Dr. Cindy Zafis, D.C., DACACD
3434 Mendocino Ave., Bldg. C, Suite B
Santa Rosa, CA 95403
707 527-7710

Welcome to the office!

In an effort to better serve you, below is a reminder check list of things to prepare before your first visit:

Before your Office Visit:

- **Fill out the complete history form before your appointment, so that we may have the entire office visit with you.**
- **Please come 5 minutes before each appointment in an effort to keep your and other appointments on time.**
- **Eat before the office visit as you may not be able to eat for 2 hours after the office visit.**

After your Office Visit:

- **No exercise for 2 hours after the visit.**
- **Depending on the session, you may not eat for 2 hours after.**

Fragrance-Free Office:

- **Do not wear fragrances, lotions, colognes, or any substance with a fragrance as people may be reactive to the fragrance.**

Payments:

- **Payments in the form of Visa, Discover, MasterCard, check and cash are collected at the time services are rendered.**

Cancellation notice:

- **New patients will be charged 50% of their initial visit fee if we are given less than a 24 hour notice for changes or cancelations from their scheduled appointment date.**
- **For returning patients the cancellation notice is 24 hour notice for changes and cancelations of 50% of fee for the appointment if the appointment time is not filled.**

Again, welcome to the office and we look forward to working with you!

Sincerely,

Dr. Cindy Zafis, D.C.

CONFIDENTIAL PATIENT INFORMATION

How did you hear about the office? _____

PATIENT DATA

Name: _____ Date:_____
Address:_____ City:_____ Zip:_____
Birth Date:_____ Age:___ Sex:___ Marital Status: _____
Height: _____ Weight: _____
Home phone: _____ Work phone:_____
Employer:_____ Occupation:_____
E-mail Address:_____
Would you like to receive a newsletter with health tips and special offers? Y_ N_

Please describe pain in your body:

_____
_____

Please describe the health issues you would like to address:

_____
_____

TREATMENT GOALS

REASONS YOU HAVE COME INTO THE OFFICE:

_____ **Eliminate pain**
_____ **Eliminate a specific reaction to a specific substance**
_____ **Work with a specific symptom or set of symptoms**
_____ **Work with a food craving/sensitivity**
_____ **Be able to function from day to day**
_____ **Eliminate or decrease a bad health habit:**
overeating/smoking/alcohol
_____ **Maintain a high level of stamina and energy on a daily basis**
_____ **Other – please explain** _____

List health goals you would like to achieve in the future and by when do you want to achieve them. _____
_____
_____
_____

History for Musculoskeletal Complaints

For ALL patients to fill out.

For patients on Disability or Medicare treating for pain - you must fill out every answer before reimbursement may occur for the next page and a half. Please put N/A if no answer is needed.

Chief complaint?

_____

_____

Onset?

_____

Frequency/Duration?

_____

What makes the symptom better? _____

_____

What makes the symptom worse? _____

_____

Does the pain refer to other areas of the body?

_____

_____

Are there other symptoms related to the chief complaint?

_____

_____

Have there been previous occurrences?

_____

_____

Are there secondary complaints to the chief complaint?

_____

_____

Other conditions?

_____

_____

Medications/Vitamins? Please list what the medications are treating.

_____

_____

_____

Spinal Injuries? _____

_____

Surgeries? _____

Hospitalizations? _____

_____

Last Examination? _____
Previous Chiropractic? _____
Other History? _____

_____

Family History? _____

_____

_____

Exercise? _____
Occupation? _____

SECONDARY COMPLAINT?

_____

_____

Onset?

_____

Frequency/Duration? _____
Better/Worse? _____

_____

Referral pain?

_____

Previous occurrence? _____
Previous treatments?_____

Patients on Disability or Medicare: All answers must be completed for previous questions in order for billing and reimbursement to occur.

PAST TREATMENTS FOR CURRENT COMPLAINT

Please fill out the doctor, tests, and treatments you have received for your current complaint.

Current Symptom	Doctor	Tests	Treatments

PAST HISTORY

Past Surgeries and approximate age they occurred:

_____

_____

Past Accidents or injuries and the approximate age they occurred:

_____

_____

Past Illnesses and approximate age they occurred:

_____

_____

Family History – Circle what symptoms run in your family: Allergies Cancer Diabetes Heart Disease Stroke

GENERAL HISTORY

Diet:

Are you vegan/vegetarian? _____ What foods are you consistently avoiding?

_____

What foods are you trying to avoid recently? _____

_____

List all foods & beverages consumed more than 3 times a week

_____

_____

_____

List cravings to these items:

Salt_____ Sugars_____ Coffee/Caffeine_____ Fats_____ Candy____
Carbohydrates_____ Drug/Alcohol____ Luncheon Meats_____

List previous allergy testing:

Scratch test _____ Blood test_____ Salvia test_____
Other_____

List known allergies to foods, medication, pollens, chemicals, or other substances.

_____

_____

_____

_____

For Detoxification Treatments:

Are you a wearer of a pacemaker or any other battery operator electrical implant? Yes No

Are you taking heart regulating medication? Yes No

Are you an organ transplant recipient? Yes No

Are you taking medications that in its absence would be mentally or physically incapacitating, such as psychotic episodes, seizures, etc.? Yes No

Are you pregnant or a breast feeding mother? Yes No

Health Symptoms

Mark the intensity of symptoms from 1 to 10. 0 is no symptoms and 10 is very symptomatic.

	Degree of Symptoms(0-10)	**Length of symptoms in years**
Allergy Symptoms		
Asthma	_____	_____
Bronchitis	_____	_____
Hay Fever	_____	_____
Colds & Flu	_____	_____
Cough	_____	_____
Mucous Productions	_____	_____
Post-Nasal Drip	_____	_____
Shortness of Breath	_____	_____
Sore throat	_____	_____
Skin Disorders		
Acne	_____	_____
Hives	_____	_____
Itching	_____	_____
Psoriasis	_____	_____
Eczema	_____	_____
Rashes	_____	_____
Addictive Disorders		
Alcoholism	_____	_____
Drug dependency	_____	_____
Eating disorders	_____	_____
Smoking	_____	_____
Mental/Emotional Disturbances		
Depression	_____	_____
Anxiety	_____	_____

Irritability	_____	_____
Mood swings	_____	_____
Obsessive Behavior	_____	_____
Mental Confusion or Disorientation	_____	_____
Insomnia	_____	_____

Vascular Disorders

Heart Irregularities	_____	_____
Hemorrhoids	_____	_____
High Blood Pressure	_____	_____

Digestive Disorders

Colitis	_____	_____
Constipation	_____	_____
Diarrhea	_____	_____
Diverticulitis	_____	_____
Heartburn	_____	_____
Gas	_____	_____
Gallstones	_____	_____
Gastric distress	_____	_____
Indigestion	_____	_____

Female Disorders

Breast swelling	_____	_____
Menstrual disorders	_____	_____
Mood swings	_____	_____
PMS	_____	_____
Heavy Menstrual Flow	_____	_____
Sugar & Carb Cravings	_____	_____

Other disorders

Edema	_____	_____
Fainting spells	_____	_____
Fatigue	_____	_____
Fever	_____	_____
Forgetfulness	_____	_____
Hair Loss	_____	_____
Migraine Headache	_____	_____
Premature Graying	_____	_____
Seizures	_____	_____
Urinary Tract Disorders	_____	_____

Our Office Policy

1. We do not bill most insurance companies. Patients that are self-billing or are paying cash are expected to take care of their fees as services are rendered. We do not claim responsibility of collecting your insurance claim or for negotiating a settlement of a disputed claim.
2. Assignment of Benefits. If the office is billing insurance, I hereby assign all medical benefits to which I am entitled. Including Major Medical, private insurance or any other health plans to Dr. Cindy Zafis, D.C.. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.
3. Letters to insurance companies and other forms will be bill at $25 a page.
4. I understand that I am financially responsible for all charges, whether or not paid by said insurance.
5. If you need to cancel your appointment, please inform us 24 hours prior to your appointment to avoid a 50% charge for the appointment if the appointment time is not filled.
6. There is a service charge of $25.00 for every returned check from the bank.
7. If you are under 18 years of age, please have your parent or legal guardian sign below.
8. Patient record files are $15 for administration fees + $.025 per page.
9. This office is required by law, to maintain the privacy and confidentiality of your protected health information. The policy is available for you to read in our waiting room or you can also request a written copy. Please ask the receptionist for more information.
10. Nutritional supplements may be returned if not opened or if returned within 2 weeks.

I have read and agree to the terms of the preceding paragraphs. All the information is true to the best of my knowledge.

_____ _____

Signature Date

CONSENT TO TREAT A MINOR CHILD

I authorize Dr. Cindy Zafis, D.C. to treat_____(Name) who is my _____(Relationship).

Adult's Signature_____Date_____

EMAIL CONSENT FROM PATIENT

I realize that the e-mail is not a secure system. I authorize Dr. Zafis to e-mail me despite the lack of security in the e-mail system.

_____ _____

Signature Date

We do not bill most insurance companies. However, if we have discussed that the clinic will be billing insurance, please fill out this information.

Primary Insurance

Insurance Co. Name: _____ Insurance Co. Phone_____

Address: _____ City: _____ State: _____ Zip:_____

Policy / Claim #: _____ Policy Holder: _____

Insured's Employer: _____

Primary or referring physician: _____ Phone: _____

Date of Injury _____

Secondary Insurance

Insurance Co. Name: _____ Insurance Co. Phone_____

Address: _____ City: _____ State: _____ Zip:_____

Policy / Claim #: _____ Policy Holder: _____

Insured's Employer: _____

Primary or referring physician: _____ Phone: _____

PATIENTS CONSENT ACKNOWLEDGEMENT AND REQUEST FOR SESSIONS

We appreciate the opportunity to join forces with you in working to improve your health.

I, _____ certify that Dr. Zafis, DC does not claim to cure any illness or disease with NAET, BioSet, or any technique used in the clinic.

I understand that NAET, BioSet, or any other techniques used in the clinic is not a medical diagnostic procedure and, therefore, does not diagnose a disease. It is understood and acknowledged that the requested sessions, work and/or techniques employed by and with Cindy Zafis, DC are considered non-medical and non-traditional and are an alternative health care practice or approach toward managing and/or working with patients with allergic conditions. I understand that this form and approach is a part of chiropractic/acupressure adjustment or treatment.

I understand that I (my ward) am to continue all medications and other treatment modalities, as they have been prescribed, unless otherwise directed by the doctor who prescribed them. During the treatment process I need to seek the appropriate physician and take appropriate medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep my (my ward's) symptoms under control while I (my ward) am treating with NAET/BioSet/techniques therapies. This way, essential NAET, BioSet, or techniques can be completed without interruption.

Additionally, I understand that no medications will be administered for this scope of my work with Dr. Zafis, DC. Further, while there may be recommendations to diet, food(s), food groups and/or meals(s) as a part of my work with Dr. Zafis, DC, and I accept full responsibility for the success of implementation of any recommendations and/or adjustments to my diet and/or meals.

I understand that while Dr. Zafis, DC clients have received and reported astounding positive results while working with Dr. Zafis, DC, each person is unique and no representations to certainty or guarantee have been made nor is any certainty or guarantee of effectiveness of such work, approach, treatments, sessions and/or techniques expected or interpreted by me and accordingly, I take full responsibility for applying, receiving and use of any recommendations of Dr. Zafis, DC and hold her harmless and indemnify her from any and all bodily reactions or any actions, claims, suits or any matter whatsoever as a result of my endeavor toward optimal health and any work with Dr. Zafis,DC.

Further, Dr. Zafis, DC has advised me that she is not a medical doctor nor a doctor of allergic medicine and that I should always consult with a medical doctor for the medical and traditional treatment of allergies and/or allergic conditions. If I am interested in weight loss, then any work in that regard with Dr. Zafis, DC will be done in accordance and within her normal practice of chiropractic separate from this work and further I understand and know that I should always consult with my doctor before beginning any weight loss program.

I the undersigned, acknowledge that I have read and have had opportunity to ask questions about its content. I understand all of the above and affirm that the work, approach, form, sessions, techniques and/or recommendations to be employed by and with me with the assistance of Dr. Zafis, DC, have been fully explained to me and that I have consulted with my doctor as recommended, required or requested or hereby of my own choice have not consulted with my doctor and further affirm, declare and attest that I am fully responsible for my own health and well-being. I agree to the terms and procedures.

_____ Date:_____
(Patients signature)

_____ Date:_____
(Patients name printed)

Directions to the Office:

Health Resolutions Treatment Center
Dr. Cindy Zafis, D.C.
3434 Mendocino Avenue
Building C
Suite B
(707) 527-7710
www. healthresolutions.net

Going North on 101:
Take the Bicentennial Way exit, take the Bicentennial East Ramp. Continue straight on Bicentennial and make a left onto Mendocino Avenue. Pass the radio station KZST on the right. The complex will be on the right.

Going South on 101:
Take Hopper Avenue Exit, turn left onto Cleveland Avenue, turn left onto the Mendocino over pass. Turn right on Mendocino Avenue. The complex will be on the left.

Directions in the Complex
Our office is located in the office complex called the Fountain Grove Office Park. The sign will say entrance for 3400-3460. There are two driveways into the complex. The northern driveway is the entrance. Building C will be on the bottom level of the office park.
Entrance to office with no stairs: When entering the office park go up the steep hill and take the first left. Park close to the entrance of the parking lot. There is a long side walk going south leading to Building C-Suite B
Entrance to the office with stairs: When entering the office park take the first right on the bottom level of the office park. Building C will be on the left. You may park on the bottom level of the office park and take the stairs to Building C.