

## Patient Intake Form

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_ Home \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Referred by \_\_\_\_\_

Pharmacy Information \_\_\_\_\_ Name \_\_\_\_\_ Phone Number \_\_\_\_\_

\_\_\_\_\_ Address \_\_\_\_\_ Fax Number \_\_\_\_\_

Credit Card Number \_\_\_\_\_ Expiration \_\_\_\_\_

Card Type \_\_\_\_\_

List your health concerns in order of importance:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

Name and telephone number of Primary Care physician: \_\_\_\_\_  
\_\_\_\_\_

### 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 Attack/Stroke:	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
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

**List All Surgeries & Hospitalizations, including date occurred:**

- |          |          |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

**Please Note When & Why You Have Had Each of the Following:**

X-Rays: _____	MRI/Cat Scans: _____	Ultrasounds: _____
Accidents: _____	TB Test: _____	HCV: _____
HIV: _____	Last Dental Visit: _____	Last Eye Exam: _____

Did you have the following Disease (D), Get Immunized (I), or Neither (N):

<b>Measles:</b> D I N	<b>Chicken Pox:</b> D I N	<b>Hemophilus (Hib):</b> D I N
<b>Rubella:</b> D I N	<b>Tetanus:</b> D I N	<b>Whooping Cough:</b> D I N
<b>Mumps:</b> D I N	<b>Hepatitis B:</b> D I N	

**Any vaccination reactions:** \_\_\_\_\_

List Yes (Y), No (N) or Past (P) regarding use of the following:

<b>Antacids:</b> Y N P	<b>Steroids:</b> Y N P	<b>Smoking:</b> Y N P	<b>Packs per day &amp; number of years:</b> _____
<b>Analgesics:</b> Y N P	<b>Laxatives:</b> Y N P	<b>Coffee:</b> Y N P	<b>Cups per day if Yes/Past:</b> _____
<b>Soda Pop:</b> Y N P	<b>Ounces per day if Yes/Past:</b> _____		
<b>Alcohol:</b> Y N P	<b>How often &amp; how much if Yes/Past:</b> _____		
<b>Any Alcohol Addiction:</b> Y N P	<b>Any Alcohol Treatment:</b> Y N P		
<b>Recreational Drugs:</b> Y N P	<b>Any Drug Addictions:</b> Y N P		
<b>Any Drug Treatment:</b> Y N P			

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and including dosage:

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**Review of Systems:**

Present Weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_ Height: \_\_\_\_\_  
 Maximum weight and when: \_\_\_\_\_ Minimum weight as adult & when: \_\_\_\_\_  
 Ideal Weight: \_\_\_\_\_

**REGARDING THE NEXT LONG SECTION:** Please circle (Y) if you have the problem **NOW**, (N) if you've **NEVER** had the problem, (P) if you had the problem in the **PAST**.

Good Energy: Y N P

Fatigue: Y N P

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

If you have fatigue, can you do what you need to during the day? Y N

**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
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<b>Congestion:</b>	Y N P		<b>Post Nasal Drip:</b>	Y N P
<b>Polyps:</b>	Y N P		<b>Seasonal Allergies:</b>	Y N P

**EYES**

<b>Dry/Watery:</b>	Y N P		<b>Blurry Vision:</b>	Y N P
<b>Double Vision</b>	Y N P		<b>Cataracts:</b>	Y N P
<b>Glaucoma:</b>	Y N P		<b>Styes:</b>	Y N P
<b>Strain:</b>	Y N P		<b>Discharge:</b>	Y N P
<b>Itchy:</b>	Y N P		<b>Dark under Eyelid:</b>	Y N P

**MOUTH/THROAT**

<b>Canker sores:</b>	Y N P		<b>Cold sores:</b>	Y N P
<b>Sore Throat:</b>	Y N P		<b>Gum disease:</b>	Y N P
<b>Dentures:</b>	Y N P		<b>Cavities:</b>	Y N P
<b>Loss of taste:</b>	Y N P		<b>Hoarseness:</b>	Y N P

**NECK**

<b>Stiffness:</b>	Y N P		<b>Swollen Glands:</b>	Y N P
<b>Full movement:</b>	Y N P		<b>Tension:</b>	Y N P

**MUSCULOSKELETAL**

<b>Weakness:</b>	Y N P		<b>Arthritis:</b>	Y N P
<b>Stiffness:</b>	Y N P		<b>Leg Cramps:</b>	Y N P
<b>Tremors:</b>	Y N P		<b>Pain:</b>	Y N P

**NERVOUS**

<b>Paralysis:</b>	Y N P		<b>Sciatica:</b>	Y N P
<b>Tingling/numbness:</b>	Y N P		<b>Carpal tunnel syndrome:</b>	Y N P
<b>Seizures:</b>	Y N P		<b>Fainting:</b>	Y N P

**Mental/Emotional**

<b>Depression:</b>	Y N P		<b>Anger/irritability:</b>	Y N P
<b>Suicidal:</b>	Y N P		<b>High-strung/tense:</b>	Y N P
<b>Anxiety:</b>	Y N P		<b>Fear/Panic</b>	Y N P
<b>Eating disorder:</b>	Y N P		<b>Psych Hospitalization:</b>	Y N P

**RESPIRATORY**

<b>Cough:</b>	Y N P		<b>TB:</b>	Y N P
<b>Shortness of breath w/ exertion:</b>	Y N P		<b>Bronchitis:</b>	Y N P
<b>Shortness of breath sitting:</b>	Y N P		<b>Pneumonia:</b>	Y N P
<b>Shortness of breath lying down:</b>	Y N P		<b>Asthma:</b>	Y N P
<b>Wheezing:</b>	Y N P		<b>Painful breathing:</b>	Y N P

**CARDIOVASCULAR**

<b>High Blood Pressure:</b>	Y N P		<b>Rheumatic Fever:</b>	Y N P
<b>Low Blood Pressure</b>	Y N P		<b>Murmurs:</b>	Y N P
<b>Arrhythmias:</b>	Y N P		<b>Palpitations:</b>	Y N P
<b>Edema:</b>	Y N P		<b>Chest Pain:</b>	Y N P

**URINARY TRACT**

<b>Incontinence:</b>	Y N P		<b>Pain w/ Urination</b>	Y N P
<b>Frequent Infections:</b>	Y N P		<b>Kidney Stones</b>	Y N P
<b>Urgency:</b>	Y N P		<b>Discharge/Blood:</b>	Y N P

**GASTROINTESTINAL**

<b>Heartburn:</b>	Y N P		<b>Bowel Movement Freq:</b>	
<b>Indigestion:</b>	Y N P		<b>Recent BM Change:</b>	Y N P
<b>Bloating:</b>	Y N P		<b>Diarrhea/Constipation:</b>	Y N P
<b>Nausea:</b>	Y N P		<b>Hemorrhoids:</b>	Y N P
<b>Vomiting:</b>	Y N P		<b>Gall Bladder Disease</b>	Y N P
<b>Change in Appetite:</b>	Y N P		<b>Liver Disease:</b>	Y N P
<b>Pancreatitis:</b>	Y N P		<b>Ulcer</b>	Y N P

**MALE GENITALIA**

<b>Testicular pain/swelling:</b>	Y N P		<b>Sexually Active:</b>	Y N P
<b>Hernia:</b>	Y N P		<b>S.T.D.:</b>	Y N P
<b>Discharge:</b>	Y N P		<b>Prostate Disease/Symptoms:</b>	Y N P
<b>Impotency:</b>	Y N P		<b>Sexual Orientation</b>	

**FEMALE GENITALIA**

Age Period Began:			How Often Period Occurs:	
How long period lasts:			Heavy menstrual bleeding:	Y N P
Menstrual cramping:	Y N P		Menstrual Pain:	Y N P
PMS:	Y N P		Food cravings:	Y N P
Times Pregnant:			How many births:	
Miscarriages:			Abortions:	
Last Pap Smear:			Sexual Orientation:	
Any abnormal paps:	Y N P		When was abnormal:	
Menopausal since what age:			Use of hormones:	Y N P
Type of hormones used:			Healthy libido:	Y N P
Dry vagina:	Y N P		Sexually Active:	Y N P
Pain w/ Intercourse:	Y N P		Vaginitis:	Y N P
S.T.D.:	Y N P		Mammography:	Y N P
Bone Density Test:	Y N P		If Yes, what were results:	

Please list any birth control used and ages used: \_\_\_\_\_  
\_\_\_\_\_

**Exercise**

How often do you exercise? \_\_\_\_\_ What type of exercise? \_\_\_\_\_  
For how long? \_\_\_\_\_ Hobbies: \_\_\_\_\_

**Sleep**

How long per night? \_\_\_\_\_ If you wake up frequently, what is the reason? \_\_\_\_\_  
Nightmares: Y N P      Wake Refreshed: Y N P      Must nap during the day: Y N P  
Sleep walk: Y N P      Grind teeth: Y N P      Snore: Y N P

**Diet**

Breakfast: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Dinner: \_\_\_\_\_

**Toxin Exposure**

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? \_\_\_\_\_

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? \_\_\_\_\_

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? \_\_\_\_\_

Are you particularly sensitive to perfumes, gasoline or other vapors? \_\_\_\_\_

Do you use pesticides, herbicides or other chemicals around your home? \_\_\_\_\_

**Social Life**

Enjoy job: Y N P Hours worked per week: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

Active spiritual practice: Y N P Quality of significant relationship: \_\_\_\_\_

History of sexual, mental/emotional, physical abuse: Y N P

What is your greatest health concern: \_\_\_\_\_

How does it limit you the most: \_\_\_\_\_

How committed are you towards making valuable changes: Little Moderately Very

**Allergies**

List all known Allergies (food, drugs, environment): \_\_\_\_\_

**Additional Information**

Please list any additional information/topics which you believe is important we address during your office visit:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Authorization for the Release of Information

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### Patient Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_

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I authorize for this office and any of its employees to release and/or disclose the medical information as indicated below to the following person(s), entity, or person I have indicated bellow.

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Patient Health Information authorized to be disclosed:

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For the specific purpose of (describe in detail)

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**DURATION:** This authorization shall become effective immediately and shall remain in effect until (date) \_\_\_\_\_, or for 1 year from the date of signature if no date entered.

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**REVOCACTION:** This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

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I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous relevance on the use or disclosures pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by his authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document it will not condition my treatment, payment enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information

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Signature of Patient or Patient's Authorized Representative

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Date

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Authorized Signature of Facility

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Date

## Informed Consent Regarding Nutritional and Herbal Supplements

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201(g) (1), the term *drug* is defined as an “article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease.” Technically vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effect on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding the use of these substances in order to upgrade the quality of foods in a patient’s diet and supplement nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

### **Sale of Nutritional Supplements at Naturopathic Vitality Wellness Center**

#### ***You are under no obligation to purchase nutritional supplements at our office***

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering (1) the quality of science behind the product and (2) the quality of the product components. The brands of supplements that we carry in our center are those that meet our high standards and tend to produce predictable results.

While these supplements may come at higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body) and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality with over the counter. There is a lack of stringent testing requirements for dietary supplements over the counter, therefore, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I, \_\_\_\_\_

Have read and understand the above statement on \_\_\_\_\_ (date)



## Health Agreement

The path to complete wellness is a journey that is traveled by both the patient and the practitioner. The practitioner is a guide whose job is to help the patient find the cause and a cure for the imbalances that have led to the manifestation of a disease. The practitioner is also a teacher, hence the term Doctor, Docere in Latin (meaning teacher), whose duty is to teach the patient how to live a more balanced life that leads to long term wellness. The patient plays an integral part in this journey and without the full commitment, active participation and intention of the patient to walk this path, complete wellness cannot be achieved.

Dr. Judy Hinojosa-Sinks understands the importance of the patient-doctor relationship and what it takes to achieve complete health. We honor our commitment to helping you walk this path in achieving your goals and we ask that you honor yourself and your commitment to your own journey to wellness. As alternative practitioners we treat the whole person and not the disease. We believe that all aspects of your life must be addressed to achieve your goals, including a person's physical, mental, emotional and spiritual wellness as well a person's social and environmental well being.

We are committed to addressing all aspects of your life. We understand the journey to health is unique to each person and it will vary for each patient depending on the complexity of the case. We ask that you set your intentions and commitment to helping us as a partnership achieve your goals. To help you get well we must walk the journey together. We thank you for the trust and commitment you place in Naturopathic Vitality Wellness Center as we set the intentions for complete wellness and healing.

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Patient

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Date

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Practitioner

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Date

## Notice of Privacy Practices

This notice describes how private health information about you may be used and disclosed, and how you may access this information.

Our Healthcare Practice takes patient privacy matters seriously. We work hard to always be respectful regarding the protection and privacy of your health records in our office. We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this NOTICE about our privacy practices, our duties, and your rights concerning your personal health information. We must follow the privacy practices described in this Notice while it is in effect. This Notice takes effect immediately, and will remain in effect until we replace it. You may request a copy of our Notice at any time, and may request additional copies, as needed, by contacting our office.

### How We Disclosed Health Information

#### Specialist Referrals:

We use and disclose health information about you for treatment within our practice, for general healthcare operations, and payment collection. That means your information is available to our immediate staff and to other practitioners who we may refer you to for additional treatment. This includes, but is not limited to, other healthcare specialists such as other doctors, laboratories and the like. We will exercise our judgment in only distributing the minimum necessary information to any outside associates.

#### General Business Operations:

Your information may be reviewed in the course of general healthcare operations for activities such as conducting quality reviews, conducting training programs, licensing, accreditation, and other business related evaluations to help us in improving our delivery of healthcare to our patients.

#### Payment and Collection:

Your health information may be sent to third party payers at your request to assist with your insurance collection. Additionally information may be used from time to time as necessary to secure payment for services. We will use our professional judgment and experience with common practice to make decisions on what information to disclose to secure payment

**Family, Friends, Personal Representatives and Others:**

We may disclose your health information to a family member, friend or other persons to the extent necessary to help with your healthcare or with payment of your healthcare. You may, however request that we not disclose to anyone other than yourself, of which we will abide. An example where we might disclose to a family member or friend might be when someone drives you to the practice and we are reporting on progress and time remaining before completion, or where a family member desires to pick up a supplement or x-rays on your behalf. We will use our professional judgment and experience with common practice when disclosing your health information to others who may be involved in your health care and are trying to ascertain your general condition.

**Marketing, Health-Related Services:**

We will not use your health information for marketing communications without your written authorization. Under Federal Privacy Rules, we will send you updated information about our practice, and send you information regarding programs and products we offer to further enhance your care and treatment. We will never provide your name to an outside organization for marketing.

**When the Law Requires Us to Disclose:**

We may disclose your health information to government agencies or others, as required by law. Example of this include, but are not limited to, law enforcement, required state agency reporting, and to military authorities for purposes such as national security.

**Abuse and Neglect:**

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence, or are the victim of possible other crimes. We disclose to the extent necessary to avert further harm to you or others.

**PATIENT RIGHTS**

**Access to Records:**

You have a right to look at copies of your health information. You may request photo copies and copies of x-rays. We will use the format you request, unless we are unable to practically do so. You must make your request for your health information in writing to our practice. We can provide you with a form to do this, or you may do it by writing a letter specifying exactly what you want to view. If we provide photo copies, we will charge you a set amount for each page copied.

### **Access to Records (Continued)**

Check with the office for the current fee schedule. If you request an alternate format, we will charge you per the expenses we incur to satisfy your request. You may prefer to ask for a summary rather than receive all of the pages in your file. We can prepare a summary depending on what you are seeking to obtain. The fee for summation will vary depending on time to compile. We have up to 30 days (and sometimes longer) to respond, depending on what is required to meet your request. Specifics will be provided upon request.

#### **Restrictions:**

You have the right to place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, however if we do agree, we will abide by our agreement except in certain emergency situations.

#### **Communications to You:**

You may request we communicate with you about your health information by alternative means or alternative locations, when you make the request in writing. You must specify the alternative means or locations and provide satisfactory explanation how payments will be made under the alternative means or location.

#### **Amendment of Your Records:**

You have the right to request that we amend your health information when requested in writing. We may deny your request, however we will note in your records your request to amend and reason. We cannot delete anything from the formal record, but we can add addendum to the record that may be able to meet your amendment request.

I have received a copy of this office's Notice of Privacy Practices:

**Print your name here:** \_\_\_\_\_

**Sign your name here:** \_\_\_\_\_

**Today's Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

## Naturopathic Vitality Policies

### **Payment Policy:**

All services and product payments are due upon completion of services or purchase of products. For all phone consultations payment must be received by the end of the service, we must have your credit card on file which will be charged at the end of the consult. For product shipment and phone orders payment must be done with a credit card.

**Payment types we accept:** Cash, Checks, Debit cards, Visa, MasterCard, and Discover.

### **Returns:**

Returned items should be unused and must be returned within 30 days of purchase in original packaging with any enclosed documentation. We will issue a credit to your account with Naturopathic Vitality for future use either for services or product purchases. A 15% restocking fee will be charged for all products.

### **Cancellation Policy:**

We must receive notice 24 hours prior to your appointment if you wish to cancel. All cancellations done under the 24 hour notice will be automatically charged a \$35.00 cancellation fee which will be submitted to the credit card on file.

### **Disability Forms, FMLA, etc:**

A \$25.00 fee will be collected each time forms are presented to Naturopathic Vitality for completion.

By signing this document I acknowledge that I have read the policy agreements and I will be held responsible for all payments.

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Print Name

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Signature

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Date