Auburn Naturopathic Medicine

PERSONAL INFORMATION

Mr/Mrs/Miss/Dr. Last Name_____ First Name: _____

Birth date:_____ Age:_____ Gender: _____

Street Address:_____ City:_____ State:_____ Zip:_____

Email Address:_____

Home Phone:_____ Cell:_____ Office:_____

Marital Status: (Circle) Minor / Single/ Married/ Widowed/ Long Term Partner

Name and address of person responsible for patient, if different from patient:

_____

Associations

Are you currently: (Circle One) Employed Retired Disabled Other:_____

Occupation:_____ Employer:_____

Primary Care Provider:_____ Contact Number:_____

How did you hear about us?_____

Name of referring patient or practioner:_____

May we contact them to thank them for referring you? YES NO

185 Cherry Ave. Auburn, CA. 95603 t530.885.5908 f530.885.5945
www.auburnnaturopathicmedicine.com

Emergency Contacts

Name of family member to contact:_____

Relationship:_____ Phone:_____ Alt Phone:_____

Friend or relative not at the same address:_____

Relationship:_____ Phone:_____ Alt Phone:_____

How To Contact You

Some patients prefer not to have health related messages left where others might hear them. Please let us know where we may leave messages that may be sensitive and initial after you make a choice.

You MAY leave messages for me on: (circle one) Home Cell Office E-mail

Initials:_____

You MAY discuss details of my health with:_____

Initials:_____

Health Concerns

Please list your main concerns that you would like to address

1.	4.
2.	5.
3.	6.

Patient Signature: _____ Date:_____

Guardian Signature:_____ Date:_____

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Informed Consent

I, _____, acknowledge that I am accepting treatment from a Naturopathic Doctor at Auburn Naturopathic Medicine. I understand that there are intrinsic differences between the care of Naturopathic Doctors and Medical Doctors. At this time it is my decision to pursue Naturopathic treatment for any condition I have. I also understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution of any or all conditions that I may have.

_____ _____

Patient/Guardian Signature Today's Date

_____ _____

Physician/Witness Today's Date

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Privacy Policy and Legal Notice

Auburn Naturopathic Medicine complies with all aspects of the federal HIPAA law, which stipulates your rights as a medical patient. At Auburn Naturopathic Medicine you have the following rights:

- All of your medical records in our possession are controlled so that only your medical provider and essential office staff are allowed to see the contents of your records.
- Your records will not be shared with anyone outside of this office except for the very rare occasions as mandated by law including a court order or in cases where the law mandates that we act to preserve life by breaking confidentiality, as in the case where we firmly believe that you might endanger the life of another or yourself.
- Clinics that contract with insurance companies are required by contract to divulge records to the insurance company as well as your social security number. Because of this we do NOT accept insurance, we will NOT share your records with outside private companies and we will only ask for your social security number if required when ordering lab work. Your social security number will NOT be saved in any form in our office.
- We believe that your medical records are YOUR records. You may request a copy of your records and we will make you a copy within 5 working days of your request. We may charge you reasonable copying fees for this service. Your "records" include anything actually in your chart, but does not include incidental notes that doctors may make for their own use, but which are never entered into the official chart notes. The HIPAA law allows doctors to refuse a request for records in extremely rare and unusual cases.
- We will not confirm or deny that you are a patient of our clinic, even to your family members, unless you give us explicit permission to do so. Your right to seek medical care with complete confidentiality is a right we take seriously.

If you have any questions or concerns about our privacy policy, or your rights as a patient in our clinic, please bring them to us at your earliest convenience.

I understand the above notice: _____ _____

Signature Today's Date

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Client Fees and Payment Policies

As we are committed to providing economical, quality health care, full payment for all charges is required at the time of service. In special circumstances, the physician may make alternative arrangements. We accept payment by check, cash, MasterCard or Visa. Checks or credit cards that are denied for lack of funds will incur a fee of $35.00.

Cancellations

We reserve your scheduled appointment time just for you and we ask that you respect this time commitment. **We require 24 hours notice received during normal business hours for cancelled or rescheduled visits.** There is no charge for visits cancelled with 24 hours notice. There may be a percentage of cost of the scheduled visit for cancellations with less than 24 hours notice or if no notice is received.

Insurance

In order to provide you with the best possible health care, we do not directly bill insurance companies. All charges incurred at Auburn Naturopathic Medicine a are your responsibility. Many healthcare insurance companies will reimburse you for services provided if you submit the invoice from our office. It is up to you to submit the proper paperwork for reimbursement. Due to plan variances, we are unable to inform you in advance of what each policy covers. It is up to you to check with your individual plan to determine coverage.

I agree to make payments according to the policies of Auburn Naturopathic Medicine. I understand that some or all of the services I receive may not be covered or may have coverage limitations or restrictions under my health insurance plan. It is my responsibility to know what my plan covers.

Patient Signature: _____ Date:_____

Guardian Signature:_____ Date:_____

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Cancer Management

This notification is for any patient who may be consulting in this office. The law in the State of California restricts the primary treatment of patients with cancer diagnosis to only physicians who are licensed as MD or DO oncologists.

Any involvement in diagnosis, treatment or other means by healthcare providers who do not have MD or DO qualifications will be considered adjunctive or ancillary care.

I acknowledge that I have been informed of the law in the State of California regarding primary cancer treatment, and as a patient will direct my healthcare in whatever way best suits my own personal needs and desires.

_____ _____

Patient/Guardian Signature Today's Date

_____ _____

Physician/Witness Today's Date

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Your Name: _____

Thank you for taking the time to tell us a little more about you. By filling this out before your appointment, it gives us much more time to discuss your concerns and our plan to address them.

1. Why did you choose to come to our office?

2. What 3 expectations do you have for your initial visit?

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

4. What behaviors or lifestyle habits do you currently engage in regularly that ***do not*** support your health?

5. What potential obstacles do you see in making changes to your lifestyle and following the directions necessary to support your health?

6. What is your present level of commitment to address lifestyle changes that are underlying causes of your signs and symptoms? Please circle a number:

(No commitment) 1 2 3 4 5 6 7 8 9 10 (100% committed)

Health History

Please List All Major Illnesses, Surgeries and Hospitalizations you have had throughout Your Lifetime:		
Approximate Dates	Illness or Reason	Outcome

Health Habits: Check all that apply				
✓	Habit	What Forms	Amount	For How Long
	Alcohol			
	Caffeine			
	Tobacco			
	Recreational Drugs			
	Exercise			

Review of Systems: Check all that apply

HEAD

	Headaches		Light-Headed		Dizziness				Earaches/Pain
	Other:								

SKIN, HAIR and NAILS

	Itching		Rashes		Breakouts		Dry Skin		Skin Tags
	Easy Bruising		Hair Loss		Ridges on Nails				
	Other:								

EYES

	Pain		Itchy		Watery		Recent Change in Vision
	Wear Glasses		Wear Contacts				
	Other:						

EARS

	Excessive Wax		Infections		Itching		Ringing		Earaches/Pain
	Other:								

NOSE AND SINUSES

	Runny Nose		Sinus Infections		Nose Bleeds		Seasonal Allergies
	Other:						

MOUTH and THROAT

	Frequent Sore Throats		Frequent Strep Throat		Recent Pain or Problems with Teeth		Trouble Swallowing	Dripping down back of Throat
	Other:							

RESPIRATORY

	Asthma		Pneumonia		Bronchitis		Cough	Difficulty Breathing
	Shortness of Breath		… with exercise		… with lying down		… at night	
	Other:							

CARDIAC

	Chest Pain		Palpitations		High Blood Pressure		Low Blood Pressure	High Cholesterol
	Other:							

GASTROINTESTINAL

	Stomach Pain		Gas		Bloating		Diarrhea	Constipation
	Heartburn		Indigestion		Nausea		Belching	Ulcers
	Blood in Stool		Mucus in Stool		Undigested Food in Stool		Colitis	Hemorrhoids
	Other:							

How often do you have a bowel movement? _____

Is this a change for you? _____yes _____no

URINARY

	Burning/Pain		Change in Frequency		Blood in Urine		Urgency		Leakage
	Other:								

GENITAL (Male)

	Testicular Mass or Pain		Erectile Dysfunction		Prostatic Hypertrophy		Poor Libido		Genital Herpes
	Heterosexual		Bisexual		Homosexual				
	Other:								

GENITAL (Female)

	Irregular Cycles		Painful Menses		Birth Control Pills		Pain During Intercourse		Yeast Infections
	Itching		Discharge		Genital Herpes		Infertility		Spotting
	PMS		Endometriosis		Heavy Bleeding		Tender Breasts		Hysterectomy
	Hot Flashes		Night Sweats		Vaginal Dryness		Poor Libido		
	Heterosexual		Bisexual		Homosexual				
	Other:								

Date of Last Period: _____ Number of Days from Period to Period: _____

Number of Days You Bleed: _____How Many of these Days are Heavy: _____

Number of Pregnancies: _____ Age your Periods began: _____

Age Menopause Began: _____

MUSCULOSKELETAL

	Muscle Pain		Joint Pain		Arthritis		Joint Swelling		Spasms
	Other:								

NEUROLOGICAL

	Weakness		Numbness		Tingling		Hyperactivity		Seizures
	Anxiety or Nervousness		Mood Swings		Poor Memory		Depression		Irritable
	Other:								

ENDOCRINE

	Cold Intolerance		Heat Intolerance		Hypoglycemia		Diabetes		Excessive Thirst
	Hyperthyroid		Hypothyroid		Fatigue				
	Other:								

How do you feel if you miss a meal? _____

IMMUNE

	Recurrent Illnesses		History of Cancer		Allergic to Everything		Chemical Intolerance		Autoimmune
	Other:								

Environmental and Toxic Exposures

What type of heat do you have for your home?

	Gas		Oil		Electric		Wood		Wood Pellets		Coal
	Other:										

Are you currently being exposed to any of the following? (check all that apply)

	Tobacco smoke		Fabric Softener		Hair Dyes/ Permanents		Electric Blankets		Metal Tooth Fillings
	Paints		Solvents		Dry Cleaning		Nail Polish		Mothballs
	Breast Implants		Dental Implants		New Carpet		Chemical Pet Collars		Candles
	Other:								

Do you have symptoms of fatigue if you are exposed to any of the above? ○ Yes ○ No

Check all that apply to you:

_____ Live in an agricultural area now or in the past
_____ Live near industrial areas
_____ Live in an area that is sprayed with herbicides or pesticides
_____ Use of pesticides on your personal grounds

List any known chemical exposures:

_____
_____
_____

Medications and Supplements

Please list any and all prescription medications, over-the-counter medications, vitamins, herbs, and stimulants you are currently taking.

On your first visit, please bring all of your supplement bottles with you.

Name of Product	Brand	Dose	Frequency/How Long
Ex) Vitamin C	Thorne Research	1.000 mg per day	2 years

Do you have any adverse (or opposite) reactions to medications: Y ___ N __
If so, please explain: