



SANA EANG, NMD
HEALTHBRIDGE MEDICAL CENTER
366 SAN MIGUEL DR #209 NEWPORT BEACH, CA 92660

IMPORTANT PATIENT INFORMATION

APPOINTMENTS

- For information regarding our cancellation policy please see the cancellation policy section in the Practice Policies document.
- As a courtesy to our patients, we will make an effort to confirm appointments. It is however, the patient's responsibility to keep the scheduled appointment or reschedule.
- Our services are as follows:

INITIAL VISITS - Naturopathic Medical Service

- Initial Intake/Comprehensive Naturopathic Medical Intake
 - 1.5 hours (allow 2 hours in case we go over)
 - Investment: \$250
- Single Problem Initial intake
 - 30 minutes
 - Investment: \$160

FOLLOW UP VISITS - Naturopathic Medical Service

- Standard Follow Up
 - 25 minutes
 - Investment: \$110
 - Can be a phone or in person visit
- 12 minute Phone Visit
 - Investment: \$60
- Extended Follow Up
 - 60 minutes
 - This type of visit is scheduled when going over more than one lab test result, and/or when going over ION test results
 - Investment: \$190
 - Can be a phone or in person visit

NEW PATIENT- Chiropractic Service

- Initial history & exam
 - Up to 1 hour
 - Investment: \$125
- Initial history & consult
 - Up to 30 minutes
 - Investment: \$95
- Initial problem focused
 - Up to 30 minutes
 - Investment: \$75

FOLLOW UP VISITS - Chiropractic Service

- Re-evaluation - Expanded
 - Up to 30 minutes
 - Investment: \$85
- Focused limited
 - Up to 30 minutes
 - Investment: \$75
- Initial problem focused
 - Up to 30 minutes
 - Investment: \$75
- Re-evaluation - Brief
 - Up to 30 minutes
 - Investment: \$65

LAB TESTS

After your initial clinical consultation or review of ongoing treatment program, the doctor may order lab tests and/or diagnostic tests. Fees for such tests are billed either directly by the lab to the patient or in some cases are due upon receipt of the lab testing kit. In many cases the lab will work directly with the patient's insurance care provider. **It is our strict policy that the Naturopathic Medical Doctors at HealthBridge Medical Center do not mark up or profit in any way from the sale of lab testing kits that we order for our patients.**

BILLING

Payment for the office visit or phone call is expected prior to service and can be in the form of check, cash or credit card payments.

INSURANCE

Dr. Eang does not accept insurance or Medicare. You can request a bill of services, known as a SuperBill, that you can submit to your insurance provider who may reimburse you for some or all of the fee at their discretion. Please note that phone visits may not be reimbursed by your insurance carrier.

Initials: _____

DrSana Important Patient Information.doc

PRIMARY CARE PHYSICIAN

Please note that Dr. Eang’s practice is a specialized practice and she is not practicing as a *primary care* physician. We strongly advise that you find a primary care physician if you do not have one so that your care can be properly coordinated for the best and highest outcome possible for you.

PATIENT SIGNATURE _____ Date _____

(or Patient Representative)

Indicate relationship if signing for patient _____

Initials: _____



HEALTHBRIDGE
MEDICAL CENTER

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PRACTICE POLICIES

Dr. Eang's intention is to provide you with a high level of integrative medical care. Your honest and active participation in your own healing processes is vital. Please follow the guidelines and procedures below which will help to ensure that Dr. Eang, in partnership with you, provides you with the utmost level of care.

This packet of information includes detailed forms designed to help Dr. Eang learn more about you. **Please fill out ALL forms and mail them back to Dr. Eang's office as soon as possible. The forms should be received in our office prior to your first visit.** If you have any questions or need assistance filling out the forms, please do not hesitate to call the office via the number at the bottom of this document.

This will allow you to maximize your time spent with Dr. Eang during your first visit. **Investing the time to fill out the forms now, will ensure that you receive the maximum benefit from your first visit with Dr. Eang.**

Your Introductory Packet includes the following documents:

- 1) Important patient information
- 2) Practice policies (this document)
- 3) Informed consent
- 4) Privacy practices
- 5) Consent for use and disclosure of health information
- 6) Arbitration Agreement
- 7) Medical questionnaire

Initials: _____

Practice Policies.doc

MEDICAL RECORDS

To ensure that Dr. Eang provides you with the best comprehensive care during your time with her, it is important that you have your medical records on hand prior to your first appointment. **The patient is responsible for obtaining medical records from previously seen physicians.** If you undergo any new tests or consultations with other healthcare providers after you have begun care, please send or fax to Dr. Eang prior to your next appointment. Please call your physician to request that medical records be sent to Dr. Eang's office. Medical records can only be released with your authorization. The office will fax or mail you an **"Authorization to Release Protected Health Information"** form for you to use with your other healthcare providers. **The records should be mailed or faxed to the location or number at the end of this document.**

PHONE APPOINTMENTS

At the time you book your phone appointment you will be provided with a phone number to call at the time of your appointment. In the event that Dr. Eang is wrapping up a visit with another patient, the office will take down your phone number and Dr. Eang will contact you upon completion of her previous appointment.

CANCELLATION POLICY

Dr. Eang intends to maximize the use of her time and energy towards helping sincere individuals lead a healthier, more joyous life. Due to the high demand to see her, we have implemented the following policy:

New Patient Initial Intake Appointments – 5 Days prior to scheduled appointment
Existing Patients Follow-up Appointments – 48 hours prior to scheduled appointment

If you fail to cancel with less notice than listed above you will be charged for the full amount of the visit. You may cancel your appointment by contacting us via the medical practices phone number listed at the end of this document.

OFFICE FEES:

Dr. Eang's practice is exclusive and limited to a finite number of patients who will receive a high level of care throughout their relationship with Dr. Eang.

See 'Important Patient Information' document included in this packet for fee information.

PAYMENT POLICIES

Payment for all services is due 48 hours prior to the time of the appointment and product purchases are due at time of order placed. Payment is accepted via American Express, Visa, MasterCard, Discover, Check, or Cash. Most laboratory tests ordered by Dr. Eang are billed directly to the patient by the laboratory. Most laboratories that Dr. Eang works with will work directly with the patient's insurance company. However, there are some laboratories that Dr. Eang has received special pricing from which can be passed on to the patient (with no markup) if paid at the time of service.

Initials: _____

Practice Policies.doc

INSURANCE INFORMATION

Dr. Eang does not accept insurance or Medicare. You can request a bill of services rendered otherwise known as a SuperBill, that you can directly submit to your insurance provider, for any reimbursements.

PHONE APPOINTMENTS, PHONE CALLS, MESSAGES AND FAXES

1. To schedule an appointment with Dr. Eang contact her office using the information listed at the end of this document.
2. Dr. Eang or office staff will be available Monday to Thursday from 10AM to 5 PM PDT.
3. If you have a medical emergency call 911 or go directly to the nearest emergency room.

PRESCRIPTION REFILL REQUESTS

To request refills of medications and/or physician-only nutritional supplements prescribed by Dr. Eang, please call Dr. Eang's office and provide the following information:

1. Your full name
2. Phone Number(s)
3. Exact name and spelling of the medication, the dosage and the quantity requested and the amount of refills requested.
4. The name, phone number and fax number of your pharmacy.
5. It may require up to 72 hours to process refills. Please plan ahead to avoid any interruptions in your medications.

COORDINATION WITH PHYSICIANS AND OTHER HEALTHCARE PROFESSIONALS

Dr. Eang is pleased to confer with your primary care physician or specialist(s) as it relates to the protocols that Dr. Eang has designed for you to support your long-term health and wellbeing. Dr. Eang's primary concern is to ensure that your health care is properly coordinated and integrated, and that the quality of your care remains the top priority. Any requested time spent in consultation/coordination with your physician will be billed in accordance with the fee schedule listed above.

LABORATORY TESTING

The laboratory testing procedures that Dr. Eang employs are focused on getting to the root cause of your health-related challenges. Beyond the typical blood tests, x-rays, and other testing procedures that you may be all too familiar with, Dr. Eang will request lab tests that look for more telling factors such as: hormone levels (estrogens, progesterone, growth hormone, IGF1, TSH, T3, T4, TPO, testosterone, PSA, cortisol, DHEA), food antibodies, neurotransmitter levels, environmental toxins, nutritional deficiencies, parasites, hidden infections and other metabolic imbalances.

Many of these tests are easily administered at home through samples of saliva, urine, capillary blood spot and stool. Occasionally you may also be required to visit a local laboratory to draw blood. In all cases, Dr. Eang can order and coordinate all initial and follow up testing.

Initials: _____

Practice Policies.doc

We look forward to the opportunity to help guide you on the path towards a life experienced with a high level of health and vitality. You are in good hands.

Yours in health,

Sana Eang, NMD
HealthBridge Medical Center
366 San Miguel Dr #209
Newport Beach, CA 92660
FrontDesk@HealthBridgeHealing.com
Tel: (949) 715-9321
Fax: (949) 340-5738

I have read and agree with the above guidelines, information, and costs associated with seeing Dr. Eang as a patient.

Name (please print): _____

Patient Signature: _____ Date: _____
(or Patient Representative)

Indicate relationship if signing for patient: _____

Initials: _____

SANA EANG, NMD
HEALTHBRIDGE MEDICAL CENTER
366 SAN MIGUEL DR #209 NEWPORT BEACH, CA 92660

INFORMED CONSENT FOR NATUROPATHIC CARE

I, _____ (Patient's Name OR the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not.

I understand that the methods of treatment may include but are not limited to herbal medicine, nutritional counseling, homeopathy, hydrotherapy, nutritional supplements, intramuscular injections, and IV therapy.

I have had an opportunity to discuss with Dr. Eang and/or other office personnel the nature and purpose of naturopathic and/or other integrative or complementary treatments and procedures. Naturopathic Medical Doctors understand that the body has an innate ability to heal itself and use the least force necessary to bring about a healing response. Because of this, the risks associated with the services offered by Dr. Eang are generally low. However, I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that you follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur.

I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon facts then known, is in my best interests. I understand that results are not guaranteed.

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME, (please print) _____

PATIENT SIGNATURE _____ **Date:** _____

(or Patient Representative)

Indicate relationship if signing on behalf of patient: _____

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NOTICE OF PRIVACY POLICIES

How We Collect Information About You: HealthBridge Medical Center. (HealthBridge) and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications and provide care.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between HealthBridge and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications and/or insurance.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors. We do not intentionally collect information about site visitors. We do use some affiliate programs that may or may not capture traffic data through our site. To avoid potential data capture that you visited a diabetes website, for example, simply do not click on any of our outside affiliate links.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of HealthBridge. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission. Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission. You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operation. Your personal information will not be used or distributed for marketing purposes or activities that may breach professional confidentiality standards. This form is designed to comply with Federal law, which requires this office to supply you with this constant form.

Notice of Privacy Practices: You have the right to read our Notice of private Practices before you decide whether you sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosure we may make of your protected health information and other important matters about your protected health information. A copy of our notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Privacy Practices. If we change our privacy practices, we will notify our patients. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, at any time by requesting one from the front desk.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice if your revocation submitted to the Contact Person list below. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

CONTACT PERSON: Sana Eang NMD, 366 San Miguel Dr #209 Newport Beach, CA 92660

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protect health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
PLEASE ASK OUR STAFF FOR A COPY.

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties to all claims, including claims arising out of or relating to treatment or services provided by health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptor ship interns who now or in the future treat the patient while employed by, working or associated with or serving as back up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, company, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent Permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments shall apply to disputes within this Arbitration Agreement. Permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments shall apply to disputes within this Arbitration Agreement. The parties further agree that the commercial Arbitration Rule or the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services rendered by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here _____. Effective as the date of first receiving professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Signature Date

Or Patient representative (indicate relationship to if signing for patient)

Office Signature Date

Initials: _____

Adult Medical Questionnaire

Initial Intake

| | | | | | | | | |
|--|--|--|------------------------------------|--|--|---------------------------|--|--|
| First Name: _____ | | | Middle Initial: _____ | | | Last Name: _____ | | |
| Address: _____ | | | | | | | | |
| City: _____ | | | State: _____ | | | Zip: _____ | | |
| Home Phone: (____) ____ - ____ | | | Birth Date (m/d/y): ____/____/____ | | | Age: ____ | | |
| Mobile Phone: (____) ____ - ____ | | | Work Phone: (____) ____ - ____ | | | | | |
| Place of Birth: _____ | | | Occupation: _____ | | | Sex: Female Male | | |
| Race/Ethnicity: _____ | | | | | | | | |
| Date of Service: _____ | | | Email: _____ | | | | | |
| Current Primary Physician (PCP): _____ | | | | | | Phone: (____) ____ - ____ | | |
| Emergency Contact: (Name & Number) _____ | | | | | | | | |

I. Chief Concerns (Please list in order of importance)

- a. _____
- b. _____
- c. _____
- d. _____

II. Last time you had blood work done and with what physician: _____

III. Living Situation

- a. With whom do you live with (include name and age)? _____

- b. Do you have any pets or farm animals? ___ Yes ___ No

i. If yes, what kind? _____

ii. If yes, where do they live? ___ indoors ___ outdoors ___ both

- c. Have you traveled outside of the United States? ___ Yes ___ No

i. If so, when and where? _____

Past Medical History

d. List all Illnesses/Diagnosis, including date occurred:

- i. _____
- ii. _____
- iii. _____
- iv. _____
- v. _____

e. List all Surgeries and Hospitalizations, including date occurred:

- i. _____
- ii. _____
- iii. _____
- iv. _____

f. Please note when & why you had the following studies done:

- i. X-rays: _____
- ii. MRI: _____
- iii. CAT Scans: _____
- iv. Ultrasounds: _____
- v. Other Studies: _____ Last Eye Exam: _____
- vi. TB test: _____ Hepatitis test: _____
- vii. HIV test: _____ Last Dental Exam: _____

g. List all Prescription Medications & Nutritional Supplements/Herbs (please include dosages):

- i. _____

h. Vaccinations History: D (Diseased) I (Immunizations) N (Neither)

- 1) Measles: ____ 2) Chicken Pox: ____ 3) Mumps: ____
- 4) Tetanus: ____ 5) Whooping Cough: ____ 6) Hepatitis B: ____
- 7) Hemophilus: ____ 8) Other vaccinations: _____

Family History:

| | Father | Mother | Siblings | Grandparents | Spouse | Children |
|---------------------|--------|--------|----------|--------------|--------|----------|
| Age if living: | | | | | | |
| Age when died: | | | | | | |
| Reason for Death: | | | | | | |
| Cancer Type: | | | | | | |
| High Blood Pressure | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| Heart Disease | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| Heart Attack/Stroke | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| Asthma/Allergies | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| Mental Illness | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| TB | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| Auto-Immune Disease | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| Diabetes Mellitus | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| Osteoporosis | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| Arthritis | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| Genetic Disorders | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |

Review of Systems:

Present Weight: ____ Weight one year ago: ____ Height: ____ Ideal Weight: ____

Energy (check one): Good ____ low ____ High ____ Fatigue ____

If you have fatigue, when in the morning, afternoon, evening is it worst? _____

Can you do what you need to do during the day? Yes ____ No ____

For the following Questions please circle one: (Y = Yes, N = No or P = Past)

Skin:

| | | | |
|--------------------|-------|--------------|-------|
| Rash | Y N P | Color Change | Y N P |
| Hives | Y N P | Lump | Y N P |
| Psoriasis / Eczema | Y N P | Itchy | Y N P |
| Dry | Y N P | Warts/Moles | Y N P |
| Cancer | Y N P | Perspiration | Y N P |

Head:

| | | | |
|----------------|-------|-------------|-------|
| Headache | Y N P | Migraine | Y N P |
| Dandruff | Y N P | Head Injury | Y N P |
| Oil / Dry Hair | Y N P | Hair Loss | Y N P |

Nose:

| | | | |
|-----------------------|--------------|---------------------------|--------------|
| Frequent Colds | Y N P | Nosebleeds | Y N P |
| Congestion | Y N P | Post Nasal Drip | Y N P |
| Polyps | Y N P | Seasonal Allergies | Y N P |

Eyes:

| | | | |
|----------------------|--------------|--------------------------|--------------|
| Dry/Watery | Y N P | Blurry Vision | Y N P |
| Double Vision | Y N P | Cataracts | Y N P |
| Glaucoma | Y N P | Styes | Y N P |
| Strain | Y N P | Discharge | Y N P |
| Itchy | Y N P | Dark under Eyelid | Y N P |

Mouth/Throat:

| | | | |
|----------------------|--------------|--------------------|--------------|
| Canker sores | Y N P | Cold sores | Y N P |
| Sore throat | Y N P | Gum disease | Y N P |
| Dentures | Y N P | Cavities | Y N P |
| Loss of taste | Y N P | Hoarseness | Y N P |

Neck:

| | | | |
|-------------------------|--------------|-----------------------|--------------|
| Stiffness | Y N P | Swollen Glands | Y N P |
| Limited movement | Y N P | Tension | Y N P |

Respiratory:

| | | | |
|----------------------------|--------------|-------------------|--------------|
| Shortness of breath | Y N P | Bronchitis | Y N P |
| Wheezing | Y N P | Pneumonia | Y N P |
| TB | Y N P | Asthma | Y N P |
| Painful Breathing | Y N P | COPD | Y N P |

Cardiovascular:

| | | | |
|----------------------------|--------------|------------------------|--------------|
| High Blood Pressure | Y N P | Rheumatic Fever | Y N P |
| Low Blood Pressure | Y N P | Murmurs | Y N P |
| Arrhythmias | Y N P | Palpitations | Y N P |
| Edema | Y N P | Chest Pain | Y N P |

Urinary Tract:

| | | | |
|---------------------|-------|------------------|-------|
| Incontinence | Y N P | Pain w/Urination | Y N P |
| Frequent infections | Y N P | Kidney Stones | Y N P |
| Urgency | Y N P | Discharge/Blood | Y N P |

Gastrointestinal:

| | | | |
|--------------------|-------|-------------------------------|-------|
| Heartburn | Y N P | Bowel Movement (BM) Frequency | Y N P |
| Indigestion | Y N P | Recent BM change | Y N P |
| Bloating | Y N P | Diarrhea/Constipation | Y N P |
| Nausea | Y N P | Hemorrhoids | Y N P |
| Vomiting | Y N P | Gall Bladder disease | Y N P |
| Change in Appetite | Y N P | Liver Disease | Y N P |
| Pancreatitis | Y N P | Ulcer | Y N P |

Musculoskeletal:

| | | | |
|-----------|-------|------------|-------|
| Weakness | Y N P | Arthritis | Y N P |
| Stiffness | Y N P | Leg Cramps | Y N P |
| Tremors | Y N P | Pain | Y N P |

Nervous:

| | | | |
|-------------------|-------|------------------------|-------|
| Paralysis | Y N P | Sciatica | Y N P |
| Tingling/Numbness | Y N P | Carpal Tunnel Syndrome | Y N P |
| Seizures | Y N P | Fainting | Y N P |

Male Genitalia:

| | | | |
|--------------------------|-------|--------------------|--------------------|
| Testicular pain/swelling | Y N P | Sexually Active | Y N P |
| Hernia | Y N P | S.T.D. | Y N P |
| Discharge | Y N P | Prostate Disease | Y N P |
| Impotency | Y N P | Sexual Orientation | Hetero / Homo / Bi |

Female Genitalia:

| | | | |
|--------------------|-------|---------------------------------|-------|
| Age Period Began | | How Often Period Occurs | |
| Length of Periods | | Heavy menstrual Bleeding | Y N P |
| Menstrual Cramping | Y N P | Food Cravings: (please specify) | Y N P |
| PMS | Y N P | How many births | |

| | | | |
|----------------------------|-------------------|---------------------------|-------|
| Times Pregnant | | Abortions | Y N P |
| Miscarriages | | Use of hormones | Y N P |
| Date of Last Pap Smear | | Healthy libido | Y N P |
| Any abnormal Paps | Y N P | Sexually Active | Y N P |
| Diagnosis of abnormal pap: | | Menopause since what age: | Y N P |
| Pain with Intercourse | Y N P | Vaginitis | Y N P |
| S.T.D. | Y N P | Vagina dryness | |
| Dexa Scan | Y N P | Mammography: | Y N P |
| Sexual Orientation | Hetero / Homo/ Bi | | |

Mammography Date & Results: _____

Dexa Scan Date & Results: _____

List Birth Controls Used & Starting Age: _____

Are you on any hormone therapy (include date & type): _____

Mental/Emotional:

| | | | |
|-----------------|-------|-----------------------|-------|
| Depression | Y N P | Anger/Irritability | Y N P |
| Suicidal | Y N P | High-Strung/tense | Y N P |
| Anxiety | Y N P | Fear/Panic | Y N P |
| Eating Disorder | Y N P | Psych Hospitalization | Y N P |

Social History:

Married _____ Single _____ Divorced _____

Religious / Spiritual Practice: _____

Key: Yes (Y), No (N) or Past (P)

I. Antacids: Y N P Steroids: Y N P Analgesics: Y N P Laxatives: Y N P

Smoking: Y N P Packs per day & # of years: _____

Coffee: Y N P Cups per day: _____ Soda Pop: Y N P Ounces per day: _____

Alcohol: Y N P How Often & How Much: _____

II. Addictions:

a. Alcohol: _____ Any past treatment: _____

b. Recreational Drugs: _____ Any past treatment: _____

III. Exercises:

How often: _____ What Type: _____

How long: _____ Hobbies: _____

IV. Sleep:

Hours per night: _____ If you wake up frequently, what is the reason? _____

Nightmares: Y N P

Sleep Walk: Y N P

Wake Refreshed: Y N P

Grind teeth: Y N P

Naps during the Day: Y N P

Snore: Y N P

Diet

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

How often do you eat out? _____ How often do you eat fast food? _____

Water Intake: _____ Frequency of Bowel Movements? _____

Color/Consistency/Odor of Bowel Movements: _____

Any Food Sensitivities/Allergies: _____

Have you had a food allergy test? Y or N If yes, please indicate the date and type of test: (i.e. blood, pin prick, etc.) _____

Do you have symptoms after eating? ____ Yes ____ No (Circle all that applies)

| | | | |
|-----------|------------|----------|---------------|
| Belching | Bloating | Sneezing | Hives |
| Itchiness | Joint pain | Headache | Excessive Gas |

Do you have any delayed symptoms after eating?

| | | | |
|---------|------------------|--------------|------------|
| Fatigue | Sinus congestion | Muscle aches | Joint pain |
|---------|------------------|--------------|------------|

Toxin Exposure

1. Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, please list the pollution you were exposed to? (including date of exposure)
 - a. _____
 - b. _____
 - c. _____
2. Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____
3. Are you sensitive to perfumes, gasoline or other vapors? _____
 - a. If yes, please answer the following questions:
 - i. Do you experience headaches? _____
 - ii. Do you get light headed / fainting/dizziness? _____
 - iii. Brain Fog/ Difficulty concentrating? _____
4. Do you use pesticides, herbicides or other chemicals around your home?

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