NATUROPATHIC
WOMENS WELLNESS

PERSONAL HEALTH QUESTIONNAIRE

All information will remain strictly confidential. Successful health care and preventative medicine address the whole person on a physical, emotional and mental level. Your time, thoughtfulness and honesty will greatly aid me in assisting your health needs. Thank you for your trust and patience.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (home): _____ (work): _____ (cell): _____

Email address: _____

Age: _____ Date of Birth: _____Place of Birth: _____Gender: Female / Male

Occupation:_____ Hours/Week: _____

Marital Status:_____ Live with (circle): Spouse/Partner/Children/Friends/Alone

Children:_____ Pets:_____

How did you hear about this clinic? _____

Has any other family member already been a patient at this clinic? _____

Emergency contact: _____ Relationship: _____

Phone: (W)_____(C)_____

Medical Doctor Information:_____

Pharmacy Information: _____ (P): _____

Would you like to receive our email newsletter for articles, news, events, and discounts? _____

What method(s) can we use to contact you? cell phone ____ home phone ____ e-mail ____ mail _____

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CONTEXT OF CARE REVIEW

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle?

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?_____

_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive?_____

_____

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?_____

_____

What do you love to do (include main interests & hobbies)?_____

_____

What specific events/trauma have impacted or changed your life?_____

_____

Are you currently receiving healthcare? Yes / No

If yes, where and from whom? _____

What is the reason? _____

What are your most important health problems? List in order of importance.

1)_____

2)_____

3)_____

4)_____

Pain, Where?_____

Do you have any known contagious diseases at this time? Yes / No. If yes, what? _____

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FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? If yes, please circle & indicate who:

Cancer	Epilepsy Arthritis	Kidney disease	Asthma
Heart Disease	Glaucoma	Anemia	Hay fever
High Blood Pressure	Tuberculosis	Mental Illness	Hives
	Stroke	Diabetes	Thyroid

Any other relevant family history? _____

What is your family heritage? _____

CHILDHOOD HISTORY

Reactions to vaccinations: _____

Please circle whether you had any of the following as a child:

Measles	Chicken Pox	Rheumatic Fever
German Measles	Scarlet Fever	
Mumps	Diphtheria	Other:

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____ year _____ _____ year _____

_____ year _____ _____ year _____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmentals or chemicals? _____

CURRENT MEDICATIONS

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

_____

_____

_____

Have you ever had a drug overdose or a drug problem? _____

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NATUROPATHIC WOMENS WELLNESS

GENERAL

Height: _____ Weight: _____ Weight one year ago: _____

Maximum Weight: _____ When: _____

Cosmetic Surgery:_____ Left/Right Handed:_____

When during the day is your energy the best? _____ Worst? _____

Exercise: Y / N If so, what kind and how often: _____

FOR THE FOLLOWING, PLEASE CIRCLE:

Y=yes/condition you have now **N**=no/never had **P**= problem in the past **S**=sometimes a problem now

GENERAL

Do you sleep well?	Y N P S
Average 6-8 hours?	Y N P S
Awake rested?	Y N P S
Have a supportive relationship?	Y N P S
Have a history of abuse?	Y N P S
Use recreational drugs?	Y N P S
Use alcoholic beverages?	Y N P S
Use tobacco?	Y N P S
If in the past, how many years? _____	
How many packs per day? _____	
Do you enjoy your work?	Y N P S
Take vacations?	Y N P S
Spend time outside?	Y N P S
Do you go on diets often?	Y N P S
Do you add salt to your food?	Y N P S
Low libido	Y N P S

NEUROLOGIC

Seizures?	Y N P S
Muscle weakness?	Y N P S
Loss of memory?	Y N P S
Vertigo or dizziness?	Y N P S
Paralysis?	Y N P S
Numbness or tingling?	Y N P S
Easily stressed?	Y N P S
Loss of balance?	Y N P S

ENDOCRINE

Hypothyroid?	Y N P S
Hypoglycemia?	Y N P S
Excessive thirst?	Y N P S
Fatigue?	Y N P S
Heat or cold intolerance?	Y N P S
Hyperthyroid?	Y N P S
Diabetes?	Y N P S
Excessive hunger?	Y N P S
Seasonal depression?	Y N P S
Difficulty exercising?	Y N P S

IMMUNE

Chronically swollen glands?	Y N P S
Slow wound healing?	Y N P S
Chronic fatigue syndrome?	Y N P S
Chronic infections?	Y N P S
Night sweats?	Y N P S

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EARS

Impaired hearing?	Y N P S
Ringing in ears?	Y N P S
Dizziness?	Y N P S
Ear aches?	Y N P S

EYES

Impaired vision?	Y N P S
Cataracts?	Y N P S
Glaucoma?	Y N P S
Spots in vision?	Y N P S
Color blindness?	Y N P S
Tearing or dryness?	Y N P S
Eye pain or strain?	Y N P S

HEAD/NECK/THROAT

Headaches?	Y N P S
Migraines?	Y N P S
Head injury?	Y N P S
Jaw or TMJ problems?	Y N P S
Frequent colds?	Y N P S
Sinus problems?	Y N P S
Nose bleeds?	Y N P S
Hayfever?	Y N P S
Loss of smell?	Y N P S
Lumps in neck?	Y N P S
Goiter?	Y N P S
Difficulty swallowing?	Y N P S
Pain or stiffness in neck?	Y N P S
Frequent sore throat?	Y N P S
Hoarseness?	Y N P S
Jaw clicks?	Y N P S
Teeth grinding?	Y N P S
Gum problems?	Y N P S
Dental cavities?	Y N P S

SKIN

Rashes?	Y N P S
Acne/boils?	Y N P S
Change in skin color?	Y N P S
Lumps or bumps on skin?	Y N P S
Eczema or hives?	Y N P S
Itching?	Y N P S
Perpetual hair loss?	Y N P S

RESPIRATORY

Cough?	Y N P S
Sputum?	Y N P S
Asthma?	Y N P S
Wheezing?	Y N P S
Bronchitis?	Y N P S
Coughing up blood?	Y N P S
Shortness of breath?	Y N P S
Shortness of breath when lying down?	Y N P S
Pain in breathing?	Y N P S
Emphysema?	Y N P S
Tuberculosis?	Y N P S

GASTROINTESTINAL

Trouble swallowing?	Y N P S
Change in thirst?	Y N P S
Change in appetite?	Y N P S
Nausea/vomiting?	Y N P S
Ulcer?	Y N P S
Jaundice?	Y N P S
Gall bladder disease?	Y N P S
Liver disease?	Y N P S
Hemorrhoids?	Y N P S
Pancreatitis?	Y N P S
Heartburn?	Y N P S
Abdominal pain or cramps?	Y N P S
Belching or passing gas?	Y N P S
Constipation?	Y N P S
Bowel movements: how often? _____	
Is this a change?_____	
Black stools?	Y N P S
Blood in stools?	Y N P S

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URINARY

Increased frequency of urination? Y N P S
Inability to hold urine? Y N P S
Pain in urination? Y N P S
Frequency at night? Y N P S
Frequent UTI's? Y N P S
Kidney stones? Y N P S

MUSCULOSKELETAL

Joint pain or stiffness? Y N P S
Arthritis? Y N P S
Broken bones? Y N P S
Weakness? Y N P S
Muscle spasms or cramps? Y N P S
Carpal Tunnel? Y N P S

BLOOD

Anemia? Y N P S
Easy bleeding or bruising? Y N P S
Deep leg pain? Y N P S
Varicose veins? Y N P S

MALE REPRODUCTIVE

Are you sexually active? Y N P S
Sexual orientation:_____
Premature ejaculation? Y N P S
Discharge or sores? Y N P S
Gonorrhea? Y N P S Herpes? Y N P S
Chlamydia? Y N P S Syphilis? Y N P S
Genital warts? Y N P S Hernias? Y N P S
Testicular masses? Y N P S
Testicular pain? Y N P S
Impotence? Y N P S
Prostate Disease? Y N P S

FEMALE REPRODUCTIVE

Age of first menses:_____
Age of last menses (if menopausal):_____
Menopausal symptoms? Y N P S
Length of cycle:_____ days
Duration of menses:_____ days
Are your cycles regular? Y N P S
Painful menses? Y N P S
Heavy or excessive flow? Y N P S
PMS? Y N P S
Symptoms:_____
Bleeding between cycles? Y N P S
Clots? Y N P S
Endometriosis? Y N P S
Ovarian cysts? Y N P S
Vaginal odor? Y N P S Discharge? Y N P S
Date of last pap smear:_____
Abnormal PAP? Y N P S
Are you sexually active? Y N P S
Sexual orientation:_____
Birth control? Type:_____
Pain during intercourse? Y N P S
Gonorrhea? Y N P S Herpes? Y N P S
Chlamydia? Y N P S Syphilis? Y N P S
Genital warts? Y N P S
Difficulty conceiving? Y N P S
Number of: pregnancies_____ live births_____
Birth control? Type:_____
Emotional state during pregnancy:_____
State of partner during pregnancy:_____

Do you do self breast exams? Y N P S
Breast pain/tenderness? Y N P S
Breast lumps? Y N P S
Nipple discharge? Y N P S

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CONSENT FOR TREATMENT

I hereby request and consent to the performance of naturopathic treatments and/or naturopathic procedures, including various modes of physical therapy and diagnostic procedures, on me (or on the patient named below, for whom I am legally responsible) by Hillary Roland, registered naturopathic doctor.

***Type of care*:** I have had an opportunity to discuss with Hillary Roland, RND, the nature and purpose of naturopathic care and procedures. Employed general diagnostic procedures including but not limited to venipuncture, pap smears, radiology, blood and urine tests, and physical exams. Employed psychology, lifestyle, nutritional, and exercise counseling. Employed herbal and natural medicine including but not limited to botanicals, minerals, and animal materials given in the form of teas, tinctures, homeopathy, pills, powders, creams, pastes, plasters, vitamin injections, and suppositories. Employed hydrotherapy and soft tissue/osseous manipulation including massage, structural integration, muscle energy technique, grade 1-4 manipulation, and visceral work. Employed cervical escharotic treatments.

Supplements Sales Disclosure: Supplement sold though this practice are sold at a discounted price to patients to address the conflict of interest between acting as a provider and making retail profits. Supplements are sold through the office because Hillary Roland, RND, can guarantee the quality of supplements that you are ingesting. You can commonly find high quality supplements at stores such as Pharmaca, or online through Fullscript. You are not obligated to purchase the supplements from the office of Hillary Roland, RND.

Notice to Pregnant Women: **All female patients must alert the doctor if they know or suspect that they are pregnant. Some supplements and treatments may interfere with pregnancy.**

Recital of Risks*:* I understand and am informed that, as in the practice of medicine, in the practice of naturopathy, there are some risks to treatment, including, but no limited to: venipuncture causing local and systemic inflammation and infection, local pain and swelling at areas that received osseous manipulation, burning and scarring from the escharotic treatment, and allergic reactions to any medications administered. I understand that I am to contact Hillary Roland, RND, immediately if there is any reaction to any type of procedure performed. I wish to rely on the doctor to exercise judgment during the course of procedures and treatments which the doctor feels at the time, based upon the facts then known, is in my best interests.

_____ ____/____/____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.) Date

_____ ____/____/____

Patient Signature (Parent/guardian signature if minor) Date

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NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police.
- Obtain payment from third party payers.

I understand that a record will be kept of the health services provided to me, which will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request. Obtaining a copy of my record may require a fee of payment.

In order to provide you with service that best meets your privacy needs, you will have an opportunity on the New Patient Info packet to tell us how best to contact you. The policy at the Naturopathic Womens Wellness Center is to leave a message either to remind you of an appointment or inform you to call the office.

_____ ____/____/____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.) Date

_____ ____/____/____

Patient Signature (Parent/guardian signature if minor) Date

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FINANCIAL POLICIES

Welcome to the Naturopathic Womens Wellness Center. I look forward to providing for your health care needs. I encourage your questions and participation in all aspects of your care. Please read the following statements and the financial policies carefully.

Service	Time in Office	Fees for Service
First Visit	75-90 minutes	$285
Pediatric First Visit (<12 years old)	60 minutes	$195
Return Visit	45 minutes	$150
Missed visit without 48 hour cancellation notice		$75
Lab work (some labs may be covered under your insurance plan)		Varies per plan and lab
Acute Office Call (for cold, flu, urinary tract infection).	30 min.	$100
Sports/Occupational Physical Exam only	30 minutes	$100
Annual Gynecological Exam	1 hour	$175 for an established patient $295 for a new patient (90 minutes)
Escharotic Treatments	30 min.	$65 per session at 10 sessions
Vitamin injections	15 min.	Varies per treatment
Phone consultations	Up to 1-1/2 hour billed in 15 min. increments	$50 per 15 minutes
Home Visits	Same as first and return visits	$285 or $150 plus gas mileage

- Payment for all services and supplements is due at the time of the visit. Accepted forms of payment include cash, check, Visa, MasterCard, and debit card. Returned checks will incur a $30 fee.
- Your health care provider may prescribe supplements. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.
- *Please call if you cannot make an appointment. There is a charge for missed appointments. You time is valuable to me. Please be courteous, if you can't make an appointment give me 48 hours' notice. If you cancel within the 48 hours prior to your appointment, you will be charged $75. Thank you.*

I have read and understand the above-stated policies of the Naturopathic Womens Wellness Center and will comply with them in all respects. I understand the cancellation policy and that full payment is due at the time of service for all fees. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

_____ ____/____/____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.) Date

_____ ____/____/____

Patient Signature (Parent/guardian signature if minor) Date

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CREDIT CARD INFORMATION FORM

CARD TYPE: VISA MASTERCARD DISCOVER

CARD NUMBER: _____-_____-_____-_____

EXP. DATE: _____/_____

SEC. CODE: _____

BILLING ZIP CODE: _____

CARD HOLDER'S NAME: _____

PHONE NUMBER: _____

SIGNATURE: _____ DATE: _____

I hearby authorize *NATUROPATHIC WOMENS WELLNESS* to take my verbal authorization as my signature for all future credit card charges.

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