

**BACKBONE OF HEALTH CLINIC
DOUGLAS C. WEEKS, M.D.**

INTRODUCTORY LETTER TO PATIENTS

Thank you for your interest in the Backbone of Health Clinic and in making an appointment to see Dr. Douglas Weeks.

Dr. Doug Weeks was a board certified emergency medical physician for 20 years and the chairman of his department at Lakewood Hospital for many of those years. Despite the positive interventions of emergency medicine in people's lives, he was drawn to the concept of preventing people from needing to be in hospitals. Since the mid 1980's he has been studying preventive and alternative medicine and, in 1995 he left emergency to practice preventive medicine full time. Since then he has worked in three different preventive medicine settings. Starting in January, 2010, he has been working in the Backbone of Health Clinic with his son, Dr. Timothy Weeks, a chiropractic physician.

We believe that, in the environment we live in today, there are many toxins and stressors that adversely affect people and that combined with high calorie malnutrition have created vulnerability to many diseases. Thus cancer and heart disease have increased greatly over the last century as well as many other diseases. Our bodies are degenerating before their time.

In our clinic we focus on nourishing the body back to health and providing a situation where there is self healing, the way we believe God intended. You will find that we use medicines sparingly and whole food nutrition generously, along with encouraging healthy eating and life styles.

We do request that you keep your family physician. We do not do many of the things that they do in early detection and disease treatment. If your doctor has prescribed medications, we will not take you off of them and you need to go back to him/her if you need refills. We would hope that you and your doctor will see improvements from what we do and perhaps decrease the use of medications over time.

Please fill out the history form and questionnaire before you come in for your first appointment so that we can be efficient. Also please be 15 minutes early. In respect to all our patients we try to keep appointments very prompt. If you arrive late, the time you have with the doctor will be reduced.

We look forward to seeing you and working with you to achieve the best health possible for you.

Douglas C. Weeks, M.D.

Dr. Douglas Weeks
Backbone of Health

4015 Medina Rd, #90, Medina OH 44256
Western Reserve Professional Bldg on corner of Rt 18 & Foote
330.764-3434

Name _____ Date _____

Address _____

City _____ Zip Code _____

Email _____

Home Phone _____ Work _____

Cell Phone _____ Fax _____

Date of Birth _____ Age _____

Social Security _____ Sex _____

Guarantor (if patient is a minor) _____

Emergency Contact _____

Home Phone _____ Cell Phone _____

Marital Status M D S Who referred you to us? _____

Name of Primary Care Doctor _____

Address _____

City, State, Zip code _____

Phone Number _____

May we send updates of your progress to your doctor? Yes No

When did you last see Wellness Physician? _____ Dr _____

Why did you see this Wellness Physician? _____

Were you helped? _____

Did you follow the program? ____ If not, Why? _____

Why are you changing Wellness Physician? _____

HISTORY OF PRESENT ILLNESS

Date:

Patient's Name:

FOR STAFF USE ONLY:

In the left column, briefly list each problem, its date of onset and what therapeutic measures have been taken by you or your physician to correct it. Include any medications, prescribed or over the counter. Use the back of the sheet if needed.

#1. PATIENT TO COMPLETE:

#2.

#3.

**HISTORY OF PRESENT
ILLNESS (contd.)**

Date:

Patient's Name:

FOR STAFF USE ONLY:

#4. PATIENT TO COMPLETE:

#5.

#6.

Patient's Name:

Date:

PAST MEDICAL HISTORY

CHILDHOOD

Unusual Illness
Frequent Antibiotics
Serious Accidents
Other _____

ALLERGIES

Hours of Sleep/Night

ADULTHOOD

Problems other than mentioned above

FAMILY HISTORY

Please list any known Medical problems with your family - indicate deceased or living & age.

Mother:

Father:

Siblings:

WEIGHT

Consistent
Going up ___ lbs/yr
Going down ___ lbs/yr

EYES

Glasses
Cataracts
Glaucoma
Macular Degeneration
Other

EARS

Hearing Ok
Impaired? (How)

SURGICAL PROCEDURES

CURRENT PRESCRIPTIONS & QTY

REVIEW OF SYMPTOMS

My Energy Level is:
Good- Fair- Bad- Poor

Sleeping Pattern:

Restless - peaceful - interrupted

DENTAL WORK

no or specify:

THYROID PROBLEMS

no or specify:

CURRENT SUPPLEMENTS

LUNG PROBLEMS

no or specify:

Patient's Name:

Date:

HEART PROBLEMS

no or specify:

DIGESTION

Good

Gassy, Bloating

Cramps

Abdominal Discomfort

BM's per day _____

Other _____

URINARY

Ok

Other _____

MUSCULOSKELETAL

Back or Joint Problems

No

Yes (specify)

METABOLIC

Cholesterol Elevated?

Yes - No

Blood Pressure Elevated?

Yes - No

Blood Sugar Elevated?

Yes - No

NEUROLOGICAL

Numb or Tingling

Areas

No

Yes (specify)

Headaches

No

Yes (specify)

Skin Problems

No

Yes (specify)

Mood

Stable

Irritable

Depressed

Other

FOR MEN

Urinary Stream

Good - Other _____

Prostate Problems

Yes - No

Infections

Yes - No

Libido (sexual interest)

Good - Other _____

Erectile Dysfunction

Yes - No

FOR WOMEN

Gynecological History

(PMS, Endometriosis etc.)

Number of Pregnancies

Number of Live Births

Last Menstrual Period

PMS?

Bone Density Test

Yes - No

Hormonal Replacement

Yes - No

Birth Control Pills

Yes - No

Libido (sexual interest)

Good - Other _____

HABITS

Smoking _____

Alcohol _____

Drugs _____

Other _____

Backbone of Health Consent/Permission to Treat Form

I hereby request and consent to treatment of preventive medicine including, but not limited to meridian and reflex testing and balancing, chelation therapy, intra-venous nutrition therapy, allergy elimination, Bio electric stress testing, muscle testing, acupuncture and other procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by Douglas Weeks, M.D. and/or other licensed doctors who now or in the future treat me while employed by working or associated with or serving as back-up for Douglas Weeks, M.D. and including those personnel working at Backbone of Health Clinic or any other office or clinic, whether signatories to this form or not.

I understand that I will be given the opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of all natural, alternative and integrative treatments and procedures before they are performed to me or asked of me. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of standard medicine, in the practice of complementary and preventive medicine there are some risks to treatment, including, but not limited to allergic reactions, side affects, or the use of needles (bleeding, venous infiltration, infection, bruising, and/or internal organ puncture), pain, and increase in symptoms or no improvement at all. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I for myself and my personal representatives, heirs, next of kin, hereby release, waive, discharge and covenant not to sue Backbone of Health, its officers and members, owners and employees from all liability to myself, my personal representatives, assigns, heirs and next of kin for all loss or damage, or any claim or damage therefore, on account of injury of any kind due to the negligence of the Backbone of Health, its officers and members, owners and employees.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have discussed and understand other treatment options that may be available to me through standard medical approaches and/or other health care providers.

Douglas Weeks M.D. does not offer to diagnose or treat any disease or condition found in the body. We are not here to replace your primary care physician. However, if during the course of an examination, we encounter unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider that specializes in that area. We may give you information or advice about your present prescriptions, we are in no way recommending you to change or go off of any of your medicine, please advise your primary care physician before making any changes.

Regardless of what the disease is called, we do not offer to treat it. You may be recommended nutrition; this nutrition is not meant to cure or treat any disease but rather to help bring about a state of balance in the body. We do not offer advice regarding treatment prescribed by others. Our only practice objective is to bring balance to the body's systems through chiropractic care so that your body may better able to heal itself.

To be completed by the patient

(Patient's Name)

(Signature of Patient)

DATE: _____

To be completed by the patient's representative if necessary e.g. if the patient is a minor or physically or mentally incapacitated

(Patient's Name)

(Print Name of Patient's Representative)

(Signature of Patient's Representative)

(Relation to Patient)

Backbone of Health

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient a record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient _____ Date _____

Signature _____