Dr. Amy Whittington-Consulting Physician-Patient Information

Name____ **Date**____________________

Address____ **Date of birth**___________________

City___________ **State** _______ **Zip.**______________ **Phone (H)(**_____**)**________________

e-Mail address_________________________________ **Phone (W)(**_____**)**________________

> ***As these are not considered "secure" communication devices: Please initial next to circle***
> Is it acceptable for us to contact you via e-mail? **Yes / No**
> Would you like to receive occasional "health-tips" via email? **Yes / No**
> Is it acceptable for us to leave messages on a voice mail / answering machine for you? **Yes / No**

Occupation____

Employer's name: ____

How were you referred to us?

____

If under 18, Parent or Guardian name(s):

____

Name and phone number of someone we may contact in an emergency____

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+

Gender: Male Female Marital status: ____________________________________

Current height: _________ **Weight:** __________ **Last physical examination:**_____________

Last blood tests:_______________________

Results: ____

Any other diagnostic tests in the past 3 years, if so what and when:_____________________

____

____

If a child, when was the last well-child exam? ___________________________

If female, when was your last Pap? _____________ **Your last Mammogram?** ___________________

If male, when was your last Prostate exam? _________ Your last PSA? _______________________

If over 50, when was your last colonoscopy? _________________

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

________________________ ____________________________ ___________________

________________________ ____________________________ ___________________

________________________ ____________________________ ___________________

Please list any past surgeries / hospitalizations: (include approximate date)

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Do you have a family history of any of the following diseases: (Check those that apply)

	Siblings	**Mother**	**Maternal GM**	**Maternal GF**	**Father**	**Paternal GM**	**Paternal GF**
Diabetes							
Cancer							
Heart Disease							
Stroke							
Other							

When was your last medical care: ____

Who did you see at that time: ____

Who is your primary care medical provider: ____

Phone number: ____

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

____

____

The following pages are for health history information: Please fill out all areas that apply to you and your case.

<u>I have questions about:</u> **Diet** **Exercise** **Supplementation**

Prevention of____

Please list your major health concerns, listing the most important concern first:

____

____

____

____

____

What treatments have you tried for the above concerns?

____

____

____

Hobbies: ____

What type of exercise do you participate in:___________________________________

How much time do you schedule for exercise weekly? ________________________

Please add comments as needed to clarify the symptoms listed, leave blank any which do not apply.

Rate the following as : 1 = three or four times yearly, 2 = monthly, 3 = once a week, 4 = Daily

HEAD:

1 2 3 4 Headaches

1 2 3 4 Dry Scalp

1 2 3 4 Acne

1 2 3 4 Dizzy

____

EYE / EAR / NOSE / THROAT:

1 2 3 4 Vision blurry

1 2 3 4 Dry eyes

1 2 3 4 Dark circles under eyes

1 2 3 4 Earwax builds up

1 2 3 4 Earaches

1 2 3 4 Hearing loss

1 2 3 4 Ringing in ears

1 2 3 4 Sinus pain / infection

1 2 3 4 Nose / sinuses dry

1 2 3 4 Nose runs

1 2 3 4 Seasonal allergies

1 2 3 4 Voice hoarse

1 2 3 4 Sore throat

1 2 3 4 Postnasal drip

1 2 3 4 Nose bleeds

CHEST:

1 2 3 4 Heart pounds

1 2 3 4 Heart "flutter"

1 2 3 4 Shortness of breath

1 2 3 4 Asthma (Triggered by ______________________)

1 2 3 4 Chest pains

1 2 3 4 Wheezing

1 2 3 4 Coughing

Diagnosed heart / cardiovascular disease: ______________

____

____

GASTROINTESTINAL:

1 2 3 4 Heartburn

1 2 3 4 Stomach aches

1 2 3 4 Gas / Bloating

1 2 3 4 Fatty meals bother

1 2 3 4 Constipation

1 2 3 4 Diarrhea

1 2 3 4 Blood or Mucus in stools

1 2 3 4 Vomiting

1 2 3 4 Hemorrhoids

Bowel movements:

___ Daily, ___ Other

1 2 3 4 Increased appetite

1 2 3 4 Decreased appetite

URINARY TRACT:

1 2 3 4 Bladder infections

1 2 3 4 Kidney infections

1 2 3 4 Burning with urination

1 2 3 4 Frequent urination

1 2 3 4 Blood in urine

1 2 3 4 Urinary incontinence (**Constant Occasional**)

____

MUSCULO-SKELETAL:

1 2 3 4 Joint pains

1 2 3 4 Back pain **Upper Lower All**

1 2 3 4 Neck pain

1 2 3 4 Muscle aches

1 2 3 4 Bruising **Easy Only with trauma**

1 2 3 4 Sprains

Locations:____________________

1 2 3 4 Joint stiffness

1 2 3 4 Arthritis

Diagnosed with Fibromyalgia **YES NO**

When_____

NEURO-ENDOCRINE:

1 2 3 4 Panic / Anxiety attacks

1 2 3 4 Irritability

1 2 3 4 Feel bad when not eating regularly

1 2 3 4 Weight gain

1 2 3 4 Weight loss

1 2 3 4 Mood swings

1 2 3 4 Snack often

1 2 3 4 Increased thirst

1 2 3 4 Insomnia

1 2 3 4 Feel restless at bedtime

1 2 3 4 Wake up easily at night

My stress level weekly averages: **1-2-3-4-5-6-7-8-9-10**

(1 is low – 10 is high)

<u>ENERGY</u>

1 2 3 4 Sleep soundly

1 2 3 4 Wake rested

1 2 3 4 Feel energetic in the morning

1 2 3 4 Heart races

1 2 3 4 Easy fatigue

1 2 3 4 Feel down / depressed

1 2 3 4 Poor memory

1 2 3 4 Slow starter

1 2 3 4 Afternoon tiredness

1 2 3 4 Tired all day

1 2 3 4 Tired, no matter how much I sleep

DIET: [Just an average day]

Breakfast:

Lunch:

Dinner:

Snacks

Beverages:

Do you smoke **Yes No**

How many drinks with alcohol do you have weekly: ________

<u>MALE ONLY: Circle what applies to you.</u>

Frequent urination (Specify**: Day Night**)

Hernias (Specify: **Current Past**)

Decrease in sex drive

Erectile difficulty

Rectal burning / itch

Other: ____________________________

<u>FEMALE ONLY: Circle what applies to you.</u>

PMS symptoms__________________________

____

Duration: **1 - 2 - 3 – ALL : Week(s) before period**

Menses painful Heavy flow Light flow

Menses change (duration, regularity, flow, pain)

Avg. cycle length **22-25 days**, **26-30 days**s, **other_____**

Date last period started:

____

Menopause Began:

____

Age your mother entered menopause?_______

Decrease in sex drive

Yeast infections

Hot flushes

Acne (**At / Before**) menses

Number of Pregnancies _____

Number of Births__________

Financial Policies _Dr. Amy Whittington

Please read and sign this form

The Spa at Trilogy is a cash-service only and payment is required at the time services are rendered. We do not file insurance but will cooperate in attempting to provide you with any necessary copies of receipts, diagnosis codes, and lab requisites, so that you can file for insurance coverage. Coverage for Naturopathic care can never be guaranteed and is not covered by most insurance companies. **I have read, understand, and agree to the above policies:**

____

Please Print Your Name

____ ______________________

Signature (Parent / Guardian, if under 18 years old) Date

The Purchasing of Supplements-Disclosure

Often times, supplements and nutrients will be recommended depending on your symptoms and health history. Because I am unable to stock a medicinary at this practice location, I have chosen to use a third-party distributor, *Natural Partners.* I am able to order physician-grade supplements of the highest quality for you and have them drop-shipped to your home, usually within days. I have chosen a distributor which stocks over 5,000 products from more than 25 reputable manufacturers. By using a third-party, I am able to offer you a wide array of supplements so that recommendations that I make are made solely based on what I believe are the best choices for you. I make a small amount of the mark-up of these supplements, which allows me to spend the time necessary to provide this service to you. I will discuss viable options for obtaining supplements during our visit.

State Law ARS32-1401(25)(ff), requires that a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. I support this law because it helps patients make reasoned financial decisions concerning their medical care. Non-routine goods and services: *Natural Partners, Inc.* (Third Party distributor)

This law provides for the acknowledgement of your having read and understood these disclosures by dating and singing this form in the spaces provided below. I will keep this signed original, please request a copy if you would like one for your records

I have read this Notice to Patients and I understand the disclosures that it contains.

___________________________ __________________

Signature Date