THE ART OF HEALTH

We can't wait to meet you!

General Information

Legal Name: _____
First *Middle* *Last*

Preferred Name: _____ Gender at birth: ☐ Male ☐ Female

Date of Birth: ____/____/____ Blood Type: ☐Unknown ☐ A ☐ B ☐ AB ☐ Rh+ ☐ O

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed LGBTQIA+? ☐ Yes ☐ No

Genetic Background: ☐ African ☐ Ashkenazi ☐ Asian ☐ European
☐ Mediterranean ☐ Middle Eastern ☐ Native American

Occupation: _____ Nature of Business: _____

Highest Education Level: ☐ High School ☐ Under Graduate ☐ Post Graduate

Contact Information

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Fax: _____

Primary Address: _____ _____
Street Address *Unit/APT #*

_____ _____ _____
City *State* *Zip code*

Who else is living in your household(#____) - *include name, age, and occupation*

_____ _____ _____

_____ _____ _____

Emergency Contact: _____ _____
Name *Relationship to patient*

(____)____-_____ _____
Phone # *Street Address* *City* *State* *Zip code*

Primary Treating Physician: _____

Office Phone #: _____ Fax #: _____

Preferred Pharmacy: _____ _____
Business Name *Phone #*

Fax #: _____ ***It is mandatory to include the pharmacy's fax number**

_____ _____
Street Address *Unit/Suite #*

_____ _____ _____
City *State* *Zip code*

How were you referred to our office? ☐ Social Media ☐ Google ☐ Friend / Family
☐ Other _____

Current Medications

Medication	Dose	Frequency	Start Date	Reason for use

Previous Medications- no longer taking

Medication	Dose	Frequency	Dates Taken	Reason for use

Nutritional Supplements – vitamins, minerals, or herbs

Supplement/Brand	Dose	Frequency	Start Date	Reason for use

Have you experienced any of the following?

- ☐ Prolonged use of NSAIDS (Advil, Aleve, Motrin, Aspirin)
- ☐ Prolonged use of Tylenol
- ☐ Prolonged use of Acid Blocking Drugs (Zantac, Prilosec, Tagamet)
- ☐ Frequent or long-term antibiotics (more than 3x per year)
- ☐ Use of steroids (Prednisone, nasal allergy inhalers)
- ☐ Use of oral contraceptives (birth control)
- ☐ Unusual side effects from supplements or medications

Describe:_____

_____

Allergies

Medication / Supplement: Reaction:

_____ _____

_____ _____

_____ _____

Complaints / Concerns

What is your main complaint, and what do you hope to achieve in your visit with us?

_____

_____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Please list current and ongoing problems in order of priority and what you have tried to treat each condition:

Describe Problem	Severity			Treatment / Approach	Did it help?
	Mild	Moderate	Severe		
					Y / N
					Y / N
					Y / N
					Y / N
					Y / N
					Y / N

If you had a magic wand and could erase 3 problems, what would they be?

1. _____
2. _____
3. _____

Please rate yourself on a scale of **1** to **5** for the following questions by circling your answer

In order to improve your health, how willing are you to: *Reluctant* ⟷ *Eager*

Significantly modify your diet	1	2	3	4	5
Keep a record of everything you eat each day	1	2	3	4	5
Take several nutritional supplements per day	1	2	3	4	5
Modify your lifestyle (work demands, sleep habits, etc...)	1	2	3	4	5
Practice relaxation techniques	1	2	3	4	5
Engage in regular exercise	1	2	3	4	5
Have periodic lab tests to assess your progress	1	2	3	4	5

In regard to your self-confidence: *Not confident at all* ⟷ *Very Confident*

How confident are you in your ability to follow through on the above life changes	1	2	3	4	5

If you are not confident, what aspects of your life lead you to question your capacity to fully engage in the above activities?

_____

_____

In regard to people you spend your time with: *Very Unsupportive* ⟷ *Very Supportive*

How supportive do you think your friends / family will be to your health journey	1	2	3	4	5

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Comprehensive Medical History— *Check all applicable boxes and provide date of onset*

GASTROINTESTINAL

- ☐ Ulcerative Colitis _____
- ☐ GERD (reflux) _____
- ☐ Celiac Disease _____
- ☐ Irritable Bowel Syndrome _____
- ☐ Inflammatory Bowel Disease _____
- ☐ Gastritis or Peptic Ulcers _____
- ☐ Crohn's Disease _____
- ☐ Other _____

CARDIOVASCULAR

- ☐ Heart Attack _____
- ☐ Stroke _____
- ☐ Heart Disease _____
- ☐ Mitral Valve Prolapse _____
- ☐ Arrythmia (irregular heart rate) _____
- ☐ Hypertension (high blood pressure) _____
- ☐ Rheumatic Fever _____
- ☐ Elevated Cholesterol _____
- ☐ Other _____

METABOLIC / ENDOCRINE

- ☐ Type 1 Diabetes _____
- ☐ Type 2 Diabetes _____
- ☐ Insulin Resistance _____
- ☐ Hypoglycemia _____
- ☐ Metabolic Syndrome _____
- ☐ Infertility _____
- ☐ Polycystic Ovarian Syndrome (PCOS) _____
- ☐ Hypothyroidism (Low Thyroid) _____
- ☐ Hyperthyroidism (Overactive Thyroid) _____
- ☐ Frequent Weight Fluctuations _____
- ☐ Binge Eating Disorder _____
- ☐ Night Eating Syndrome _____
- ☐ Weight Gain _____
- ☐ Weight Loss _____
- ☐ Bulimia _____
- ☐ Anorexia _____
- ☐ Endocrine Problems _____
- ☐ Other _____

CANCER

- ☐ Breast Cancer _____
- ☐ Lung Cancer _____
- ☐ Colon Cancer _____
- ☐ Prostate Cancer _____
- ☐ Ovarian Cancer _____
- ☐ Skin Cancer _____

GENITAL / URINARY SYSTEMS

- ☐ Kidney Stones _____
- ☐ Gout _____
- ☐ Frequent UTI _____
- ☐ Frequent Yeast Infections _____
- ☐ Erectile or Sexual Dysfunction _____
- ☐ Interstitial Cystitis _____
- ☐ Other _____

MUSCULOSKELETAL PAIN

- ☐ Osteoarthritis _____
- ☐ Other _____
- ☐ Fibromyalgia _____
- ☐ Chronic Pain _____

INFLAMMATORY / AUTOIMMUNE

- ☐ Lupus SLE _____
- ☐ Genital Herpes _____
- ☐ Food Allergy _____
- ☐ Latex Allergy _____
- ☐ Environmental Allergy _____
- ☐ Multiple Chemical Sensitivities _____
- ☐ Chronic Fatigue Syndrome _____
- ☐ Immune Deficiency Disease _____
- ☐ Autoimmune Disease _____
- ☐ Poor Immune Function _____
- ☐ Frequent Infections _____
- ☐ Infectious Disease _____
- ☐ Rheumatoid Arthritis _____
- ☐ Other _____

RESPIRATORY DISEASES

- ☐ Asthma _____
- ☐ Emphysema _____
- ☐ Tuberculosis _____
- ☐ Chronic Sinusitis _____
- ☐ Sleep Apnea _____
- ☐ Other _____
- ☐ Bronchitis _____
- ☐ Pneumonia _____

SKIN DISEASES

- ☐ Eczema _____
- ☐ Psoriasis _____
- ☐ Melanoma _____
- ☐ Skin Cancer _____
- ☐ Acne _____
- ☐ Other _____

NEUROLOGIC / MOOD

- ☐ Depression _____
- ☐ Anxiety _____
- ☐ Headaches _____
- ☐ Migraines _____
- ☐ Autism _____
- ☐ Mild Cognitive Impairment _____
- ☐ Memory Problems _____
- ☐ Parkinson's Disease _____
- ☐ Multiple Sclerosis _____
- ☐ Bipolar Disorder _____
- ☐ Schizophrenia _____
- ☐ ADD/ADHD _____
- ☐ ALS _____
- ☐ Seizures _____
- ☐ Other _____

Comprehensive Medical History Continued -*Check all applicable boxes*

DENTAL HISTORY

☐ Tooth Pain ☐ Implants ☐ Silver Mercury Fillings How many?_____
☐ Gingivitis ☐ Difficulty Chewing ☐ Root Canals How many?_____
☐ Bleeding Gums ☐ Gold Fillings **Do you Floss regularly?** ☐ YES ☐ NO

GI HISTORY

Do you feel like you digest food well? ☐ YES ☐ NO Do you feel bloated after meals? ☐ YES ☐ NO
Have you ever had severe: ☐ diarrhea ☐ gastroenteritis
Wilderness Camping? ☐ YES ☐ NO When and where? _____
Foreign Travel? ☐ YES ☐ NO When and where? _____

PATIENT BIRTH HISTORY *what happened when YOU were born*

Pregnancy or Birth Complications? _____
☐ Bottle fed ☐ Breast fed Until what age? _____ ☐ Born Full Term ☐ Premature
Age at introduction of: Solid foods _____ Dairy _____ Wheat _____
Did you eat a lot of sugar or candy as a child? ☐ YES ☐ NO

PREVENTATIVE TESTING *check any that apply and provide date of most recent*

☐ Full Physical Exam _____ ☐ EKG _____ ☐ Upper Endoscopy _____
☐ Bone Density Scan _____ ☐ MRI _____ ☐ Upper GI Series _____
☐ Colonoscopy _____ ☐ CT Scan _____ ☐ Ultrasound _____
☐ Cardiac Stress Test _____ ☐ EBT Heart Scan _____ ☐ Hemoccult (stool test) _____

SMOKING

Currently Smoking? ☐ YES ☐ NO How many years?_____ # Packs per day? _____ Attempts to Quit?_____
Previous Smoker? ☐ YES ☐ NO How many years?_____ # Packs per day? _____ Attempts to Quit?_____
Second hand smoke exposure? ☐ YES ☐ NO

ALCOHOL INTAKE [1 drink = 5oz wine / 12 oz beer / 1.5oz liquor]

How many drink do you consume per week? ☐ NONE (skip section) ☐1 to 3 ☐4 to 6 ☐7 to 10 ☐more than 10
Previous Alcohol intake? ☐ None ☐ Light ☐ Moderate ☐ Heavy
Have you ever been arrested or hospitalized due to drinking?.....☐ YES ☐ NO
Have you ever noticed your alcohol tolerance is higher than others?.....☐ YES ☐ NO
Have you ever been told you should cut down on your alcohol intake?.....☐ YES ☐ NO
Have you ever been thought about getting help to control or stop your drinking?.....☐ YES ☐ NO

OTHER SUBSTANCES

Do you regularly consume caffeine? ☐ YES ☐NO
Preferred type of caffeine: (ex. Regular/diet soda, energy drinks, coffee etc)_____
Cups of **coffee** per day: ☐ 1 ☐ 2-4 ☐ more than 4 Cups of **tea** per day: ☐ 1 ☐ 2-4 ☐ more than 4
Do you drink caffeinated soda? ☐ YES ☐ NO Preferred type: _____
How many 12oz cans/bottles do you consume per day?: ☐ 1 ☐ 2-4 ☐ more than 4
Are you currently using any recreational drugs ☐ YES ☐ NO
Have you ever used IV or inhaled recreational drugs? ☐ YES ☐ NO

[TOP section for WOMEN only]

Gynecologic History *Check all applicable boxes*

MENSTRUAL HISTORY

Age at first period: _____ Has your period ever skipped? ☐ YES ☐ NO For how long? _____

Menses Frequency: _____ Menses Duration:_____ (days)

Use of hormonal contraception: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring For how long? _____

Other contraception methods: ☐ IUD ☐ Diaphragm ☐ Condoms ☐ Partner Vasectomy

Date of last menstrual period: _____ Age at Menopause: _____ Currently in Menopause ☐ YES ☐ NO

Menopausal Symptoms:

☐ Concentration/Memory ☐ Vaginal Dryness ☐ Hot Flashes ☐ Mood Swings ☐ Decreased Libido

Premenstrual Symptoms:

☐ Carbohydrate Cravings ☐ Decreased Sleep ☐ Constipation ☐ Irritability ☐ Breast Tenderness
☐ Chocolate Cravings ☐ Increased Sleep ☐ Diarrhea ☐ Fatigue ☐ Bloating

Menstrual Symptoms:

☐ Scanty Periods ☐ Heavy Periods ☐ Irregular Periods ☐ No Periods
☐ Spotting Between ☐ Cramps ☐ Pain ☐ Clotting

DISORDERS / HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Weight Gain ☐ Vaginal Discharge
☐ Breast Lumps ☐ Painful Periods ☐ PMS ☐ Headaches ☐ Vaginal Odor
☐ Breast Tenderness ☐ Joint Pains ☐ Poor Libido ☐ Ovarian Cysts ☐ Vaginal itch
☐ Loss of control of urine ☐ Palpitations ☐ Heavy Bleeding ☐ Infertility ☐ Vaginal Pain with Sex

☐ Use of Hormone Replacement Therapy How Long?_____

Date of last Mammogram _____ Breast Biopsy Date: _____ Result: ☐ Normal ☐ Abnormal

Date of last PAP Test: _____ Result: ☐ Normal ☐ Abnormal

Last Bone Density Test: _____ Result: ☐ Low ☐ Within normal range ☐ High

OBSTETRIC HISTORY

☐ Pregnancies #_____ ☐ Living Children #_____ ☐ Post Partum Depression

☐ Caesareans #_____ ☐ Abortions #_____ ☐ Toxemia

☐ Vaginal Deliveries #_____ ☐ Miscarriages #_____ ☐ Gestational Diabetes Baby Over 8 lbs

☐ Breast feeding For how long? _____

[This section for MEN only]

Men's History *Check all applicable boxes*

☐ Prostate Enlargement ☐ Prostate/Urinary Infection ☐ Ejaculation Problems

☐ Change in Libido ☐ Genital Pain ☐ Difficulty Obtaining an Erection

☐ Lumps in Testicles ☐ Discharge from Penis ☐ Difficulty Maintaining an Erection

☐ Change in urinary stream (Urgency / Hesitancy) ☐ Loss of control of urine

☐ Nocturia (urination at night) How many times at night? _____ ☐ Impotence

Have you ever had a PSA done? ☐ YES ☐ NO PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ Above 10

Exercise—*complete all that apply*

Activity Type	Duration	Frequency
☐ Stretching	_____# minutes	_____times per week
☐ Cardio / Aerobics	_____# minutes	_____times per week
☐ Strength Training	_____# minutes	_____times per week
☐ Yoga / Pilates / Other _____	_____# minutes	_____times per week
☐ Sports (ex. golf, tennis, roller blading)	_____# minutes	_____times per week

Rate your current level of motivation for including exercise in your routine ☐ Low ☐ Medium ☐ High

List any problems that limit your activity :

_____

_____

Do you feel unusually fatigued after exercise? ☐ YES ☐ NO

Do you usually sweat when exercising? ☐ YES ☐ NO

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ..... ☐ YES ☐ NO

Do you feel your life has meaning and purpose? ..... ☐ YES ☐ NO

Do you like the work you do? ..... ☐ YES ☐ NO

Are you happy? ..... ☐ YES ☐ NO

Have you experienced any major losses in your life? ..... ☐ YES ☐ NO

Would you describe your childhood as happy and secure? ..... ☐ YES ☐ NO

Do you spend the majority of you time and money to fulfill responsibilities and obligations? ..... ☐ YES ☐ NO

Have you ever been abused, a victim of a crime, or experienced significant trauma? ..... ☐ YES ☐ NO

STRESS / COPING

Is excessive stress presently reducing the quality of your life? ..... ☐ YES ☐ NO

Do you feel you are capable of easily managing the stress in your life? ..... ☐ YES ☐ NO

Rate your daily stressors on a scale of 1(easiest to manage) to 10(hardest to manage)

Work____ Family____ Social____ Finances____ Health____ Other: _____

Do you practice any of the following relaxation techniques?:

☐ Yoga ☐ Meditation ☐ Visualizing ☐ Breath Work ☐ Tai Chi ☐ Prayer ☐ Other: _____

Have you ever sought counseling? ☐ YES ☐ NO Are you currently in therapy? ☐ YES ☐ NO

Describe your experience: _____

What resources do you rely on for emotional support? ☐ Family ☐ Friends ☐ Pets ☐ Religious/ Spiritual

Are you satisfied with your sex life? ☐ YES ☐ NO

SLEEP / REST

Average number of hours you sleep per night: ☐ Less than 6 ☐ 6-8 ☐ 8-10 ☐ More than 10

Do you struggle with insomnia? ☐ YES ☐ NO

Do you have trouble falling or staying asleep? ☐ YES ☐ NO

Do you feel rested upon awakening? ☐ YES ☐ NO

Do you snore? ☐ YES ☐ NO

Do you use sleep aids? ☐ YES ☐ NO What kind? _____

CHILDREN– *List each child's name, age, and gender*

_____ _____ _____

_____ _____ _____

Family History

X all that apply to your family members

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sister (s)	Brother(s)	Biological Children	Other	Other
Current Age											
Age at Death											
ADHD											
ALS or Motor Neuron Diseases											
Asthma											
Autism											
Bipolar Disorder											
Cancer: Type_____											
Celiac Disease											
Dementia											
Depression											
Diabetes											
Eczema / Psoriasis											
Environmental Sensitivities											
Food Allergies / intolerances											
Genetic Disorders											
Heart Disease											
Hypertension											
Inflammatory Arthritis											
Inflammatory Bowel Disease											
Irritable Bowel Syndrome											
Lupus											
Multiple Sclerosis											
Obesity											
Parkinson's											
Psychiatric Disorders											
Schizophrenia											
Stroke											
Substance Abuse / Alcoholism											
Thyroid Problems											

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Nutrition History

Physical Demographics

Height [Feet/Inches]: _____	Current Weight: _____Lbs.
Highest Adult Weight: _____Lbs.	Lowest Adult Weight: _____ Lbs.
Body Fat %_____	Desired weight range: _____+/- 5lbs

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
Have you ever had a nutrition consultation? ☐ YES ☐ NO
Have you ever had your Resting Metabolic Rate checked? ☐ YES ☐ NO Result? : _____
Have you made any changes to your eating habits due to your health? ☐ YES ☐ NO
Describe: _____

Are you currently following a specific diet or nutritional program? ☐ YES ☐ NO
Check any that apply:

☐ Low Fat Diet ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Vegetarian ☐ Vegan
☐ No Dairy ☐ No wheat ☐ No Gluten ☐ Diabetic Diet
☐ Weight Loss/ Maintenance Program: _____ ☐ OTHER: _____

What Foods do you avoid and why? _____
If you could only eat a few foods a week what would they be? _____
Who does the grocery shopping for the food you eat? _____
Do you read the nutrition labels on food you buy? ☐ YES ☐ NO
Who does the cooking for the food you eat? _____
How many times a week do you dine out: ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ > 5 meals per week

Below are some lifestyle factors that may affect your eating habits. *Check all that apply to you*

☐ Fast Eater	☐ Reliance on Convenience Items	☐ Healthy Food Often Unavailable
☐ Eat Too Much	☐ Poor Snack Choices	☐ Love to Eat
☐ Erratic Eating Pattern	☐ I Don't Plan Meals / Menus	☐ Eat Because I Have To
☐ Frequent Dieting	☐ Time Constraints	☐ Negative Relationship with Food
☐ Late Night Eating	☐ Travel Frequently	☐ Emotional Eater
☐ I Dislike Healthy Food	☐ Eat more than 50% of meals away from home	☐ Over Eats When Stressed
☐ My Family Members Dislike Healthy Food	☐ Confused About Nutrition Advice	☐ Under Eats When Stressed
☐ Family Members Have Special Dietary Needs	☐ Sensitive to Food Texture	☐ Struggle with Disordered Eating
☐ Don't Care to Cook	☐ Difficulty Gaining or Losing Weight	☐ Poor Appetite

What do you believe is the most important thing you should change about your diet in order to improve your health?
_____

List any known food sensitivities and reactions:
_____ _____
_____ _____
_____ _____

Do you have an adverse reaction to caffeine? ☐ YES ☐ NO
Do feel you have a dependency to caffeine? ☐ YES ☐ NO
How does caffeine make you feel? ☐ Irritable ☐ Wired ☐ Aches / Pains ☐ Other _____

Environmental and Detoxification Assessment

Do you have adverse reactions to any of the following?:

☐ Red Wine
☐ Aspartame (Nutrasweet)
☐ Bananas
☐ Cheese
☐ Chocolate
☐ Citrus Foods
☐ Garlic
☐ Monosodium Glutamate (MSG)
☐ Preservatives (ex. Sodium Benzoate)
☐ Red Wine
☐ Sulfite containing Foods (dried fruit/ wine/ canned food)
☐ Other: _____

Are you significantly affected by : ☐ Cigarette Smoke ☐ Perfumes/ Cologne ☐ Auto Exhaust Fumes

Do you dry clean your clothes frequently? ☐ YES ☐ NO
Do you have any pets or farm animals? ☐ YES ☐ NO
Have you ever had Jaundice (turned yellow)? ☐ YES ☐ NO
Have you ever been told you have Gilbert's Syndrome? ☐ YES ☐ NO
Have you ever been told you have a liver disorder? ☐ YES ☐ NO
Have you ever had to work in a damp / moldy environment? ☐ YES ☐ NO

Have you had any known exposures to any of the following harmful chemicals / toxins:

☐ Herbicides Date Range of Exposure: _____
☐ Insecticides (frequent visits of exterminator) Date Range of Exposure: _____
☐ Pesticides Date Range of Exposure: _____
☐ Organic Solvents Date Range of Exposure: _____
☐ Heavy Metals Date Range of Exposure: _____
☐ Electromagnetic Radiation Date Range of Exposure: _____
☐ Mold Date Range of Exposure: _____
☐ Chemicals: _____ Date Range of Exposure: _____
☐ Other: _____ Date Range of Exposure: _____

INJURIES *Check any that apply and provide date*

☐ Back Injury _____ ☐ Neck Injury _____ ☐ Head Injury _____
☐ Broken Bones _____ ☐ Other _____

SURGURIES *Check any that apply and provide date*

☐ Appendectomy _____ ☐ Angioplasty or Stent _____ ☐ Tonsillectomy _____
☐ Gall Bladder _____ ☐ Heart Surgery / Bypass Valve _____ ☐ Dental / Jaw Surgery _____
☐ Hernia _____ ☐ Joint Replacement (Knee or Hip) _____ ☐ NONE
☐ Pacemaker _____ ☐ Hysterectomy +/- Ovaries _____ ☐ Other _____

HOSPITALIZATIONS *If applicable*

Date:_____ Reason:_____
Date:_____ Reason:_____
Date:_____ Reason:_____

Symptom Review—*Please check all symptoms present within the last 6 months*

GENERAL

- ☐ Cold Hands and Feet
- ☐ Cold Intolerance
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

HEAD, EYES, EARS

- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing / Buzzing
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Headache
- ☐ Lid Margin Redness
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision Problems
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

NEUROLOGICAL

- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-outs
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fearfulness/ Paranoia
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Phobias :_____
- ☐ Panic Attacks
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling : _____
- ☐ Tremor / Trembling
- ☐ Vertigo
- ☐ Visual Hallucinations

DIFFICULTY WITH

- ☐ Balance
- ☐ Concentration
- ☐ Judgement
- ☐ Memory
- ☐ Speech
- ☐ Thinking

UPPER GI

- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Bloating After Meals
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at corners of lips
- ☐ Dentures (poor chewing)
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Heartburn
- ☐ Indigestion
- ☐ Nausea
- ☐ Reflux
- ☐ Upper Abdominal Pain
- ☐ Vomiting
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Undigested Food in Stomach

LOWER GI

- ☐ Alternating Diarrhea & Constipation
- ☐ Anal Fissures
- ☐ Anal Spasms
- ☐ Bloating -Lower Abdomen
- ☐ Bloating -Whole Abdomen
- ☐ Blood in Stool
- ☐ Diarrhea
- ☐ Excess Flatulence (gas)
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stool
- ☐ Strong Stool Odor

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SKIN PROBLEMS

- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Eczema
- ☐ Lack Of Sweating
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/ Change in Color/Size
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN

- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet Hands Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp Throat

DRYNESS

- ☐ Dandruff
- ☐ Dry Eyes
- ☐ Feet Cracking/ Peeling
- ☐ Hair Unmanageable
- ☐ Hands Cracking/ Peeling
- ☐ Mouth/Throat
- ☐ Scalp
- ☐ Skin In General

NAILS

- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft Nails
- ☐ White Spots/Lines

Thickening of:

- ☐ Fingernails
- ☐ Toenails

RESPIRATORY

- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Postnasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

HAY FEVER

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Change Of Season

URINARY

- ☐ Bed Wetting
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

LYMPH NODES

- ☐ Enlarged neck
- ☐ Tender neck
- ☐ Other Enlarged / Tender

_____

CARDIOVASCULAR

- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

MUSCULOSKELETAL

- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasm: Where:_____
- ☐ Muscle Stiffness
- ☐ Muscle Twitching (eyes)
- ☐ Muscle Twitching (arms/legs)
- ☐ Muscle Weakness
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

Amy M Anderson, D.O.
Phone: (360) 692-7919 Fax: (360) 692-7960
20696 Bond Rd. NE #210, Poulsbo, WA 98370

CANCELLATION / NO SHOW POLICY

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time.

It is the responsibility of the patient to keep track of any appointments they schedule. As a courtesy, an appointment reminder call will be attempted one(1) business day prior to your scheduled appointment.

We understand that there are times when you must miss an appointment due to emergencies or obligations to work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from taking the time slot and getting much needed care.

Effective July 15, 2018: Any established patient who fails to show or cancels / reschedules an appointment without at least 24 hours notice will be considered a No Show and charged a $50.00 fee.

This charge is Non-Negotiable and cannot be disputed.

No Show fees will be billed to the patient. This fee is not covered by insurance.
All no show fees MUST be paid before another appointment can be scheduled.

Dr. Amy Anderson, DO reserves the right to terminate the doctor-patient relationship of established patients due to no shows.

Late Policy

We understand that delays can happen, however we must try to keep all scheduled appointments on time.

If you arrive 10 minutes or more past your scheduled time the appointment may be rescheduled.

MEDICATION POLICY

Please be advised you are responsible to keep your medications up to date and active.

EXPEDITED APPOINTMENTS FOR REFILLS ARE NOT POSSIBLE

Please call and set an appointment with ample time before your refills run out or medication expires.

If you are on a controlled substance you are required to follow-up with the doctor every 3 months. It is best to schedule those follow-up appointments after your last appointment to ensure you do not have a lapse in medication.

Medication refills must be requested through your pharmacy; they will send us the requests for approval.

Please allow 72 business hours for completion of your refill.

ADDITIONAL COPIES FEE

There will be a **$15.00 fee** for any additional copies of patient documents including superbills, receipts, or itemized invoices.

Please understand that reprinting documents is time consuming, labor intensive, and increases the cost of our supplies. Thank you for understanding.

By signing this document I attest that I have read and agree to the above policies

Printed Patient Name	Signature of Patient/ Guardian	Date
		/ /

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INFORMED CONSENT FOR TELEHEALTH

To aid in ease of access to care, Amy Anderson D.O. may recommend engaging in telehealth services with me to provide treatment over a digital connection.

I understand there are potential risks to using telehealth technology, including but not limited to: interruptions, unauthorized access, and technical difficulties such as poor internet connection which may result in interruption of my scheduled session.

I understand that The Art of Health is not responsible for any technological problems of which Amy Anderson D.O. has no control over. I further understand that The Art of Health does not guarantee that technology will be available or work as expected.

I understand that I am responsible for information security both on the device I use to access the telehealth appointment and the environment I am in during the telehealth appointment. I understand that either myself or Amy Anderson D.O. can discontinue the telehealth consult/visit if it is determined by either party that the telehealth connections or protections are not safe or adequate for the situation.

To maintain confidentiality, I will not share my telehealth appointment, or the information shared within, with anyone who is not authorized to attend the session.

I agree that I will not record any audio or video of any telehealth visit, unless I notify Amy Anderson D.O. and this is agreed upon prior to beginning a session.

I understand that the same fee rates apply for telehealth as for in-person treatment. It is my obligation to contact my insurer before engaging in care in person or via digital connection to determine if there are applicable co-pays or fees which I am responsible for. Insurance or other managed care providers may not cover telehealth sessions. I understand that if my insurance does not cover the telehealth sessions, I will be solely responsible for the entire fee of the session.

I understand that either myself or Amy Anderson D.O. can discontinue telehealth or in-office services if those services do not appear to benefit me therapeutically or for other reasons which will be explained to me as decided.

TREATMENT CONSENT

I understand there is no guarantee that suggested treatment modalities will be effective.

I understand that it is my obligation to notify The Art of Health of any change to my contact information prior to each treatment session.

The Art of Health is NOT an emergency or urgent care service. In the event of an emergency, I will use a phone to call 9-1-1 and/or other appropriate emergency contacts. To utilize healthcare services or medical advice I must contact my primary care physician to schedule an appointment or visit a designated Urgent Care Facility.

I recognize that regardless of being treated in office or through a telehealth visit, The Art of Health and Amy Anderson D.O. may need to notify emergency personnel in the event there is a suspected safety or emergency medical concern, including but not limited to, a risk to self/others.

By signing this document I attest that I have read and understand the information provided above regarding telehealth, and I hereby give informed consent to be treated in person, or via Telehealth as deemed necessary by Amy Anderson DO and The Art of Health.

		/ /
Printed Patient Name	**Signature of Patient/ Guardian**	**Date**

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