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_____

_____

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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:_____**

Last mammogram:_____. Do you do self breast exams ? Yes / No

Please list <u>all medications, vitamins, herbs, hormones, and other prescriptions</u> 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: _____

Please list *ALL your known ALLERGIES*; <u>Drug, Food, Insect, Animal, etc</u>.:

_____

_____

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.

I have questions about:

Diet **Exercise** **Vaccinations** **My current medications**

Prevention of_____

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

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**_____

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

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_____

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, credit card information required.

Initial consultation $195.00

Initial cancer consultation $235.00

Acupuncture visits $85.00/visit

Follow up visits $85.00

**Specific tests and treatment procedures carry varying charges. These will be discussed with you.

Phone follow-up consultations $85.00

Check which method of payment you prefer:

____Cash _____ Check _____Charge

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 half the office visit 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: _____

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 discussing them with you. 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 **Date**

INFORMED CONSENT FORM

I, _____, seek and consent to the services of Vanessa Edwards ND to provide supportive, naturopathic care for myself or my minor child or children. Naturopathic services use natural means and remedies to further health and wellness, including assessment and patient education and counseling about nutritional interventions; herbal and homeopathic remedies; lifestyle modifications and a range of other natural interventions/consultation.

Non-Medical and Complementary Nature of Services

I understand that Vanessa Edwards ND is not a medical doctor and that naturopathy is not a medical specialty but a separate and distinct health care tradition. I understand that Vanessa Edwards ND, is a licensed, board-certified naturopathic physician in the State of Vermont based upon her four-year graduate training in an accredited institution as a naturopathic physician. Naturopathic physicians are licensed in 14 states, and in the District of Columbia, but the State of Ohio does not currently offer such licensing. Where naturopathic physicians are not licensed, their scope of practice does not encompass the diagnosis and treatment of disease, but is focused upon consultations regarding natural remedies. Vanessa Edwards's ND consultations include discussion of nutritional issues and of diet, nutrition and supplementation, such as the use of dietary supplements and botanical substances; homeopathic remedies; mind-body supportive counseling; promotion of healthy lifestyles and wellness.

Vanessa Edwards' ND work in Ohio does not allow her to offer the full range of services within her training, but the educational consultations she provides are at the core of the naturopathic approach to health. I understand that her assessments and recommendations are intended to assist me in using natural means to support my health and are not intended to provide medical diagnosis or treatment. I should not avoid any diagnostic work-ups or change or discontinue any medical treatment based upon my consultation with Vanessa Edwards, and if I believe that modifications may be sensible in the light of these natural approaches, I agree to first discuss such changes with my prescribing medical physician.

If I believe that I have a condition that requires medical care, I will consult my primary care physician or an appropriate specialist. It is important that I maintain regular visits with my primary care physician and medical specialists as appropriate, both to ensure proper medical care and because Vanessa Edwards ND is not affiliated with a local hospital and I should have a medical physician who can provide care in the event of an emergency or hospitalization. When appropriate, Vanessa Edwards ND may communicate with members of my health team regarding my conditions, treatment options, and/or any other health related issues. **I agree to follow-up on referrals for medical care when necessary.**

Naturopathic practice uses methods that are known as complementary, alternative, or holistic care, and may not be accepted by the larger community of medical physicians. Vanessa Edwards ND may suggest laboratory tests, some of which are used by holistic physicians and naturopathic practitioners but which are not in widespread use in the medical community. Further, the interpretation of some tests may be different than in mainstream medicine. It is a good idea for me to get the advice of my medical physician as I make decisions that affect my health.

Vanessa Edwards ND will explain her assessment to me and describe the nature of her recommendations, the expected prognosis without such care, and the anticipated costs, risks, benefits and experience of following various options. I understand that a core approach taken by naturopathy is achieving better health status through improvements in diet and the use of dietary supplements to improve biological function, as well as exercise and other lifestyle modifications. The focus of naturopathic care is to alleviate the underlying conditions that can bring about illness rather than the treatment of symptoms. While I may experience some immediate improvement from the use of herbs, homeopathic remedies and other botanical and naturopathic methods, I understand that the most effective results occur when I make a long-term commitment to rebuild my health. It is my responsibility as a patient to follow-up with Vanessa Edwards ND within a recommended time period for evaluation of treatment results or to change treatment protocols as necessary.

I understand that Vanessa Edwards ND does not offer after hour services or provide any hospital-based services. If I have difficulty with any of remedies or other aspects of my work with Vanessa Edwards ND, I understand I should call during business hours to discuss concerns I may have.

Potential Risks: As with any method of care, naturopathy can involve some risk. I understand that I may experience aches, pains, or even new symptoms as the body responds by shifting its balance. This is generally a positive sign and shows the body is making positive movement. Some people may experience a healing crisis, a short period in which symptoms worsen or a period of a flu-like illness with mild fever, chills, dizziness, loss of appetite, or similar symptoms. Such an experience can signal the body is detoxifying.

While herbs and botanical products are generally available over-the-counter and are considered safe based upon their long history of use, many of them have not been widely tested. Negative reactions to natural remedies may include rare allergic reactions, including headaches, itching, hives, difficulty breathing, and very rarely, even shock or death. I understand that the interactions between herbs, and between herbs and drugs my medical physician might prescribe, are not yet well known, and that while unlikely, I could have an adverse reaction or experience a reduction or increase in the effect of other medications. This can have serious consequences for some medications, such as for the control of high blood pressure or blood sugar. I understand that I should let my physician know what herbs I am taking, particularly prior to surgery or other procedures. Negative reactions to homeopathy are extremely rare given the doses used; an effective dose may result in a temporary increase in my symptoms or healing crisis. I understand that it is my responsibility to alert Vanessa Edwards ND of any adverse effects or reactions.

Notice to Pregnant Women: All female clients must alert Vanessa Edwards ND if they know or suspect that they are pregnant as some of the remedies used could present a risk.

No Guarantees: I am aware that such consultations are an art, that like many medical interventions, many naturopathic efforts have not been subjected to rigorous scientific study, and that there are wide individual differences in responses to these services. No guarantees are made that I will gain any benefit or not suffer any adverse consequences. In the event that a dispute arises that we cannot resolve amicably, I understand that Vanessa Edwards ND is not practicing medicine and that if a legal case is brought, I agree that Vanessa Edwards ND shall be judged by the standards and principles of complementary, alternative, and/or holistic care and not the standards of consensus conventional medicine.

Supplement Purchases: I understand I am not obligated to purchase nutritional or herbal products recommended by Vanessa Edwards ND, from this office or from any specific vendor, and I will be given the same level of attention without regard to my purchases. I understand that Vanessa Edwards ND may profit from the sale of supplements and other products made available to patients.

Privacy Policy: My privacy is important and my records will be held confidential unless I request in writing that they be released to me or to other care givers. The HIPAA privacy regulations I have seen in other offices do not apply, as I do not submit claims to insurers, which must be done electronically before HIPAA regulations apply.

Important Insurance and Payment Notices: Vanessa Edwards ND's services are, with few exceptions, not reimbursed by insurance or Medicare and she does not accept insurance. Insurance generally provides services

only when delivered by individuals licensed to provide health care services in the state in which care is delivered.

Vanessa Edwards ND is therefore unable to accept insurance payment and does not provide billing statements for insurance reimbursement. Payment in full is required at each visit. I understand I am responsible for payment even if I submit and am denied reimbursement, even if my insurer determines that services are not medically necessary. I understand that appointments can be made by phone or in person. Vanessa Edwards ND requires 24-hours notice for canceling or rescheduling appointments. For any visits canceled with less than 24-hours notice, the patient will be charged half of the original visit fee except in the case of family or medical emergency. This charge will be applied to the following visit or billed directly to the client. Late arrivals will not receive an extension of scheduled service times and will be responsible for full service fee. In the event legal action is required to collect payment, I agree to be responsible for attorney fees and costs.

Informed Consent for Naturopathic Consultation

I hereby authorize naturopathic assessment and consultation and certify that I understand the nature of this health care method, including the risks of possible adverse reactions and choices I may have about other approaches. I understand that no recommendations are being made to me to discontinue any treatment being provided by any other health care professional. I understand that Vanessa Edwards ND does not function as a primary care or medical physician, and that she offers her services as a complement to other services I receive. I have been adequately informed, and questions I have asked have been satisfactorily answered. I represent that I am seeking assessment and consultation in order to further my own health and for no other reason and do not represent a third party. I sign this voluntarily and am aware that I may withdraw this consent and discontinue following the recommendations at any time.

Date _____

_____

Signature of Client or Legal Guardian Witness

_____

Client's Printed Name

_____

Street Address

_____

City

_____

State / Zip Code

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

1. Permission to Use and Disclose My Health Information. By signing this form, I give Vanessa Edwards ND permission to use and/or disclose my health information to carry out treatment, payment or health care operations.
2. Right to Refuse. I have the right not to sign this consent. If I refuse to sign this consent, Vanessa Edwards ND will not provide me with treatment until I consent. However, treatment required by law, such as emergency care, can be provided to me whether or not I sign this consent.
3. Right to Review Notice of Privacy Practices. Vanessa Edwards ND has provided me with a copy of their Notice of Privacy Practices which describes how Vanessa ND may use and disclose my health information. I have the right to review this Notice before signing this consent.
4. Changes to the Privacy Notice. Vanessa Edwards ND may change the Notice of Privacy Practices as needed. I may obtain a current copy of Vanessa Edwards ND's Notice of Privacy Practices by contacting Vanessa Edwards ND.
5. Right to Request Restrictions on Use/Disclosure. I have the right to request that Vanessa Edwards ND restrict how She uses and/or discloses my protected health information for the purpose of providing treatment, obtaining payment for services, and/or conducting health care operations. Vanessa Edwards ND is not required to agree to any restriction I request. If Vanessa Edwards ND does decide to agree to my request, she must restrict their use and/or disclosure of my health information the way I asked. Because of the number, complexity, and nature of the services they deliver, Vanessa Edwards ND will rarely agree to requests to restrict uses and disclosures of my health information for the purposes of treatment, payment, and healthcare operations. If I wish to request restrictions I can contact Vanessa Edwards. Vanessa Edwards ND will notify me of his decision to accept or decline my restrictions.
6. Right to Withdraw Consent. I have the right to withdraw this consent at any time. I must do this in writing. If I want to withdraw this consent, I can contact Vanessa Edwards ND at 937-275-9473. Note that my withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Vanessa Edwards ND, by law, is unable to provide to me further treatment or follow-up, other than required emergency services.
7. Effective Period. This consent is effective upon the date signed and remains effective until I withdraw it in writing.
8. References to "I" or "me". References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am the legal guardian, parent, or agent under an active Power of Attorney for Health Care, and am legally authorized to sign this Consent on behalf of the individual.

Patient Signature:_____ Date:_____