Name: ____ DOB: ______________

Address: ____

City: ________________ State: _______ Zip: ________

Phone (home): ______________________ Phone (cell): ______________________

E-mail:____

Occupation: ____

Employer's Name: ____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: ____

Phone: ______________________

Marital status: ______________________

Height: __________ Weight: __________

Last physical exam: ______________________ Last blood tests: ______________________

Results: ____

Any other diagnostic tests in the past 3 years? If so, what and when?

____

____

If applicable, when was your last pap smear? ________________ Mammogram? ________________

If applicable, when was your last prostate exam? ________________ Last PSA? ________________

If over 50, when was your last colonoscopy? ______________________________________

When was your last medical care? ________________ Who did you see? ________________

Who is your primary care provider? ______________________ Phone: ________________

Please list all your known allergies (drug, food, animals, insects, etc.):

____

____

____

Please list all medications, vitamins, herbs, hormones, and other prescriptions you currently take:

____

____

____

Please list any past surgeries / hospitalizations and approximate date:

____

____

____

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

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

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

____

____

____

What treatments have you tried before for the above concerns?

____

____

____

Hobbies? ____

Exercise? ____

<u>DIET</u> (*<u>just an average day</u>*):

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages: ____

Do you smoke? YES NO How many drinks with alcohol do you have weekly? _________

Please add comments as needed to clarify the symptoms listed and 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 Dizzy

1 2 3 4 Dry Scalp

1 2 3 4 Acne

EYES / EARS / NOSE / THROAT:

1 2 3 4 Blurry Vision

1 2 3 4 Dry Eyes

1 2 3 4 Dark Circles

1 2 3 4 Earaches

1 2 3 4 Hearing Loss

1 2 3 4 Ringing in Ears

1 2 3 4 Earwax Buildup

1 2 3 4 Sinus Pain / Infection

1 2 3 4 Nose / Sinuses Dry

1 2 3 4 Runny Nose

1 2 3 4 Nose Bleeds

1 2 3 4 Seasonal Allergies

1 2 3 4 Sore Throat

1 2 3 4 Hoarse Voice

1 2 3 4 Postnasal Drip

CHEST:

1 2 3 4 Chest Pains

1 2 3 4 Heart Pounding

1 2 3 4 Heart Flutter

1 2 3 4 Shortness of Breath

1 2 3 4 Wheezing

1 2 3 4 Coughing

1 2 3 4 Asthma

Trigger(s):________________________________
_

Diagnosed heart / cardiovascular disease:

____
_

____
_

GASTROINTESTINAL:

1 2 3 4 Heartburn

1 2 3 4 Increased Appetite

1 2 3 4 Decreased Appetite

1 2 3 4 Stomach Aches

1 2 3 4 Fatty Meals Bother

1 2 3 4 Gas / Bloating

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 _____

URINARY TRACT:

1 2 3 4 Kidney Infections

1 2 3 4 Bladder Infections

1 2 3 4 Burning with Urination

1 2 3 4 Blood in Urine

1 2 3 4 Frequent Urination

1 2 3 4 Urinary Inconsistence

Constant _____ Occasional _____

MUSCULO-SKELETAL:

1 2 3 4 Joint Pains

1 2 3 4 Joint Stiffness

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

Location(s): ______________________________

1 2 3 4 Arthritis

Diagnosed with Fibromyalgia? YES NO

If yes, when?

____

NEURO-ENDOCRINE:

1 2 3 4 Panic / Anxiety Attacks

1 2 3 4 Irritability

1 2 3 4 Mood Swings

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 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

Weekly Stress Average: (*1 is low, 10 is high*)

1 2 3 4 5 6 7 8 9 10

ENERGY:

1 2 3 4 Sleep Soundly

1 2 3 4 Wake Rested

1 2 3 4 Feel Energetic in Morning

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 Amount of Sleep

1 2 3 4 Heart Races

1 2 3 4 Easy Fatigue

1 2 3 4 Feel Depressed

1 2 3 4 Poor Memory

FEMALE ONLY:

PMS symptoms? ____

Heavy flow? YES NO Light flow? YES NO Menses painful? YES NO

Average cycle length? 22-25 days 26-30 days other: _____________ Duration: _____________

Date of last period: ________________ Menopause began: ________________

Age your mother entered menopause: ______

Decrease in sex drive? YES NO Yeast infections? YES NO

Hot flashes? YES NO Acne before or after menses? YES NO

Number of pregnancies: _____ Number of births: _____

MALE ONLY:

Frequent urination? DAY NIGHT   Hernias? CURRENT PAST

Rectal burning / itch? YES NO

Decrease in sex drive? YES NO   Erectile difficulty? YES NO

Financial Policies - *Please read and sign this form.*

Dr. Amy Whittington and her affiliates do not process insurance and payment is required at the time services are rendered. We will cooperate providing you with any necessary copies of receipts, diagnosis codes, etc., so that you can file for insurance reimbursement if you'd like. Medicare patients are not able to file for coverage of naturopathic care. Additionally, labs ordered for Medicare-age patients are out-of-pocket. For this reason, we can either try to coordinate orders with your primary provider or proceed with out-of-pocket lab work. Coverage for Naturopathic care can never be guaranteed. We are happy to accept payment via Health Savings Accounts.

I have read, understand, and agree to the above policies:

____
Print your name

____   _____________
Signature   Date

Purchasing of Supplements – Disclosure

Often times, supplements and nutrients will be recommended depending on your symptoms and health history. We are able to provide them for you, but you are in no way obligated for any additional purchase and all can be found elsewhere as desired.

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. We support this law because it helps patients make reasoned financial decisions concerning their medical care.

This law provides for the acknowledgement of your having read and understood these disclosures by dating and signing 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 disclosure that it contains.

____   _____________
Signature   Date

Consent for Treatment

I, ____, understand that Dr. Amy Whittington and her affiliates' services are are intended for the purposes of consultation as well as for health and well-being advice and improvement. Dr. Whittington is not intending to act as a primary care physician in this setting and therefore continued care with an appropriate general practitioner or specialist is advised as necessary.

I am also aware that with certain prescribed herbs, nutritional supplements, hormones, medications, and homeopathy that although side effects are rare, there is an inherent risk to any treatment. Intravenous and intramuscular injections can lead to local site irritation and have the potential to cause allergic reaction, or can lead to other very rare side effects, including death.

In the case of acupuncture, I understand that the potential benefits of acupuncture include drugless relief of my symptoms and an improved state of health. I understand that the potential risks of acupuncture include local discomfort and bruising, with a rare potential for infection at the site of the needle insertion. I understand that acupuncture does not replace treatment from a primary care physician.

I understand that if I am choosing to pursue hormone therapy of any kind, that inherent risk including the possible increase for some for certain types of cancers, as well as rare risk for endometrial, or prostate dysfunction or disease. I also understand the need to pursue yearly or bi-yearly pap-smears, gynecological exams, and mammograms (female) and prostate exams (male) as recommended as I continue hormone therapy.

In the case of weight loss aids, I understand risks versus benefits and acknowledge possible side effects. I understand the contraindications or will get clarification and I assume any additional risk.

With my understanding of the above, I voluntarily consent to receive treatment using a combination or nutritional counseling, vitamin and nutrient supplementation, hormones, medications, herbs, homeopathy, and acupuncture. Upon signing, I also agree to make Dr. Whittington and affiliates aware of any change in my current health, medications, and supplementation.

____ ________________

Signature Date

Notice of Privacy Practices

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received Notice of Private Practices.

____ _______________

Signature Date

____ _______________

Behalf of the Patient Relationship Date

Revisions (if any):

____

____

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Commitment to your privacy:

This practice is dedicated to maintaining the privacy of your health information. Healthcare practices are required by law to maintain the confidentiality of your health information. Also in accordance with the law, you must be provided with the following information:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary, to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Disclosures will only be made to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers compensation or similar programs.

Your rights regarding your health information:

1. You can request that this practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask to be contacted at home, rather than work. Any reasonable requests will be accommodated.
2. You can request a restriction in the use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request the disclosure of your health information to be restricted to only certain individuals involved in your care or the payment for your care, such as family member and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Amy Whittington, NMD, c/o 4080 W. Harrison St. Chandler, AZ 86226. Note: this request must be responded to within 30 days.
4. You may ask that your health information be amended if you believe it is incorrect or incomplete, and as long as the information is kept by of for this practice. To request an amendment, your request must be submitted to Dr. Amy Whittington, NMD, c/o 4080 W. Harrison St. Chandler, AZ 86226. You must provide a reason that supports your request for an amendment. Note: This practice must respond to your request within 60 days. If a physician believes the information is complete and accurate, that physician can refuse to make any changes.
5. You are entitled to receive a copy of the Notice of Privacy Practices. You may ask us to give you a copy of the notice at any time. To obtain a copy of the notice, contact Dr. Whittington.
6. If you believe your privacy rights have been violated, you may file a complaint with this practice or with the Secretary of the Department of Health and Human Services. To file a complaint with this practice, contact Dr. Amy Whittington, NMD, c/o 4080 W. Harrison St. Chandler, AZ 86226. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. This practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
8. If you have any questions regarding this notice or our health information privacy policies, please contact Dr. Amy Whittington, NMD, c/o 4080 W. Harrison St. Chandler, AZ 86226.

For Office Use Only---

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____

____