

The Light Touch Healing Center  
Integrative Medicine

Dr. Jeffrey Benton, D.C., N.D.

Health History Summary

*Confidential*

Date: \_\_\_\_\_

PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ May Dr. Benton contact you via e-mail? Y N

Phone (home): \_\_\_\_\_ (Work): \_\_\_\_\_ Cell: \_\_\_\_\_

Preferred form of contact: \_\_\_\_\_ Best Time(s) to Reach you: \_\_\_\_\_

Occupation: \_\_\_\_\_ (full/part time) Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to Contact: \_\_\_\_\_

Credit Card # \_\_\_\_\_ Expiration \_\_\_\_\_

3 digit security code \_\_\_\_\_

Last Physician or Health Practitioner Seen: \_\_\_\_\_ When? \_\_\_\_\_

What is the name of your Primary Care?  
\_\_\_\_\_

Contact Information for Primary Care: \_\_\_\_\_  
\_\_\_\_\_

Last Blood testing was done when? \_\_\_\_\_ What kind? \_\_\_\_\_

Are you currently seeing (a) medical specialist (s)? Y N

If yes, for what reason?  
\_\_\_\_\_

# The Light Touch Healing Center

## Integrative Medicine

Name and contact information for the medical specialist (s):

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Do you have any known contagious diseases at this time? Y N

If yes, what?

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How did you hear about The Light Touch Healing Center ?

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What do you expect from your visit today? Please be as thorough and specific as necessary.

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How willing are you to make changes in your diet, lifestyle, etc. to feel better? (please circle)

1-----2-----3-----4-----5  
Not Willing Very Willing  
to Make Changes Make Changes

### CURRENT HEALTH PICTURE

What is the main reason for your visit?

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If you have a specific health condition, please describe in detail

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When was the very first time that you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation?

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# The Light Touch Healing Center

## Integrative Medicine

How long has your main concern been troubling you?

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Is your current main concern getting [better, worse, same] and for how long?

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List in order of importance other health concerns:

1. \_\_\_\_\_ Length of Time \_\_\_\_\_

2. \_\_\_\_\_ Length of Time \_\_\_\_\_

3. \_\_\_\_\_ Length of Time \_\_\_\_\_

4. \_\_\_\_\_ Length of Time \_\_\_\_\_

5. \_\_\_\_\_ Length of Time \_\_\_\_\_

Have you ever seen a Naturopathic Physician, Chiropractor, Acupuncturist, or other alternative health practitioner for your current main concern? Y N

What therapies were used and what were the results?

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How long has it been since you felt really good?

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What Habits do you Engage in Regularly that you feel contribute to your Health Concerns?

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### HEALTH HISTORY

The general state of your health is (please circle one): Excellent Good Average Fair Poor

On average describe your energy level from 1-10 \_\_\_\_\_ (10 is highest, 1 is lowest)

When during the day is your energy the best? \_\_\_\_\_ Worst? \_\_\_\_\_

What is your current: Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Weight 1 year ago: \_\_\_\_\_

As an adult, what has been your maximum weight (not including pregnancy) \_\_\_\_\_

# The Light Touch Healing Center

## Integrative Medicine

Please list the 3 most significant, stressful events in your life, from the most recent to the most distant.

Please circle the most significant one.

1. \_\_\_\_\_ Date \_\_\_\_\_
2. \_\_\_\_\_ Date \_\_\_\_\_
3. \_\_\_\_\_ Date \_\_\_\_\_

Are you currently working with a professional counselor, psychologist, social worker, pastor, or other therapist? \_\_\_\_\_ Have you in the past? \_\_\_\_\_

### Childhood Illnesses:

Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Chickenpox \_\_\_\_\_ Whooping Cough \_\_\_\_\_  
Polio \_\_\_\_\_ Diphtheria \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_ Scarlet Fever \_\_\_\_\_  
Smallpox \_\_\_\_\_ Typhoid Fever \_\_\_\_\_ Tuberculosis(TB) \_\_\_\_\_ Mono/EBV \_\_\_\_\_

Other: \_\_\_\_\_

### Previous Surgeries and Hospitalizations:

Please include dates (also include Cesareans and outpatient surgeries):

<u>Surgery</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### Social

Which of the following do you currently use (please indicate amount, including how often, how much and for how long)

Alcohol \_\_\_\_\_ Tobacco \_\_\_\_\_  
Hormones \_\_\_\_\_ Coffee \_\_\_\_\_  
Cortisone \_\_\_\_\_ Laxatives \_\_\_\_\_  
Sedatives \_\_\_\_\_ Antacids \_\_\_\_\_

# The Light Touch Healing Center

## Integrative Medicine

Do you exercise? What exercise activities do you engage in? \_\_\_\_\_  
 \_\_\_\_\_

Do you currently live with? Spouse \_\_\_\_\_ Partner \_\_\_\_\_ Friends \_\_\_\_\_ Children \_\_\_\_\_ Alone \_\_\_\_\_

Are you? Married \_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_ In a Supportive Relationship \_\_\_\_\_

What is your current level of education? \_\_\_\_\_ Are you satisfied with this? Y N

What is your occupation? \_\_\_\_\_ Do you have job satisfaction? Y N

Do you have children? \_\_\_\_\_ How many? \_\_\_\_\_

Do your children have any health problems? \_\_\_\_\_

Do you have a spiritual connection? \_\_\_\_\_ Are you happy with it? Y N

**Allergies/Sensitivities:** Please list any allergies/sensitivities to drugs, herbs, foods, animal or other and what reaction it causes  Check here if none

Substance	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

**Medications:** Please give full name, dosage, and length of time that you have been taking medication

<u>Pharmaceuticals</u>	<u>Dose</u>	<u>When/ How often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Vitamins/ Herbs</u>	<u>Dose</u>	<u>When/How often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

# The Light Touch Healing Center

## Integrative Medicine

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### Past Medical History and Review of Systems

Please circle if you have had or are presently experiencing any of the following:

- |                           |                          |                                  |                       |                           |
|---------------------------|--------------------------|----------------------------------|-----------------------|---------------------------|
| 1. High blood pressure    | 11. Bronchitis           | 21. Heart disease                | 31. Arthritis         | 41. T.B.                  |
| 2. Head or neck Radiation | 12. Abdominal discomfort | 22. Unexplained weight gain/loss | 32. Low back problems | 42. Hepatitis or Jaundice |
| 3. Change in bowel habits | 13. Diabetes             | 23. Asthma                       | 33. Skin diseases     | 43. Ulcers                |
| 4. Kidney disease         | 14. Palpitations         | 24. Nausea                       | 34. Blood disorders   | 44. Colitis               |
| 5. Chest pain/tightness   | 15. Hay fever            | 25. Difficulty urinating         | 35. Venereal diseases | 45. Headache              |
| 6. Shortness of breath    | 16. Indigestion          | 26. Constipation                 | 36. Anxiety           | 46. Blood in stool        |
| 7. Frequent urination     | 17. Cancer               | 27. Swollen ankles               | 37. Depression        | 47. Kidney stones         |
| 8. Gall bladder disease   | 18. Gout                 | 28. Thyroid disease              | 38. Anemia            | 48. Hemorrhoids           |
| 9. Lightheadedness        | 19. Vomiting             | 29. Pneumonia                    | 39. Alcohol abuse     | 49.                       |
| 10. Persistent cough      | 20. Drug abuse           | 30. Rheumatic fever              | 40. Diarrhea          | 50.                       |

Other:

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What is your weakest organ system and why? \_\_\_\_\_

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### Female Reproductive/Gynecological/Obstetrical History

Age of first menses: \_\_\_\_\_ If periods have stopped, at what age did they stop? \_\_\_\_\_

Are your cycles regular? Y N    Period begins every \_\_\_\_\_ days    Lasting \_\_\_\_\_ days

Are your periods? Heavy/Medium/Light    What color is the blood? Light/Dark, Medium Red/Clots

Do you have any spotting or bleeding in between periods? Y N    Any cramps with period? Y N

Circle any premenstrual symptoms:

Water Retention    Breast Tenderness    Irritability    Headaches    Depression    Mood Swings

**The Light Touch Healing Center**  
**Integrative Medicine**

Food Cravings Other \_\_\_\_\_

Pregnancies: \_\_\_\_\_ Births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

Any problems getting pregnant? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Do you get yearly PAP smears? Y N      Do you perform monthly Self-Breast Exams? Y N

Are you currently sexually active? \_\_\_\_\_ How often? \_\_\_\_\_ Is this more or less than 1 year ago? \_\_\_\_\_

Have you been tested for sexually transmitted diseases? Y N      When? \_\_\_\_\_

Are you currently using birth control? \_\_\_\_\_ What type(s)? \_\_\_\_\_

Do you experience any of the following:

Prolonged or abnormal bleeding:     No     Yes    Please describe: \_\_\_\_\_

Leakage of urine:                         No     Yes    Please describe: \_\_\_\_\_

Pelvic pain:                                 No     Yes    Please describe: \_\_\_\_\_

Abnormal discharge:                     No     Yes    Please describe: \_\_\_\_\_

History of abnormal Pap smear:       No     Yes    Type of treatment: \_\_\_\_\_

History of abnormal Breast Exam:     No     Yes    Please describe: \_\_\_\_\_

Have you ever been physically, sexually, emotionally or verbally abused? Y N  
How old and how often? \_\_\_\_\_

Other: \_\_\_\_\_

**Male Reproductive**

How often do you have to get up at night to urinate? \_\_\_\_\_

Is this more than a few years ago? Y N

Are you currently sexually active? \_\_\_\_\_ How often? \_\_\_\_\_ Is this more or less than 1 year ago? \_\_\_\_\_

Have you been tested for sexually transmitted diseases? Y N      When? \_\_\_\_\_

Any history of sexually transmitted disease(s)? Y N    If yes, What was the treatment? \_\_\_\_\_

Any abnormal discharge from penis? Y N      Sores on penis or groin? \_\_\_\_\_

# The Light Touch Healing Center

## Integrative Medicine

Are you currently using protection during intercourse? \_\_\_\_\_ What type(s)? \_\_\_\_\_

Any Problems with impotency (getting or maintaining an erection)? Y N

Do you currently have, or have a history of prostate problems? (please describe) \_\_\_\_\_

Date of last prostate exam? \_\_\_\_\_ Abnormal findings? Y N, please describe \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

PSA? \_\_\_\_\_ Other pertinent information: \_\_\_\_\_

Have you ever been physically, sexually, emotionally or verbally abused? Y N How old and how often?

\_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

### Digestion and Elimination

Do you have any problems with gas, bloating or fullness after eating? Y N  
How often (please circle)? Often/ Sometimes/ Never How severe? \_\_\_\_\_

Gas in Upper/Lower Abdomen or Both/Neither? How long have you had this problem? \_\_\_\_\_

Current Bowel movement frequency: \_\_\_\_\_ Is this typical for you? \_\_\_\_\_

Do you ever have (please circle) Blood/ Mucus/ Undigested Food/ Floating stool/ Black stool?

Any rectal itching? Y N Do your stools tend to be (please circle): Formed / Loose / Alternating

How often do you have diarrhea? \_\_\_\_\_ constipation? \_\_\_\_\_

Do you ever have alternating constipation & diarrhea? Y N

How would you describe the color of your stool (please circle)?

Yellow / Brown / White / Dark / Black / Green Other: \_\_\_\_\_

How often do your stools have a strong disagreeable odor? Often Sometimes Never

Have you ever fasted? Y N; juice or water For how long have you fasted? \_\_\_\_\_

How did you feel while you were fasting? \_\_\_\_\_

Have you traveled outside the US in the past 5 years? Y N Where? \_\_\_\_\_

Have you gone camping in the last 5 years? Y N Where? \_\_\_\_\_

# The Light Touch Healing Center

## Integrative Medicine

### Kidneys and Bladder

Have you had recurrent bladder infections? Y N How were they treated? \_\_\_\_\_

How many bladder infections have you had in the past 3 years? \_\_\_\_\_

Do you have any burning sensation during or after urinations? (past or present)

Do you have difficulty starting or stopping when urinating? Y N

Does your urine have a strong odor to it? Y N

Do you have difficulty perspiring? Y N Do you perspire during exercise? Light/Medium/Heavy

Do you perspire other times than when exercising? Y N When? \_\_\_\_\_

Does your perspiration have a strong smell? \_\_\_\_\_

### Occupational / Household / Environmental Exposures

How long have you lived at your present address? \_\_\_\_\_ What state did you previously live in? \_\_\_\_\_

Please describe current location, if old or new place, i.e. new construction, damp or moldy, near power lines or industrial buildings, etc.

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New Carpet or flooring? \_\_\_\_\_ Recent painting or remodeling? \_\_\_\_\_

Do you have specialized air filtration in home? Y N Do you live in the city? Y N

Do you work in an office building? Y N Do the windows open? Y N

Do you have specialized filtration in your work place? Y N

Do you work in the presence of toxic fumes or chemicals? Y N

Do any of your hobbies involve toxic materials? Y N

Are you exposed to second hand smoke currently? Y N

What do you use for your drinking water (please circle) ? Bottled Filtered Tap

As far as environmental exposures, do you have anything else you would like to comment on?

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The Light Touch Healing Center  
Integrative Medicine

Dr. Jeffrey Benton D.C., ND  
Financial Policy

**Thank you for choosing me as your healthcare provider. I will do my best to provide you with the highest quality medical services. I feel that it is very important that my patients have a clear understanding of my expectations regarding billing and payment. Please read and sign the following financial policy prior to your treatment. Should you have any questions, feel free to ask.**

Jeffrey Benton D.C. does accept some insurances. However, payment will be expected at time of service. If you would like to submit paperwork to your insurance company on your own, please ask and you will be provided you with the appropriate *Superbill* to do so.

Some of the laboratory work performed at the office and through adjunct lab testing locations are covered by insurance. If this is the case, your insurance information must be provided and sent with the labs. The laboratory companies will bill your insurance company. Please understand that although they will attempt to bill your insurance company for you, if your insurance rejects coverage, you will be required to provide full payment for these services. Please understand that this is all handled by the independent lab companies, and Dr. Benton is not involved in the insurance billing process.

If a payment is made by check and the check is returned for non-sufficient funds, you will be charged an additional \$25 to your account. If that happens, you will be asked to remit the amount of the check plus the service charge in cash within 10 days. If your account has not cleared by then, we will refer it for collection action.

I also ask for a credit card number from you up-front. This is because I offer the option of phone consultations for my patients' convenience. This will require a credit card to be charged in my office to cover this consultation. I also offer to ship my patients' supplements to their home if they are unable to come to the office to pick up refills. Again, for this service, it is required to have a credit card number on hand in the office.

Showing up for your scheduled appointment time is very important. If you are unable to make your appointment, please give our office 24 hours notice so that we may give another patient that time.

**Patients that "no show" or do not cancel 24 hours prior to their appointment will be charged the full amount of that appointment.**

Fee Schedule:

Initial Visit: \$250.00

Follow - Up Visits: \$125

**I HAVE READ AND FULLY UNDERSTAND Dr. JEFFREY BENTON'S POLICY.**

Signature of responsible party \_\_\_\_\_ Date \_\_\_\_\_

# The Light Touch Healing Center

## Integrative Medicine

### INFORMED CONSENT FOR TREATMENT

I, \_\_\_\_\_, hereby authorize Dr. Jeffrey Benton, D.C. to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

**Physical medicine:** Hydrotherapy, stretching, Chiropractic manipulation, and electrical muscle stimulation.

**Medicinal use of nutrition:** Therapeutic nutrition, nutritional supplementation, and intravenous and muscular vitamin injections

**Homeopathic medicine:** The use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.

**Lifestyle counseling and hygiene:** Diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: adverse reactions to prescribed supplements and herbs, side effects of natural medications, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from procedures. **Notify Dr. Benton if you experience any symptoms.**

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, relief of pain, and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Benton regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or my representative, or unless it is required by law. I understand that my medical record will be kept for a minimum of three, but no more than seven years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

# The Light Touch Healing Center

## Integrative Medicine

### Notice Of Privacy Practices

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

#### **OUR PLEDGE REGARDING MEDICAL INFORMATION**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

#### **OUR LEGAL DUTY**

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

#### **USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. **We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization.** Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

The Light Touch Healing Center  
Integrative Medicine

## Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I, \_\_\_\_\_ (printed name of patient or legal guardian), acknowledge that **Jeffrey Benton D.C.** will provided a written copy of its Notice of Privacy Practices for Protected Health Information for (print name of patient): \_\_\_\_\_ upon request.

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_/\_\_\_/20\_\_\_  
Date (mm/dd/yyyy)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship