
_____
_____
_____
_____

16: How do you deal with your stress?

_____
_____
_____
_____
_____

17: Please answer the following questions YES or NO:
If I am feeling down, a snack makes me feel better. YES NO
I sometimes have a hard time going to sleep without a bedtime snack. YES NO
I get tired and/or hungry in the mid-afternoon. YES NO
I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or desert. YES NO
Now and then I think I am a secret eater. YES NO
At a restaurant, I almost always eat too much bread before the meal is served. YES NO
I have difficulty concentrating, or frequent fuzzy or spacey patterns. YES NO
I experience cravings for sugar, breads, pasta and baked goods. YES NO
I feel shaky if I do not eat on time or if I do not snack. YES NO
I often find myself irritable or angry. YES NO

18: Check off if any of the following that have applied to you within the last 30 days:

_____ Do you feel nauseous?	_____ Do you have abdominal/intestinal pain?
_____ Do you have bloating?	_____ Do you get bloated after meals?
_____ Do you get heartburn?	_____ Do you have diarrhea?
_____ Do you have constipation?	_____ Do you travel outside the U.S.
_____ Do you have gas?	_____ Are your stools compact/hard to pass?
_____ Do you belch following meals?	_____ Do you have gurgles in your stomach?
_____ Do your bowel movements alternate between constipation and diarrhea?	

24: In your estimation, how physically fit are you right now?
Unfit _____ Below Average _____ Average _____ Above Average _____ Very Fit _____

25: How often do you exercise? _____
What is your exercise regime?

_____
_____
_____
_____
_____

26: If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

_____
_____
_____
_____
_____

27: What are your fitness goals? (Check all that apply)

_____ General fitness endurance	_____ Muscle toning
_____ Weight loss/maintain weight	_____ Muscle strengthening
_____ Osteoporosis prevention	_____ Muscular coordination/balance
_____ Specific sport enhancement	_____ Other
_____ Flexibility	

28: Surgeries, starting with the most recent:

_____
_____
_____
_____
_____

29: Hospitalizations:

_____
_____
_____
_____
_____

30: Briefly describe where you have lived since childhood:

_____
_____
_____
_____
_____

31: What is your heritage? (Irish, German, Spanish, ext.)

_____
_____
_____
_____
_____

32: Circle “Now” or “Past” for only those items which you identify. Ignore anything that does not apply to you.

Is your life:	Do you often:
NOW PAST Satisfactory	NOW PAST Feel depressed
NOW PAST Boring	NOW PAST Have anxiety
NOW PAST Demanding	Do you often:
NOW PAST Unsatisfactory	NOW PAST Have irrational fears
Do you worry over:	NOW PAST Feel upset
NOW PAST Home life	NOW PAST Feel things go wrong
NOW PAST Marriage	NOW PAST Feel shy
NOW PAST Children	NOW PAST Cry
NOW PAST Job	NOW PAST Feel inferior
NOW PAST Income	Have you:
NOW PAST Money problems	NOW PAST Seriously considered suicide
	NOW PAST Attempted suicide

Policies and procedure
New Patients:
First appointment:
Your first consultation will be 45 minutes – 1 hour. During this time we will determine the appropriate lab test to order to address your specific health concerns.

1: Payment is due at time of consultation.
2: Methods of payment are: cash, check, or credit/debit card.
A 3.75% processing fee will be applied to all credit/debit card transactions.

Appointments:
Follow up consultations may be scheduled for 15, 30, 45 or 60 minutes.
We encourage you to book your appointment 2 weeks in advance.

Lab Tests:
The results of your lab test(s) will be sent to us 2 to 4 weeks after mailing your specimens to the lab.
We will evaluate the results. After evaluation you will be contacted to schedule a follow-up appointment.

Cancellations:
If you are unable to keep your scheduled appointment, you must notify our office a minimum of 24 hours before your scheduled time or you may be charged for that appointment.

Important Notes:
We do not service medical emergencies. If you have a medical emergency, you must contact your primary care physician or dial 911.
Please notify our staff if you are not clear on any of our policies or procedures.

I _____ have read and understood the Policies and Procedures.

Date: _____

Signature: _____

Please complete this form of you would like us to share information about your progress with another person or healthcare professional.

Authorization to Release Medical Information

HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits Chatham Chiropractic Center from discussing appointments, medication, test results, or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA form.

Name of Individual _____ Relationship to Patient _____
Name of Individual _____ Relationship to Patient _____

I, _____ request the following information:

_____ Test results	_____ History	_____ Records	_____ Diagnosis
_____ Treatment	_____ Reports	_____ Progress	_____ Billing

Concerning my: _____ Accident _____ Injury _____ Illness
Other _____
To be released to:
_____
(Name of Practitioner, Doctor, Family Member, ect.)
Address:
_____
_____
Fax: _____
For the purpose of: _____

Signed: _____ Date: _____

_____ Patient	_____ Spouse	____ Parent	_____ Guardian