NATURE MEDICA
Detox Spa & Naturopathic Clinic
1 West Wetmore Road, Suite 101
Tucson, Arizona 85705
phone: 520.887.4287
fax: 520.887.0100

Patient Name: _____ Date of 1st Visit: ____/____/_____

Date of Birth: ____/____/____ Age: ____ Parent/Guardian Name(if under 18): _____

Place of Employment: _____ Occupation: _____

Phone Numbers (below):

Home: ( )	Work: ( )	Cell: ( )
□ OK to leave a message	□ OK to leave a message	□ OK to leave a message

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: M S W Spouse/Partner's Name: _____

Spouse's/Partners or Parent's (if minor) workplace: _____ Phone: (____)_____

How did you hear about us? □ Phonebook □ Ad □ Other: _____

□ Friend: _____ □ Doctor: _____

Nearest Relative or Close Friend Not Living With Patient: _____

Relationship: _____ Phone: (____)_____

Insurance: _____

Reason for Visit: _____

_____

_____

Chief Complaints

1. _____
2. _____
3. _____
4. _____

List your Physicians and other caregivers and their specialties:

1. _____
2. _____
3. _____
4. _____

Past Medical History:

Major Illnesses, Operations and Injuries (list dates):

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

List current prescription medications:

	Drug Name	Dosage	Taking since…
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

List all vitamins, minerals, herbs and other natural supplements you are currently taking:

	Supplement Name and Dose	Brand	Purchased where?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Allergies:

Drugs: _____ Contact Allergies: _____

Inhalants: _____ Medications: _____

Food Allergies or Sensitivities:

	Foods	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____

Review of Symptoms (please check off any symptoms you are currently having)

HEAD
- Migraine headaches
- Sinus Headaches
- Tension Headaches
- Other
- Have you ever hit your head badly?
- Suffered a head injury?
- TMJ

MUSCULOSKELETAL
- Muscle pain
- Muscle Weakness
- Joint Pain
- Shoulder Problems
- Knee Problems
- Neck Problems

Other: _____

EYES
- Glaucoma
- Cataracts
- Burning eyes
- Light sensitivity
- Eyestrain

EARS
- Loss of hearing
- Ringing
- Recurrent Infections
- Dizziness
- Itching

NOSE
- Chronic Congestion
- Sinus Problems
- Nosebleeds
- Sinus Infections
- Allergies

HEART AND LUNGS
- Chest Pain
- Palpitations
- Varicose Veins
- High Blood Pressure
- Shortness of Breath

LUNGS
- Cough
- Asthma
- Wheezing

BREAST
- Lumps
- Tenderness
- Nipple Discharge
- Breast Cysts
- History of Abnormal Mammograms

THROAT AND MOUTH
- Hoarseness
- Post-Nasal Drip
- Recurrent Sore Throats
- Coldsores
- Frequently coated tongue
- Oral ulcers inside mouth or under tongue

GASTROINTESTINAL
- Upset Stomach
- Burning in Stomach
- Pain in Abdomen
- Belching
- Reflux
- Nausea
- Indigestion
- Gas
- Bloating
- Constipation
- Diarrhea
- Itchy Anus
- Black, Tarry Stools
- Hemorrhoids

GENITO-URINARY
- Frequent Urination
- Difficult Urination
- Genital Itching or Burning

SKIN
- Acne
- Dry Skin
- Eczema
- Hives
- Rashes

ENDOCRINE
- Weight Gain
- Weigh Loss
- Excess Thirst
- Fatigue
- Excess Urination
- Cold Extremities
- Excessive Hair Loss
- Change in Hair Texture

GENERAL
- Depression
- Anxiety
- Insomnia
- Poor Memory
- Poor Concentration

MEN ONLY:
- Loss of Normal Erections
- Prostate Problems

WOMEN ONLY: (If you suspect you have hormonal imbalances and are over the age of 30, be sure to fill out the women's health history form)

Age of First Period: _____ Age of Menopause: _____ Date of last Pap: ____/____/____

Period: Days Between Cycles: _____ Regular Irregular Days You Bleed _____

Lifestyle:

Exercise:

Description of Exercise	Duration	Times/week
1)		
2)		
3)		
4)		

Diet: (Please list typical daily diet)

Breakfast	Lunch	Dinner	Snack

Food Groups (check amounts typically consumed):

Foods	None	Low	Moderate	Excessive
Fruits				
Vegetables				
Chicken				
Fish				
Beef				
Pork				
Dairy				
Sugar				
Bread				
Pasta				
Coffee				

What do you use when you use a sweetener?

□ Sugar □ Agave Syrup □ Honey □ Stevia □ Sucanat □ Equal □ Sweet n Low □ Splenda

How many hours a week do you work?_____

What do you do to relax?

1. _____
2. _____
3. _____
4. _____

Height: _____ Do you smoke? □ Yes □ No

Weight:_____ If so, how many cigarettes per day: ____

Ideal Weight: _____ Drink alcohol? □ Yes □ No

Blood Type: _____ Type: _____ Frequency: _____

Biggest Sources of Stress? 1. _____

2. _____

3. _____

Any Pets: □ cat(s) □ dog(s) □ indoor □ outdoor

Do you have any children? (if so, please provide names and ages)

Name	Age	Name	Age

Family History:

Relation	Current Age	Age at Death	Illnesses
Mother			
Father			
Grandmother (P)			
Grandfather (P)			
Grandmother (M)			
Grandfather (M)			
Siblings			

Additional Family History (check all that apply)

□ Thyroid disease □ Cancer □ Heart Disease □ Allergies □ Diabetes □ Stroke

Environment:

Reaction To:	None	Mild	Moderate	Very severe	Not Sure
Cigarette Smoke					
Perfumes					
Chlorine Bleach					
Car Exhaust					
Molds/Mildews					
Dust					
Formaldehyde					

Water: What type of water do you drink?

□ Tap □ Bottled □ Distilled □Reverse Osmosis □Other: _____

Do you buy organic fruits and vegetables?

□ Never □ A few things when I can □ Most of what I buy

Yes	No	Unsure	Have you ever…
			Lived on or near a farm where chemical spraying had occurred?
			Lived or worked in new construction with new materials?
			Lived or worked in a severely moldy environment?
			Lived or worked in a place that you or others suspected to be toxic?

Women's Health History

Menstrual History (Please check off the boxes that apply)

Are your periods…

□ Regular □ Irregular □ no longer have periods. Date of last period?_____

How many days between cycles? ____ How many days do you bleed? ____

Flow:

□ Light □ Moderate □ Heavy

Color of blood:

□ Bright red □ Medium red □ Brown

Clotting? □ Yes □ No

Do you have spotting?

□ Yes □ No

If so, when?

□ Before period - # of days? ____

□ Mid-cycle - # of days? ____

□ After period - # of days? ____

Cramps:

□ Mild □ Moderate □ Severe □ Progressively worsening over the years

PMS:

□ Never □ Sometimes □ Each time □ Severe □ Don't notice

If applicable, how many days? _____

Headaches with menses?

□ Yes □ No

If so, when and what type? Check all.

□ Before □ During □ After □ Mid-cycle

□ Migraine □ Tension □ Other

Breast tenderness? □ Yes □ No

Fatigue with menses? □ Yes □ No

Hysterectomy (if applicable):

Have you had a hysterectomy? □ Yes □ No

If so, when? _____

To what extent?

□ Partial (ovaries left) □ Full

Reason for hysterectomy? □ Heavy bleeding □ Fibroids □ Uterine Prolapse

□ Endometriosis □ Other: _____

Urinary Incontinence:

Urine leakage while laughing or sneezing? . . . . . □ Never □ occasionally □ often

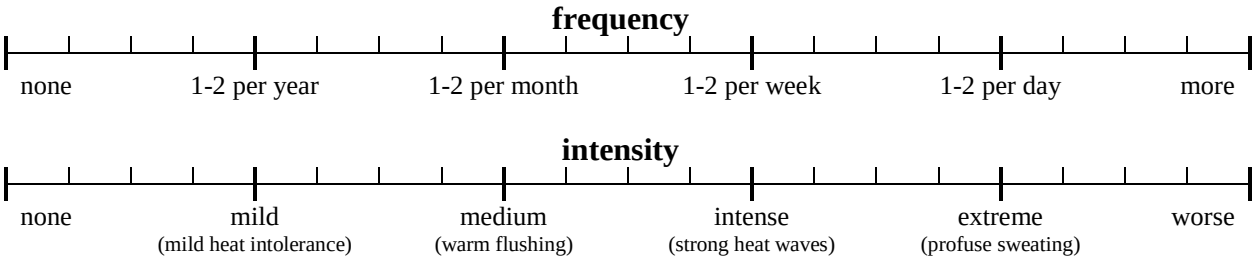
Urine leakage when bladder is too full? . . . . . □ Never □ occasionally □ often

Urine leakage when walking, running, jumping? □ Never □ occasionally □ often

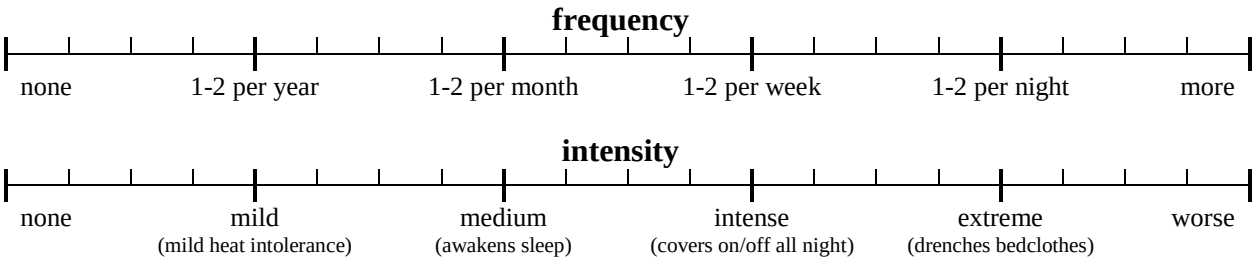
Check off the symptoms you are experiencing
(star any ones that are particularly bothersome):

□ Anxiety □ Depression □ Irritability □ Feeling like you're just not yourself
□ Weepiness □ Insomnia □ Achey joints □ Foggy thinking □ Poor memory
□ Poor word recall □ Weight gain □ Breast tenderness □ Heart Palpitations
□ Unusual skin sensations □ Headaches □ Water retention □ Dizziness

Hot Flashes: (mark appropriate level)



Night Sweats: (mark appropriate level)



Have you ever taken hormones before? Please list below along with doses and effects:

_____
_____
_____
_____

Have you tried anything natural to help with hormones? (ie; herbs, vitamins, homeopathy, etc.) Please list below along with doses and effects:

_____
_____
_____
_____

Sexual History

(This section can be omitted all or in part if you have no concerns
or are uncomfortable with any of the questions.)

Are you currently sexually active? □ Yes □ No

Partner is…□ male □ female

Vaginal Lubrication is:

□ Good □ Dry at times □ Dry all the time □ Not sure

Ability to orgasm:

□ Good
□ Never have experienced this in my life
□ Few and Far between
□ More difficult than in earlier times
□ No longer able to

Libido is:

□ Good
□ Low for me
□ Non-existent
□ Up and down

My partner's libido is:

□ More than mine □ less than mine □ about the same as mine

My libido:

□ Is not a big issue currently
□ Is lower, but I'm okay with it
□ Is a bit of a concern
□ Really bothers me and impacts my life negatively
□ I would like help in this area: □ Yes □ No

If libido is low, I believe these could possibly be some of the reasons why:
(check as many as you think may apply)

□ Hormonal imbalance □ Pelvic Pain □ Vaginal Dryness □ Fatigue
□ Ever since my hysterectomy □ Past abuse issues □ Other health issues
□ Antidepressants or other meds I am currently taking □ Help! I have not a clue
□ Relationship struggles □ Body image issues □ Other:_____

NATURE MEDICA
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Treatment Policy and Financial Agreement

Thank you for choosing us as your healthcare provider; we are committed to providing you with the best possible care. Please review the following, initial where indicated, and sign below.

Consent for Care and Treatment:
You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision, whether or not to undergo any suggested treatment or procedure after knowing any risks involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform an evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

Financial Policy:
Appointments: ***(Please Initial)***

_____ We have exclusively reserved the doctor, nurse or staff and facilities for your personal health care. Because of this, you may have been asked to provide a deposit to reserve your spot for certain appointments. Appointments which are missed or not cancelled with at least 24 hours notice (by end of the previous business day) will either forfeit their deposit or incur a cancellation fee of $25 to $60 depending upon the length of the appointment. Please call us right away if you are unable to keep an appointment. Simply not coming for an appointment or canceling on very short notice does not allow us to offer the time to someone else. The cancelation and no-show fees must be paid in full prior to your next appointment.

_____ If you have three or more cancelled, no-showed or a combination thereof in a 12 month period, you may be asked to pre-pay for your future appointments.

_____ We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in these instances may be waived, but only with managerial approval.

_____ While we offer you the courtesy of a reminder call, text or email, it is your responsibility to remember your scheduled appointment time. Non receipt of a reminder is not an excuse for a missed appointment.

Our practice firmly believes that a good physician/patient relationship is based-upon understanding and good communication. We are happy to discuss any questions you may have about our cancelation and no-show policy and fees.

Payments: ***(Please Initial)***

Unless payment arrangements have been made and approved in advance of scheduling your appointment, **payment is due in full at the time of service**. We accept cash, checks, Visa, MasterCard, Discover and American Express.

_____ Services here are considered self-pay. Our office does not bill insurance but, upon request, we will provide you with a receipt showing appropriate codes needed for you to submit a claim to your insurance yourself.

_____

Your insurance coverage is a contract between you and your insurance company. We are not a party to that contract, nor are we bound to any provisions set forth in that contract. All charges are your responsibility.

_____ We use laboratories that will bill most insurance companies (excluding Medicare and AHCCS). If you choose to have the Lab bill your insurance, this transaction is between you and the Lab. It is your responsibility to check with your insurance regarding their policy on coverage for labs and which lab they prefer you use.

_____ Medicare/Medicaid/AHCCS: Services provided to Medicare, Medicaid and AHCCS patients by a naturopathic physician or their staff **are not** covered by Medicare, Medicaid or AHCCS.

_____ Returned checks will be assessed a $25.00 fee. Additional re-billing and collection fees may be charged on accounts over 60 days. If your account reaches a point of delinquency that requires further collection action, an administrative fee of $50.00 will be added to your balance.

We realize temporary financial problems do arise and we encourage you to contact us promptly for assistance in the management of your account. Special arrangements can generally be made. We are here to help you.

Signature:

I voluntarily request a physician, or their designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements regarding NatureMedica's Treatment and Financial Policy and consent fully and voluntarily to its contents.

_____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative Relationship to Patient