

Water Of Life NaturoPathic Healthcare ~ Patient Medical History

**** Please be sure to read and sign the last two pages of this form ****

Name _____ Date _____

Address _____ Date of birth _____ Age _____

City _____ State _____ Zip. _____ Phone (H)(____) _____

E-Mail address _____ Phone (W)(____) _____

As these are not considered "secure" communication devices:
Is it acceptable for us to contact you via e-mail? **Yes / No**
Is it acceptable for us to leave messages on a voice mail / answering machine for you? **Yes / No**

Occupation _____

Employers name: _____

How were you referred to us? _____

Social Security Number: _____

If under 18, Parent or Guardian name(s): _____

Name and phone number of someone we may contact in an emergency _____

+++++

Gender: Male Female Marital status: _____

Current height: _____ Weight: _____ Last physical examination: _____

Are all vaccines current? _____ Have elected to decline vaccination _____

Last chest X-Ray: _____ Last blood tests: _____

Last eye examination: _____ Last dental visit: _____

If adult, when was your last:

Pneumonia vaccine: _____ Tetanus booster: _____ Flu vaccine: _____

Any other diagnostic tests in the past 3 years, if so what and when: _____

****If child**, last well child visit: _____
****If male**, last prostate exam / PSA evaluation: _____
****If female**, last Pap test: _____, physical exam: _____, breast exam: _____

Please list all medications, vitamins, herbs, hormones, and other prescriptions you currently take:

Please list any past surgeries / hospitalizations: (include approximate date)

Do you have a family history of any of the following diseases: (Check those that apply)

	Brother/Sister	Mother	Maternal GM	Maternal GF	Father	Paternal GM	Paternal GF
Diabetes							
Cancer							
Heart Disease							
Stroke							
Other							

When was your last medical care: _____

Who did you see at that time: _____

Who is your primary care medical provider: _____

<p>Please list <i>ALL</i> your known <i>ALLERGIES</i>; <u>Drug, Food, Insect, Animal, etc.:</u></p> <hr/> <hr/>
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The following pages are for health history information: Please fill out all areas that apply to you and your case. If you are in for URGENT / ACUTE CARE, these can be filled in later. Turn to the last page and read / sign it.

<p><i>I have questions about:</i></p> <p>Diet Exercise Vaccinations My current medications</p> <p>Prevention of _____</p>

Please list your major health concerns, listing the most important concern first:

What treatments have you tried for the above concerns?

Occupation: _____

Hobbies: _____

What type of exercise do you participate in: _____

How much time do you schedule for exercise weekly? _____

Are there any foods that you know you have reactions to, and what are those reactions:

Please add comments as needed to clarify the symptoms listed, leave blank any which do not apply.

Rate the following as : 1 = three or four times yearly, 2 = monthly, 3 = once a week, 4 = Daily

HEAD:

1 2 3 4 Headaches

1 2 3 4 Dry Scalp

1 2 3 4 Acne

1 2 3 4 Dizzy

EYE / EAR / NOSE / THROAT:

1 2 3 4 Vision blurry

1 2 3 4 Dry eyes

1 2 3 4 Dark circles under eyes

1 2 3 4 Earwax builds up

1 2 3 4 Earaches

1 2 3 4 Hearing loss

1 2 3 4 Ringing in ears

1 2 3 4 Sinus pain / infection

1 2 3 4 Nose / sinuses dry

1 2 3 4 Nose runs

1 2 3 4 Seasonal allergies

1 2 3 4 Voice hoarse

1 2 3 4 Sore throat

1 2 3 4 Postnasal drip

1 2 3 4 Nose bleeds

CHEST:

1 2 3 4 Heart pounds

1 2 3 4 Heart "flutter"

1 2 3 4 Shortness of breath

1 2 3 4 Asthma (Triggered by _____)

1 2 3 4 Chest pains

1 2 3 4 Wheezing

1 2 3 4 Coughing

Diagnosed heart / cardiovascular disease: _____

GASTROINTESTINAL:

1 2 3 4 Heartburn

- 1 2 3 4 Stomach aches
- 1 2 3 4 Gas / Bloating
- 1 2 3 4 Fatty meals bother
- 1 2 3 4 Constipation
- 1 2 3 4 Diarrhea
- 1 2 3 4 Blood or Mucus in stools
- 1 2 3 4 Vomiting
- 1 2 3 4 Hemorrhoids

Bowel movements:

___ Daily, ___ Other

- 1 2 3 4 Increased appetite
- 1 2 3 4 Decreased appetite

URINARY TRACT:

- 1 2 3 4 Bladder infections
- 1 2 3 4 Kidney infections
- 1 2 3 4 Burning with urination

NEURO-ENDOCRINE:

- 1 2 3 4 Panic / Anxiety attacks
- 1 2 3 4 Irritability
- 1 2 3 4 Feel bad when not eating regularly
- 1 2 3 4 Weight gain
- 1 2 3 4 Weight loss
- 1 2 3 4 Mood swings
- 1 2 3 4 Snack often
- 1 2 3 4 Increased thirst
- 1 2 3 4 Insomnia
- 1 2 3 4 Feel restless at bedtime
- 1 2 3 4 Wake up easily at night

My stress level weekly averages: **1-2-3-4-5-6-7-8-9-10**
(1 is low – 10 is high)

ENERGY

- 1 2 3 4 Sleep soundly
- 1 2 3 4 Wake rested
- 1 2 3 4 Feel energetic in the morning
- 1 2 3 4 Heart races
- 1 2 3 4 Easy fatigue
- 1 2 3 4 Feel down / depressed
- 1 2 3 4 Poor memory
- 1 2 3 4 Slow starter
- 1 2 3 4 Afternoon tiredness
- 1 2 3 4 Tired all day
- 1 2 3 4 Tired, no matter how much I sleep

- 1 2 3 4 Frequent urination
- 1 2 3 4 Blood in urine
- 1 2 3 4 Urinary incontinence (Constant Occasional)

MUSCULO-SKELETAL:

- 1 2 3 4 Joint pains
- 1 2 3 4 Back pain **Upper Lower All**
- 1 2 3 4 Neck pain
- 1 2 3 4 Muscle aches
- 1 2 3 4 Bruising **Easy Only with trauma**
- 1 2 3 4 Sprains Locations: _____
- 1 2 3 4 Joint stiffness
- 1 2 3 4 Arthritis
- Diagnosed with Fibromyalgia **YES NO When**_____

DIET: [Just an average day]

Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

Do you smoke **Yes No**

How many drinks with alcohol do you have weekly: _____

Circle things you eat MORE than 3 times a week:

TUNA OTHER FISH RAW VEGETABLES
CHEESE WHEAT PRODUCTS SOY PRODUCTS
RAW NUTS/SEEDS POULTRY RED MEAT

MALE ONLY: Circle what applies to you.

Frequent urination (Specify: **Day Night**)

Incomplete urination

Discharge from urethra

Trouble initiating urination

Hernias (Specify: **Current Past**)

Decrease in sex drive

Erectile difficulty

Rectal burning / itch

FEMALE ONLY: Circle what applies to you.

PMS symptoms _____

Duration: **1 - 2 - 3 – ALL : Week(s) before period**
Menses painful Heavy flow Light flow
Menses change (duration, regularity, flow, pain)
Avg. cycle length **22-25 days, 26-30 days, other** _____
Date last period started: _____
Menopause Began: _____
Ages your mother & Grandmother entered menopause?____
Decrease in sex drive
Vaginal discharge
Yeast infections
Hot flushes
Acne (**At / Before**) menses
Pain in breasts (Specify **With cycle / Constant**)
Hair growth on face
Difficulty in: (Conception, Carrying to term)
Hernias (Specify **Current Past**)
Number of Pregnancies _____
Number of Births _____

Financial Policies Statement ~ Water Of Life NaturoPathic Healthcare

Please read and sign this form

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1. Health insurance is a contract between you and the insurance carrier. We require payment for services when rendered.
 2. If a collection service becomes necessary for payment of the account, you agree to pay all collection fees in addition to any balances due.
 5. A late fee of 1.5% per month may be added to delinquent balances.
 6. **Medicare: Medicare does NOT cover services or supplies provided in this office.**
 7. **Release of information:** *By signing this, I give this office permission to release information required by law or insurance regulation to insurance agencies involved in my case. This **does not** give permission for any other release of information by this office, which has not been authorized by me.*
 8. Some Lab testing and other services (such as IV therapy) may not be covered by your insurance. It is your responsibility to verify coverage for such services, or alert our office if there are questions regarding a specific service. Once such services are rendered or ordered they become your financial responsibility.

I have read, understand, and agree to the above policies:

Signature (Parent / Guardian, if under 18 years old)

Date

**INFORMATION AND CONSENT FORM:
LABORATORY PROCEDURES**

**** PLEASE READ CAREFULLY - THIS MAY AFFECT CHARGES BILLED TO YOU ****

Laboratory tests ordered through this office are sent to many outside laboratory providers. In some cases we

will have information about your insurance and the particular lab test and laboratory being used. In many cases we do not have such information. The following is a listing of common occurrences regarding laboratory testing and payment of such services, and is designed to give you information prior to the ordering and incurrence of charges for laboratory tests.

- 1: Our office orders the test(s) we believe to be medically necessary for your case. After that we have no involvement in the charges for those tests, the billing of those tests, or the insurance companies payment or non-payment of those tests. These issues are between you the patient, your insurance carrier, and the laboratory used. If clarifications of indication for the test or coding from our office are required we will provide the additional information to the lab or insurance company.

- 2: Laboratory testing is often very expensive. We have nothing to do with the fees that the laboratories charge once the lab test is ordered.

- 3: It is possible that even after your insurance carrier authorizes a lab test that they will refuse to pay for it. You need to be aware of this, and realize that you are liable (To the laboratory) for the charges if your insurance does not pay. We have no control over, nor responsibility for this eventuality.

I have read, and understand this information regarding laboratory fees:

Patient Signature

Office Staff Signature

Date

Water Of Life NaturoPathic Healthcare

NEW PATIENT OFFICE POLICY

Water Of Life Naturopathic Healthcare is a cash based office. Therefore, payment is expected at time of service. If you are unable to pay in full, you will be asked to sign a payment plan. Initial visit \$125.00 includes medical history and partial or whole physical exam if necessary.

Acupuncture visits \$75.00 / visit

Follow up visits \$75.00 **Specific tests and treatment procedures carry varying charges. These will be discussed with you.

Phone consultations \$75.00

Check which method of payment you prefer:

_____Cash _____ Check

We also have a 24-hour cancellation/reschedule policy. If you do not call the Medical Clinic within 24 hours prior to your scheduled appointment, you will be charged a \$25.00 fee for the appointment.

By signing below, I agree that I have read and understood this policy. I guarantee payment of all charges incurred as a patient of Water Of Life NaturoPathic Healthcare.

Signed: _____ Date: _____

Printed Name: _____

Parent or Guardian (minor): _____ Date: _____