THE CENTER FOR HEALTH & WELLBEING
mindful medicine

Naturopathic Medical History

If possible, please fax these completed forms to CHWB
for review, before your appt.
Fax: (619) 794-0260

Name: _____ Date: _____

Date of Birth: _____ Who referred you here? _____

Occupation (last 10 years):_____

Are you currently receiving other health care? ❒ yes ❒ no

If yes, where and from who? _____

I. Primary 'Dis-eases'

Please describe the primary problems you are experiencing or the reasons you have requested this appointment. Please provide a history of each, including:

Complaint:	Started when:	Cause	Severity	What makes it better/worse:	Treatments you've tried:

Attach additional sheet if needed.

What do you intuitively think is causing these imbalances? _____

What do you believe needs to be done for you to get better? _____

What do you enjoy most in your life? _____

Please grade how committed you are to change at this time, in pursuit of achieving health (mark with **X**)

1 (unwilling) _____ 10 (completely committed)

Do you have financial constraints which limit your ability to create a treatment plan (this may include lab evaluations, supplements, food and lifestyle changes, exercise equipment, etc)? (mark with **X**)

1 (constrained, fixed income/no room for adjustments) _____ 10 (sufficient financial resources)

II. Past Medical History

Serious Illness/Disorders/Diagnosis: _____

_____

_____

Surgeries (age and any complications): _____

_____

Psychiatric Illness: _____

Allergies (and the reaction they cause):

Drugs: _____ Foods: _____

Environmental/animal: _____

Prescription medications and dose:

_____ _____ _____ _____

_____ _____ _____ _____

Supplements and dose:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

What is your daily stress level? ❒ Very high ❒ high ❒ moderate ❒ slight ❒ none

Detoxification:

Have you ever lived/traveled outside of the United States? ❒ yes ❒ no

Did you get sick while you were there or after returning? ❒ yes ❒ no

List any chemicals, solvents, fumes, or mold that you may be exposed to at work or with hobbies: _____

_____

List any emotional or personal conflicts that you may be exposed to repeatedly: _____

_____

Do you eat large fish (tuna, swordfish, shark, etc.) more than twice weekly? ❒ yes ❒ no

Mental/Emotional:

Have you ever been emotionally/sexually/physically abused as a child or adult? ❒ yes ❒ no

Are you generally (circle): Happy Moody Angry Anxious Depressed Alone

Are you easily (circle): Weepy Irritable Fearful Nervous Sad Panic/Unable to tolerate stress

Energy 1 (none whatsoever), 10 (abundant)

Morning energy:	1 ----------	5 ----------	10
Midday energy:	1 ----------	5 ----------	10
Evening energy:	1 ----------	5 ----------	10
Average daily:	1 ----------	5 ----------	10
After exercise:	1 ----------	5 ----------	10

Sleep:

What time do you go to bed? _____ PM. What time do you wake? _____ AM.

How long does it take you to get to sleep: _____ (minutes). Number of times you wake: _____ .

Do you return to slumber if you wake before morning? ❒ yes ❒ no

Do you wake feeling refreshed? ❒ yes ❒ no

Current weight: _____ Ideal weight: _____ Lt time at ideal: _____

Thank you for taking the time to complete this history, although please fill out the 3 Day Diet Recall as well.

If you have any questions, please ask!

3 Day Diet Recall

	DAY 1	DAY 2	DAY 3	
BREAKFAST				
SNACK				
LUNCH				
SNACK				
DINNER				
DESSERT				
BEVERAGES				
ALCOHOL				
COFFEE/TEA				
NICOTINE				
OTHER				

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Patient Information

(Please complete this form in its entirety. Thank you.)

Last _____ First _____ Middle _____ SS#_____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Home Address: Street _____ City _____ State _____ Zip _____

How did you find or hear about us?

Please circle one: Internet Search Friend/Family Referral Physician Referral

Email Address: _____

Please circle one: Single Married Widowed Divorced Separated

Occupation: _____ Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Payment Policy Statement

Payment is due at time of services rendered unless a PPO, Champus, Medicare, or a Managed Care Program that we bill directly insures you. All deductibles, co-payments, and services not covered by your plan are your responsibility. An annual finance charge of 12%, per California statue, may be charged on all accounts over 60 days past due. There will be a $45 charge on all returned checks. Should collections be necessary, the patient shall pay the Provider, on demand, all costs, including reasonable attorney fees, incurred in collecting payment due under this agreement.

I plan to settle my bill today by circle one: Cash MasterCard Visa Personal Check

I have read and agree to the above payment policy and I understand that I may be charged a cancellation fee of $75 for missed appointments not cancelled without 24 hours notice.

_____ Initial**

Authorization:

I hereby consent to any necessary medical treatment/physical examination required by the minor or myself named above for whom I am legally responsible.

Assignment:

I permit payment directly to The Center for Health and Wellbeing, for any benefits due to the Doctors for the services rendered. I understand that I am financially responsible for all charges, whether or not covered by my insurance company.

Medical Records:

Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original. Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Prescription Dispensing Disclosure:

Our office offers, as a service to our patients, dispensing of some prescribed medications. Please note that you have a choice between obtaining the prescription from our office and having us provide you with a prescription that can be filled at the pharmacy of your choice.

Signature: _____ Date: _____

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Medical History and Lifesyle Questionnaire

By filling out this questionnaire you have made a conscious decision to begin the journey towards better personal health and a more enriched lifestyle. Please answer all the questions and provide us with as much background as possible about your current health. We are sure you will enjoy taking part in all phases of your "wellness" program as YOU begin to look and feel healthier, and enjoy life more!

Please describe why you are seeing a healthcare provider today: _____

_____

_____

I. Past Medical History

Please check ✓ any of the following that apply to you:

- ☐ Abdominal Pain
- ☐ Abnormal Pap
- ☐ Allergies
- ☐ Anemia/Blood Disease
- ☐ Angina/Heart Attack
- ☐ Anorexia/Bulimia
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Arthritis/Gout
- ☐ Breast Lump
- ☐ Bruising or Bleeding Tendencies
- ☐ Cancer, Type:
- ☐ Cataracts/Glaucoma
- ☐ Chest Pain/Palpitation
- ☐ Chronic Fatigue
- ☐ Diabetes
- ☐ Diarrhea/Constipation
- ☐ Dizziness/Fainting
- ☐ Drug/Alcohol Abuse
- ☐ Elevated Blood Pressure
- ☐ Elevated Cholesterol
- ☐ Erectile Dysfunction
- ☐ Epilepsy/Seizures
- ☐ Gallbladder Disease
- ☐ Heartburn/Ulcers
- ☐ Headaches/Migraines
- ☐ Kidney/Bladder Problems
- ☐ Liver Disease
- ☐ Low Back/Neck Pain
- ☐ Menopausal Symptoms
- ☐ Muscle Aches (no injury)
- ☐ Osteoporosis
- ☐ Pain w/sex
- ☐ Prostate Problems
- ☐ Rash/Skin Problems
- ☐ Scarlet/Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinusitis, Frequent
- ☐ Sleeping Problems
- ☐ Stroke/TIA
- ☐ Suicide Attempts
- ☐ Swelling of Feet
- ☐ Thyroid Disease
- ☐ Traumatic Injuries
- ☐ Tuberculosis/+TB Test
- ☐ Venereal Disease (STD)
- ☐ Other

☐ _____

☐ _____

II. Family History

Please check ✓ all that apply for each family member:

CONDITION	FATHER	MOTHER	FATHER'S PARENT	MOTHER'S PARENT	SISTER/ BROTHER	OWN CHILD
Alcoholism/drug abuse						
Arthritis						
Bleeding disorder, Blood Clots						
Cancer, Type: _____						
Depression or severe anxiety						
Diabetes						
Elevated Cholesterol						
Epilepsy						
Glaucoma						
Heart Disease						
High Blood Pressure						
Mental Illness						
Osteoporosis						
Stroke						
Thyroid Disease						
Other						

Patient's Name _____

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III. Women's Health/Gynecological History Please answer the following:

Age at first period: _____ years
Patient's last period _____ days
Interval between periods: _____ days
(from first day of one to first day of next)
Number of Pads or Tampons: _____
(on heaviest day of flow)
Cramps (check one): __None __ Mild __Moderate __Severe
Mid-cycle pain or bleeding __ No __ Yes
Pregnancies _____ Abortions _____

Are you using contraception? __ No __ Yes
If yes, what type? _____
Are you satisfied with method? __ No __ Yes
Are you in menopause? __ No __ Yes
If yes, date when started: _____
Have you had a hysterectomy? __ No __ Yes
If yes, when: _____
Date of last bone density scan:_____ Result: _____
Date of last PAP: _____ Result: _____
Date of last mammogram: _____ Result: _____

IV. Men's Health Please check ✓ any of the following that apply to you:

Prostate Problems : __ Yes __ No
Explain: _____
Hemorrhoids: __ Yes __ No
Change in urination pattern: __ Yes __ No
Explain: _____
History of STDs: __ Yes __ No (sexually transmitted disease)
Explain: _____

Use of condoms: __ Yes __ No
Sexual concerns: __ Yes __ No
Balding concerns: __ Yes __ No
Overall Health concerns: __ Yes __ No
Muscular/skeletal pain/foot pain __ Yes __ No
Nutritional/weight/dietary concerns: __ Yes __ No
Explain: _____
_____
_____

V. Medicine/Supplements Please list current prescriptions & "over the counter medications" that you take:

PRESCRIPTIONS AND OVER THE COUNTER MEDICATIONS, INCLUDING HERBS AND SUPPLEMENTS:	
1	5
2	6
3	7
4	8

VI. Hospitalizations and Surgeries List reason and dates: _____

_____

VII. Vaccinations Please check ✓ current vaccinations; or provide copy of vaccination record.

MMR: _____ Date: _____
Tetanus: _____ Date: _____
Hepatitis A, B: _____ Date: _____
Flu: _____ Date: _____

Chicken Pox: _____ Date: _____
Pneumovax: _____ Date: _____
Other: _____ Date: _____
Other: _____ Date: _____

VIII. Allergies Please list any allergies:

Are you allergic to any medications?: _____ Yes ___ No
Are you allergic to any foods?: _____ Yes ___ No
Are you allergic to environmental factors?: _____ Yes ___ No If "yes" specify below:

1
2
3
4
5
6

IX. Lifestyle and Social History Please answer the following:

Do you smoke: Yes ❒ No ❒ # Packs per day: _____ How many years: _____ Date you quit: _____

Coffee or other caffeine: # cups/ day: _____

Do you take vitamins? Yes ❒ No ❒ _____

Trouble falling asleep regularly? Yes ❒ No ❒ _____

Frequent trouble staying asleep? Yes ❒ No ❒ _____

Participate in regular exercise? Yes ❒ No ❒ _____

Are you a dieter? Yes ❒ No ❒ _____

Current or past recreational drug use? Yes ❒ No ❒ _____

Alcohol? Number of drinks: _____ per day _____ per week

Diet: Any particular you follow? (vegetarian, lactose intolerance, fast foods only) Yes ❒ No ❒ _____

Always wear seat belt in car? Yes ❒ No ❒ _____

Highest lever of school completed? High School ❒ College Degree ❒ Other: _____

Current and past occupations? _____

Satisfied with current work? Yes ❒ No ❒

Number of years in San Diego County? _____ Where raised? _____

Do you have a significant other? Yes ❒ No ❒ If yes: Name _____ How long? _____

I have sexual concerns Yes ❒ No ❒

Health of partner? (If applicable) _____

Sexually active? Yes ❒ No ❒

Number of years in San Diego County? _____ Where raised? _____

I live with? Spouse ❒ Partner ❒ Roommate(s) ❒ Child(ren) ❒ Parent ❒ Alone ❒

Current Stress (describe): _____

_____

X. Other Health Care Providers

Please check which other doctors and/or health care providers you have seen within the past 3 years:

Acupuncturist	❒	Date last seen _____	For What _____
Chiropractor	❒	Date last seen _____	For What _____
Massage Therapist	❒	Date last seen _____	For What _____
Naturopathic Doctor	❒	Date last seen _____	For What _____
Counselor/Mental Health	❒	Date last seen _____	For What _____
Podiatrist	❒	Date last seen _____	For What _____
Other _____	❒	Date last seen _____	For What _____

Patient's Name _____ Date _____

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XI. Wellness

How do you rate your satisfaction in the following categories: (1 = Very unsatisfied and 5 = Very satisfied)

#	Function	1	2	3	4	5	Dr. use only Wellness Score
1	Energy Level	❒	❒	❒	❒	❒	
2	Fitness & Exercise Consistency	❒	❒	❒	❒	❒	
3	Body Weight	❒	❒	❒	❒	❒	
4	Mental Focus	❒	❒	❒	❒	❒	
5	Memory	❒	❒	❒	❒	❒	
6	Physical Stamina	❒	❒	❒	❒	❒	
7	Sexual Function	❒	❒	❒	❒	❒	
8	Nutritional Habits	❒	❒	❒	❒	❒	
9	Stress Management	❒	❒	❒	❒	❒	
10	Digestion	❒	❒	❒	❒	❒	
11	Mood/Emotional State	❒	❒	❒	❒	❒	
12	Body Pain Experiance	❒	❒	❒	❒	❒	
13	Overall Health	❒	❒	❒	❒	❒	
14	Life Satisfaction Overall	❒	❒	❒	❒	❒	
15	Other (explain) _____						

Ask you provider about your Wellness Score

Total point maximum is 70 • Greater than 60 is excellent

Greater than 55 is good • Less than 42 needs improvement

After reviewing my symptoms and lifestyle, I believe that I would benefit from the following treatments:

- ❒ Massage Therapy
- ❒ Chiropractic
- ❒ Acupuncture/Herbal Medicine
- ❒ Naturopathic Medicine (Holistic Healthcare)
- ❒ Mental Health Counseling
- ❒ Podiatry (foot and ankle care)
- ❒ Fitness Training
- ❒ Energy Medicine
- ❒ Weight Management/Nutrition
- ❒ Vitamins/Supplementation
- ❒ Homeopathy
- ❒ Physical Therapy

Authorization for Release of Medical Records

This authorization to receive or release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56, et seq., of the California Civil code and current HIPPA guidelines.

I hereby authorize: _____
(name of physician, hospital or healthcare provider)

_____
(complete address of records holder)

_____
(phone and/or fax for records holder)

To furnish to: _____
(Name of recipient)

_____
(complete address of recipient)

_____
(phone and/or fax of recipient)

Please note: There is a fee of $45.00 for records provided to patients upon written request and signed authorization. Records sent directly to another physician will have reproduction fee discounted as a professional courtesy. _____ (initial here)

I understand that I have the right to limit the type of information to be released. I have indicated below the information that is authorized for release:

(select one) _____ All medical information, without exception, including information regarding HIV testing, AIDS, psychological or psychiatric treatment and drug or alcohol abuse.
OR: _____ All information except: _____

Dates of services to be released: _____

The reason for the release is: _____

I understand the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is permitted by law.

I understand that I have the right to receive a copy of this authorization.

I understand that I may revoke the authorization at any time by notifying the healthcare provider in writing. The revocation will be effective on the date of its writing and will not be retroactive.

Name: _____ Date of Birth: _____
(print full name)

Signature: _____

Date: _____ Phone: _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice takes effect on June 14, 2007 and remains in effect until we replace it.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

Law requires us to:

1. Follow the terms of the notice that is now in effect.
2. Keep your medical information private.
3. Give you this notice describing our legal duties, privacy practices, and your rights regarding medical information.

We Have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the law permits the changes.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practice, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We my disclose medical information about you to doctors, nurses, medical assistants, technicians, medical students, or other people who are taking care of you. We may also share medical information to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.

NOTIFICATION: Medical information to notify: a family member, your personal representative or another person responsible for your care. We will get your permission before we share medical information, or give you the opportunity to refuse permission. In case of emergency, and you are unable to give permission we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information about you.

APPOINTMENT REMINDERS AND HEALTH-RELATED INFORMATION:
Covered entity may contact the individual to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to the individual.

RESEARCH IN LIMITED CIRCUMSTANCES: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to insure the privacy of medical information.

USES AND DISCLOSURES FOR WHICH NO PERMISSION IS REQUIRED:

PUBLIC HEALTH REPORTING: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements. To track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or other wise be at risk of contracting or spreading a disease or condition.

VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

WORKERS COMPENSATION: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

HEALTH OVERSIGHT ACTIVITIES: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

COURT ORDERS AND JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose medical information in response to court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share you medical information with law enforcement officials. We may share limited information with law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person.

YOUR INDIVIDUAL RIGHTS

YOU HAVE A RIGHT TO:

1. Look at or get copies of your medical information. You may also request copies by filling out a release form from our office which will be handled by the medical records department. If you request copies, there will be a per-page charge and a postage charge. Contact our medical records department for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergency.)
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the medical records department.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact our privacy officer. You may also submit written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health an Human Services. We will not retaliate in any way if you choose to file a complaint.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided and opportunity to review it.

NAME: _____ DOB: _____

SIGNATURE: _____ DATE: _____