Heart Sound Recorder Intake Form

First Name_____ Last Name_____

Address_____ City_____ Zip_____

Contact Number ( )_____-_____ Contact Email _____

How would you like us to remind you of your future appointments: ☐Text ☐Phone Call ☐Email

Current Symptoms – Please Mark Each Symptom You Have

Tingling or Numbness	Chest Pain	Valve Replacement	Breathless with Activity
Dizziness	Mental Confusion	Flushed Cheeks	Trip/Fall Easily
Fatigued	Lack of Stamina	Lack of Motivation	Depression
Digestive Issues	Difficulty Swallowing	Hear Heartbeat In Ear	Pain in Shoulders
Pain in arms	Pain in neck	Pain in back	Pain in Jaw
Pain in throat	Palpitations	Weakness	Nausea
Sweating	Anxiety	Irregular Heartbeat	Pounding in Chest
Difficulty Catching Breath	Swelling/Edema	Rapid Weight Gain	Chronic Cough
Cold Extremities	Recurrent Infections	Fainting	Low Grade Fever

Other:_____

How frequently do you exercise?:_____

What forms of exercise do you do?:_____

Are you on a specific type of diet?:_____

Consumption of caffeinated beverages: ☐ Yes ☐ No How much per day in cups:_____

Do you consume mineral salt? ☐ Yes ☐No or ☐Salt Free Diet

Have you ever played sports or in dance/gymnastics/cheer?: ☐Yes ☐No
Please list:_____

Have you ever had any moderate to severe head injuries that may include concussion, stitches or monitoring after the accident?: ☐Yes ☐No

Scale 1 – 10, 10 being the worst, what is your current stress level? Please circle

1 2 3 4 5 6 7 8 9 10

Have you ever worked around power lines or other sources of electricity? ☐ Yes ☐ NO

Do you wear a FitBit? ☐ Yes ☐NO

Do you work around WiFi all day? ☐ Yes ☐NO

Do you have a Smart Meter on your home? ☐Yes ☐NO

Is your home over 30% wireless? ☐Yes ☐ NO

Women

☐Breast Pain ☐Wear Underwire Bras ☐Low Sex Drive

Men

☐Inability to Get/Maintain Erection ☐ Inability to Achieve Orgasm ☐ Prostate Issues ☐Low Sex Drive

Do you have silver or gold fillings, implants, or other oral devices? ☐Yes ☐No

Do you have any metal staples, appliances, or replacement parts in your body? ☐Yes ☐NO

Please List All Surgeries:_____

_____

Please List Current Medications, Supplements, Herbs, Homeopathy or Essential Oils:

_____

_____

_____

Please List All Medical Diagnosises: _____

_____

_____

Family Medical History:_____

Heart Sound Recorder Patient Consent Form

I give _____ permission to record the sound of my heart and to create a graph of that sound on the Heart Sound Recorder (a general wellness cardiac stress monitor). I have been informed and understand that the Heart Sound Recorder is not an electrocardiograph like those in hospitals or physicians and that it is not capable of diagnosing heart conditions and is not in any way a substitute for such a device. I further understand that the Heart Sound Recorder has not been reviewed or cleared by the US Food and Drug Administration. I understand that if I have or believe I have a heart condition, that I should see a physician qualified to evaluate and treat that condition.

Any suggested nutritional or dietary advice is not intended as treatment or therapy for any disease or symptom of disease. Nutritional counseling, supplement recommendations, and exercise considerations provided to me are to support the normal physiological processes of the body.

I understand that any techniques, treatments, or lifestyle changes suggested after the use of this device should be undertaken only with the guidance of a licensed physician, therapist, or healthcare practitioner.

The findings from this device can be used to support, but should not be used in place of sound medical therapies and recommendations.

I am giving permission to _____ to share my graph with other practitioners for educational purposes only so long as my name and other personal information are removed.

By signing below, I agree to the above.

Print Name: _____

Signature :_____

Date:_____

How To Prepare For Your Heart Sound Recorder Session

1. No caffeinated beverages 3 hours prior to your test.
2. Drink 2 cups of water at least one hour before your test.
3. Do not take any supplements 2 hours prior to your test.
4. Do not eat 1.5 hours before test.
5. Please wear a shirt/blouse that is thin. The recorder can't read through thick fabric.
6. Women – please wear a soft cup bra or a sports bra
7. Please remove FitBit or Apple watch one hour prior to your test.
8. Please remove watches, necklaces, earrings, money clips or any other metal devices or jewelry. (That can be removed)
9. Cell phones are not allowed in testing room.

Unless you were told otherwise, your initial office visit is $83.00 for a one hour session, excluding the cost of supplements. Your follow up office visits are $43.00 for 30 minutes, excluding the cost of supplements. The fees are not billable to insurance.

For each person that you refer for a heart sound recorder session, you will receive a $10.00 gift card that can be applied either to your supplement purchase or to your office visit fee. This is our way of saying "Thank You" for having such a great ♥ for your family and friends!

Due to practitioner schedules, we require 24-hour cancellation notifications. Please call 360.438-6559 or email us at laceychiro7@gmail.com to reschedule your appointment.