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: ________________
Weight:________________
Ideal Weight: ___________
Blood Type: ____________

Do you smoke? ☐ Yes ☐ No
If so, how many cigarettes per day: ____
Drink alcohol? ☐ Yes ☐ No
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?

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