Austin's Favorite Pharmacy

CONFIDENTIAL CLIENT PROFILE

Today's Date: _____ Name_____ Age_____

Birthdate: _____Sex: _____ Weight: _____Height:_____ Occupation: _____

Please circle those that apply: Single Married Significant Other

Do you have children? Yes No Ages: _____

Live with: Spouse:____ Partner:____ Parents:____ Children:____ Friends:____ Alone:____

Phone Number: _____

May I contact you at this number? Yes No
May I leave a voice message for you at this number? Yes No

Personal Email address: _____

May I contact you at this email address? Yes No

Please complete this two sided questionnaire as thoroughly as possible. This is a confidential record and will not be released, except when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH AND WELLNESS CONCERNS

Please list most important health concerns in their order of significance	Prior diagnosis of this problem? If so, what?
1	
2	
3.	

What goals and/or expectations do you have for your visit today?

_____

_____

Please list any severe or life-threatening allergies: _____

Please list prescription and over-the-counter medications that you are currently taking, with dosages (if known):

1._____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

List natural supplements, herbs, remedies including athletic performance supplements you are currently taking, with dosages:

1. _____ 2._____ 3. _____

4. _____ 5. _____6. _____

Julia Strickler, ND julia@peoplesrx.com drjuliastrickler.com

DIET

What does your diet typically include:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

LIFESTYLE AND PERSONAL HABITS

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

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive?

How do you perceive your current state of health?

Do you follow any particular diet regimens or restrictions? If yes, please describe:

_____

Do you exercise at least 3 hours per week? Never Rarely Sometimes

Regularly Competitively

If yes, what type of exercise do you do?

_____

Do you have a regular spiritual, prayer, meditation, mindfulness or reflection practice? Yes No

If yes, please describe

_____

Do you smoke cigarettes/cigars or use nicotine gum? Yes No How much/often?_____

How would you rate your stress level? (1= Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

How would you rate your stress handling? (1=Poor, 10= Excellent) 1 2 3 4 5 6 7 8 9 10

In the past year, have you had one or more major stressors- for example, changed or lost your job, got separated or divorced, moved, or lost a loved one? Yes No

During the last year, stress in your life has had:

◯ Significant impact on your health
◯ Some impact on your health
◯ No impact on your health

Which statement is closest to the truth regarding your support system:

◯ I have lots of friends, family, or others with whom I am quite open and readily share personal information
◯ I talk to friends, family, or others from time to time about personal information.
◯ I rarely tell friends, family members, or anyone what is going on in my life or what I am thinking or feeling.
◯ I don't have any family or friends around with whom I can talk.

Do any of the following statements apply to you (check all that apply):

- ◯ I feel tired and have no energy much of the time
- ◯ I perceive myself as worthless and don't like myself
- ◯ I feel guilty much of the time
- ◯ I have a hard time concentrating
- ◯ I often feel agitated, restless, or irritable
- ◯ I often feel hopeless and helpless
- ◯ None of the above

Do any activities and situations give you pleasure? (examples include movies, theatre, sports, sex, being with friends or family, hobbies, etc.)

- ◯ Yes, I enjoy many things in my life
- ◯ Sometimes I enjoy activities in my life but other times I don't enjoy them
- ◯ There are many times when nothing will make me happy
- ◯ No, I do not enjoy things in my life. I tend to withdraw and not participate in activities
- ◯ None of the above

Do you feel depressed a lot or have you had significant depression in the past? Yes No

How much alcohol do you drink?

- ◯ Don't drink
- ◯ Less than 1 drink per day
- ◯ 1-2 drinks per day
- ◯ 3 or more drinks per day

Do you eat 5-9 servings of fruits and vegetables each day? (One serving is equivalent to a medium-sized apple, pear, or orange; a small banana; or a half-cup of a vegetable like lettuce or broccoli)

- ◯ Always
- ◯ Usually
- ◯ Sometimes

How often do you eat red meat, cheese, fried foods or other high fat foods?

- ◯ Everyday
- ◯ Most days
- ◯ Some days
- ◯ Never

Do you suffer from body aches, joint pain, or backache? Yes No *If so, is the pain:* mild moderate severe

Do you have any cravings? Yes No
If so, are your cravings for: sweets/carbs caffeine/stimulant salt

Do you suffer from headaches or migraines? Yes No *If so, are the headaches:* mild moderate severe

Do you have any digestive issues (constipation, gas/bloating, loose stools, irritable bowel, acid reflux, etc.)? Yes No

How likely are you to consider exercising more or eating better in the near future?

- ◯ I am not currently considering it
- ◯ I am considering it, but don't know how to start
- ◯ I have thought of how to do it and am going to start soon
- ◯ I just started in the past month
- ◯ I have already been exercising and eating healthfully for a long time

Do you tend to overeat? Always Sometimes Never Only under times of stress

When was your last time you saw your MD? ◯ Within the last year ◯ Between 1 and 2 years ago ◯ More than 2 years ago

When was your last routine bloodwork? ◯ Within the last year ◯ Between 1 and 2 years ago ◯ More than 2 years ago

When was your last dental exam? ◯ Within the last year ◯ Between 1 and 2 years ago ◯ More than 2 years ago

What is your total cholesterol? ◯ <200mg/dL ◯ 200mg/dL – 240mg/dL ◯ >240mg/dL ◯ >200mg/dL but I am on medication ◯ Don't know

Julia Strickler, ND julia@peoplesrx.com drjuliastrickler.com

What is your HDL cholesterol? ◯<40mg/dL ◯40 – 59 mg/dL ◯60mg/dL or above ◯Don't know

What is your blood pressure? _____ ◯Don't know

Do you know your most recent fasting blood sugar level? _____ ◯Don't know

Do you have a close family member (parent, grandparent, sibling, or child) who has diabetes? Yes No Not sure

Have you been screened for colon cancer by colonoscopy or other diagnostic method? Yes No Not sure

Do you have a close family member (parent or sibling) who was diagnosed with colon cancer before age 60 or do you have a personal history of colon polyps or inflammatory bowel disease (Crohn's disease or ulcerative colitis)? Yes No Not sure

Do you examine your skin for new or changing lesions on a monthly basis? Yes No Not sure how

Female only: Do you have a close relative (mother, sister, daughter) who has had breast cancer?

◯Yes and this relative was diagnosed after age 50
◯Yes and this relative was diagnosed before age 50
◯No

When was your last mammogram or thermography screening?

◯Within the last year
◯More than 1 year ago
◯I have never had either screening

SLEEP HABITS

How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia

How long has this been happening? _____

How many hours do you sleep each night on average? _____

Do you wake up tired? Yes No How long has this been happening? _____

Is your room completely dark when you sleep at night? (no night light, street lamp, TV, etc.) Yes No

Do you get at least 30 minutes of outside daylight time, several days each week? Yes No

Peoples Rx Wellness Consultation Policy

Cancellation Policy

There is a $50 charge for cancellations of less than 24 hours or failure to show up for a scheduled appointment.

E-mail Policy

E-mail may be used for answering brief, clarifying questions at your practitioner's discretion. If you are e-mailing about a new or more detailed concern, you will be asked to schedule a phone or office consultation to ensure effective communication and comprehensive care.

ND Consultation Fees

Initial Consultation is typically 60 minutes for 1-2 primary concerns. Follow-up visits typically range from 30-60 minutes.
90 minutes $195.00
60 minutes $145.00
30 minutes $85.00

Phone Consultation Fees (available *for established clients)* No charge: < 5 minutes

$ 40 for 15 minutes
$ 85 for 30 minutes
$ 125 for 45 minutes
$ 145 for 60 minutes

Costs of any laboratory tests are paid directly to the lab and do not include the fee for follow-up consultation to discuss the results.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosure of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

   Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that physician has the necessary information to diagnose or treat you.

   Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health care plan to obtain approval for the hospital admission.

   Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a

sign-in sheet at the registration desk where you will be asked to sign your name and indicated your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health Issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Privacy Notice Acknowledgement Form

The Federal Health Insurance and Portability and Accountability Act (HIPAA) regulates how health care providers may use and disclose health information, and also requires that patients be notified of the provider's privacy practices.

I, _____ (Printed Name of Patient or Patient's Representative), acknowledge receipt of the "Privacy Notice Acknowledgement Form" and "Wellness Consultation Policies".

_____ _____ Signature (Patient or Patient's Representative)
Date

Complementary and Alternative Health Client Bill of Rights

As a valued client, it is important that you are fully aware of the laws surrounding Naturopathic Medicine. If you have any questions or concerns please talk with myself, Dr. Julia Strickler, N.D. I will be more than happy to discuss them with you.

The state of Texas does not regulate Naturopathic Doctors, or the use of the title "N.D." For this reason it is especially important to verify your Naturopathic Doctor's training and certification. I attended a fully accredited four-year post graduate program at Bastyr Univeristy in Seattle Washington. I passed national board exams in the and I hold a current and valid Vermont license (VT lic 099.0074462). Texas does not license Naturopathic Doctors at this time.

Due to lack of State licensing in Texas, I am not legally able to prescribe pharmaceutical drugs, perform minor surgeries, administer injections, diagnose or treat disease. I AM able to use natural methods like supplements, homeopathy, herbs and lifestyle changes to improve your health as a whole person. The goal is to increase your overall health and vitality as a whole person thereby decreasing the symptoms you suffer and encouraging vibrant health. If you are interested in learning more about naturopathic medicine and current licensing efforts please see our national association, the AANP at www.naturopathic.org or our state association, TXAND at www.txand.org.

I stand firmly behind the quality of care you will receive. Please do not hesitate to ask questions or give feedback. I look forward to being your partner in health.

Peoples Rx Wellness Consultation Consent Form

I hereby understand, agree, and attest to the following:

1. I fully understand that the Wellness Consultant I am seeing in this office is not a physician, and I am not consulting for medical, diagnostic, or treatment procedures. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a license is required.
2. Since the Wellness Consultant is not a medical doctor or primary care physician, it is recommended that I continue services with my primary care physician.
3. The services offered by the Wellness Consultant are at all times restricted to helping me gain a better understanding of 'health' (not disease), so that I will have greater self-awareness and be able to use a self-care plan for daily living.
4. The wellness plan offered (which may include discussion and or sale of nutritional supplements, nutrition and lifestyle modifications, homeopathic remedies, vitamins, minerals, food grade herbs, and other dietary supplements) pertains to the whole body concept of nutrition rather than addressing a specific ailment or condition.
5. The Wellness Consultant does not provide emergency or after-hours care. In the event of an emergency, I will dial 911 or proceed to the nearest emergency room.
6. Laboratory testing may be conducted for screening purposes only and does not constitute a diagnosis of any medical condition. It is my responsibility to follow up with a medical doctor if any of the lab results are abnormal.
7. Women who are pregnant or planning pregnancy must inform their Wellness Consultant, as this will likely alter the recommendations that are made.
8. Since they are not prescribing physicians, the Wellness Consultants will not be able to advise me to discontinue or change doses of my medications. I am advised to consult with my prescribing physician concerning any modifications of my pharmaceutical medications.
9. Potential benefits of following a wellness plan include health optimization, symptomatic relief, and disease prevention. Potential risks include rare allergic reactions, paradoxical reactions to supplements (example: valerian is a relaxing herb for most people, but it is stimulating in some people), and drug-supplement interactions. Although there is a growing body of information regarding such interactions, I understand that not all drug-supplement interactions are known at this time.
10. There are wide individual differences in response to a wellness plan, and no guarantees are made that I will gain any benefit nor suffer any adverse consequences. 11. While I may experience immediate benefits from the wellness plan, I understand that the most effective results will occur when I make a long-term commitment to rebuild my health, which will likely involve some lifestyle modifications.

_____ _____

Signature of Client or Client's Representative Printed Name of Client or Client's Representative

Phone Number:(_____)_____-_____

Date: _____

Referred By: _____

ARBITRATION AGREEMENT for Dr Julia Strickler, ND

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover noneconomic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the People's Rx Wellness Center 512.219.8600 www.peoplesrx.com Peoples Wellness Center fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here_____. Effective as the date of first professional services.
If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____

Patient Signature (or representative) Relationship to Patient Date

_____ _____

Office Signature Date