Austin's Favorite Pharmacy

Wellness Consultation Policies

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

Email Policy: Email may be used for answering brief clarifying questions at your practitioner's discretion. If you are emailing 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.

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.

Consultation Fees:

Practitioner	90 minutes	60 minutes	30 minutes	15 minutes
PharmD, DC, or ND	$195	$145	$85	$30
Classical Homeopath, CCN, L.Ac., MS, RD, or RN	N/A	$110	$75	N/A
ACN, Ayurvedic, Certified Herbalist, NA, or LMT	N/A	$85	$55	N/A
Chiropractic Adjustment	$40 per visit			

Austin's Favorite Pharmacy

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.

PEOPLES Rx
Austin's Favorite Pharmacy

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

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: _____

whole health solutions
personalized natural wellness

Amy K. Tyler, N.D
Naturopathic Doctor

Confidential Health Questionnaire

Please fax (512.215.9495) or email (amy@amytylernd.com) your completed forms at least 24 hours prior to your appointment, if possible. Otherwise, please bring your completed forms with you to your appt.

Since Texas does not license Naturopathic Doctors, Amy Tyler, ND cannot prescribe pharmaceutical drugs, diagnose, or treat disease in the state of Texas. For this reason, if you choose to consult with Amy Tyler, ND, it is recommended that you also continue services with your primary care physician.

General Client Information

Name: _____

Today's Date: _____

Nickname / Preferred Name: _____

Date of Birth: _____ Age: _____

Gender:_____ Ethnicity: _____

♀ Are you pregnant, planning, or lactating? _____

Phone # that I may contact you at: _____

Email address that I may contact you at:_____

Home Address:_____

_____

Name of general doctor: _____Phone #:_____

Name of other provider/specialist:_____ Phone#:_____

Primary Health Concerns: *Please prioritize 1 or 2 health concerns that you would like to address during your first appointment.*	*If applicable, list prior approaches related to your concerns:*		
	Prior Diagnoses	Prior Labs/Imaging	Prior Treatments
1)			
2)			

Note: *If there is an extensive history associated with your health concern(s), please attach a separate piece of paper with a timeline of events, including symptoms, diagnoses, lab tests, treatments- what has helped & what hasn't, etc*

Please list other health concerns or symptoms that you are experiencing:_____
_____

What expectations/goals do you have for your ***first*** consultation?_____
_____

What are your ***long-term*** health goals while working with us?_____
_____

What behaviors or lifestyle habits do you engage in regularly that you believe support your health? *(please list)* _____
_____

What behaviors or lifestyle habits do you engage in regularly that you believe are destructive to your health? *(please list)* _____
_____

To what extent are you open to addressing & changing lifestyle habits that may be contributing to your symptoms? *Please circle:*
(least open) 1 2 3 4 5 (most open)

What potential obstacles do you foresee in addressing the lifestyle factors and following recommended therapeutic protocols?
_____

When did you last feel completely well?_____ Any significant events in the 6 months prior to becoming unwell?
(mention anything, even if it seems unrelated) _____

Any ideas about what triggered or caused your symptoms?_____
_____

Confidential Health Questionnaire

Medications & Supplements

Current Prescriptions, Over-the-Counter Medications, & Supplements ***(include oral, topical, and suppositories):***

Please don't forget commonly used items such as antacids, aspirin, pain-relievers, & multivitamins

Name of Product (Include brand for supplements)	Date Started	Prescribed by (Dr.'s name or Self)	Reason for taking	Dosage ex. *drugs*: 100 mg *supplements*: 2 capsules, 1 tsp, etc	Frequency Ex. 3 x/day	Has it helped?

Do you have a history of extensive use of any of the following (please check):
€Antibiotics €Steroids (prednisone, cortisone, etc) €Hormone Therapy *If Yes, please explain:*_____
_____

Please ***circle*** the forms of supplements/medications that you prefer, and ***put an 'X'*** through any that you definitely do not like:
•No preference •Capsules •Tablets •Liquids •Powders •Tinctures (alcohol-based) •Teas • I have difficulty taking supplements •Other:___

Past Medical History

Allergies & Sensitivities *Please list all substances that you react adversely to (even if the reaction is minor):*

	Substance & Type of Reaction (ex. peanuts → hives & breathing difficulty):
Food	
Medicines & Supplements	
Environmental (dust, trees, etc)	
Other	

Have you ever experienced a life-threatening allergic reaction? Y / N *If Yes, Please explain:* _____
_____

Hospitalizations, Surgeries, & Major Illnesses *(remember to include infections such as Mono, Lyme Dz & surgeries such as removal of appendix, gallbladder, tonsils, as well as hysterectomies):*

Age or Year	**Condition or Procedure**	**Any ongoing problems related to this?**

Did you receive vaccinations as a child? Y / N As an adult? Y / N Any adverse reactions? Y / N / Maybe

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Confidential Health Questionnaire

Past Medical History Continued

Please list major childhood illnesses, with approximate age (include chronic/frequent infections such as strep throat & ear infections):

_____

Screening Exams *Please check exams, labs, & imaging which you have received & indicate date of most recent:*

	√	Date	Normal Results?		√	Date	Normal Results?
Physical Exam	☐		☐ Yes ☐ No	Bone Density Scan (DEXA)	☐		☐ Yes ☐ No
Cholesterol / Lipids	☐		☐ Yes ☐ No	Mammogram ♀	☐		☐ Yes ☐ No
Blood Sugar	☐		☐ Yes ☐ No	Pap Smear ♀	☐		☐ Yes ☐ No
Colon Cancer Screening				Prostate Check ♂			
Colonoscopy	☐		☐ Yes ☐ No	PSA	☐		☐ Yes ☐ No
Sigmoidoscopy	☐		☐ Yes ☐ No	Digital rectal exam	☐		☐ Yes ☐ No
Fecal Occult Blood	☐		☐ Yes ☐ No				
EEG (Brain study)	☐		☐ Yes ☐ No	CT Scan / MRI for:_____	☐		☐ Yes ☐ No
EKG/ECG (Heart study)	☐		☐ Yes ☐ No	X-ray for:_____	☐		☐ Yes ☐ No
HIV/STD Screen	☐		☐ Yes ☐ No	Ultrasound for:_____	☐		☐ Yes ☐ No
Skin Cancer Screening	☐		☐ Yes ☐ No	Other: _____	☐		☐ Yes ☐ No

Family History

* ♀= Maternal Grandparents * ♂= Paternal Grandparents	Father	Mother	Grandmother *		Grandfather *		Sibling 1	Sibling 2	Child	Self
			♀	♂	♀	♂				
Age (if living):										
Health: G= Good; F= Fair; P=Poor										
Age at death:										
Cause of death:										
Please check all that apply:										
Alcohol/drug addiction										
Allergies/eczema										
Alzheimer's Dz or dementia < age of 70										
Asthma										
Autoimmune Dz										
Cancer (list type)										
Celiac Dz										
Colitis / Crohn's										
Depression										
Diabetes										
Epilepsy										
Heart Disease										
↑ Blood Pressure										
↑ Cholesterol										
Kidney Disease										
Liver Disease										
Mental Illness (specify)										
Stroke										
Other:										

Do any other significant medical conditions or symptoms run in, or are present in, your family? _____

_____

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Confidential Health Questionnaire

Review of Symptoms

Please Circle As Follows: Y= a condition you have now, P= a condition you had in the past, N=no *(note: for past problems, only circle if they were significant*. For example, everyone has had a cough due to a cold, so you don't need to circle this unless it was significant or recurrent).

General

Weight _____
Weight 1 yr. Ago _____
Maximum Weight _____
(when was this) _____
Desired Weight _____
Height _____
Fatigue Y P
Fever / Chills Y P
Night Sweats Y P
Unintentional weight
Gain or weight loss Y P
Sensitive to:
Smells/chemicals Y P
Light/noise Y P
Alcohol/medications Y P
Change in thirst? Y N
Change in appetite? Y N

Skin, Hair, Nails

Rashes, hives Y P
Eczema Y P
Psoriasis Y P
Acne Y P
Itching Y P
Dry Skin Y P
Brittle Hair & Nails Y P

Eyes

Impaired Vision Y P
Glasses/contacts Y P
Eye Pain Y P
Tearing or dryness Y P
Double vision Y P
Glaucoma Y P
Cataracts Y P
Poor Night Vision Y P
Dark circles under eyes Y P

Ears

Impaired hearing Y P
Ringing in ears Y P
Earache Y P
Dizziness Y P

Nose & Sinuses

Nose bleeds Y P
Stuffiness/Congestion Y P
Hayfever (seasonal
allergies) Y P
Post-Nasal Drip Y P

Mouth and Throat

Frequent sore throat Y P
Thrush Y P
Gingivitis Y P
Hoarseness Y P
Dental cavities Y P
# of amalgam fillings: _____
Root Canals Y P

Other:

_____
_____
_____
_____
_____

Respiratory

Cough, dry Y P
Couch, productive Y P
Spitting up blood Y P
Wheezing Y P
Asthma Y P
Emphysema Y P
Bronchitis/Pneumonia Y P
Difficulty breathing Y P
Pain on breathing Y P
Shortness of breath Y P
- with exertion Y P
- at night Y P
- lying down Y P
Tuberculosis Y P

Cardiovascular

Heart Disease Y P
Stroke Y P
Angina (Chest Pain) Y P
Chest Tightness Y P
High Blood Pressure Y P
Low Blood Pressure Y P
High Cholesterol Y P
Murmurs Y P
Rheumatic fever Y P
Swelling in ankles Y P
Palpitations, fluttering Y P

Peripheral Vascular

Deep leg pain Y P
Cold hands/feet Y P
Varicose veins Y P
Thrombophlebitis Y P
Deep Vein
Thrombosis Y P

Gastrointestinal

Trouble swallowing Y P
Heartburn Y P
Nausea Y P
Vomiting Y P
Vomiting blood Y P
Bloating Y P
Abdominal Pain Y P
Irritable Bowel Y P
Belching Y P
Flatulence (gas) Y P
Jaundice (yellow skin) Y P
Liver Disease Y P
Gall Bladder disease Y P
Ulcers Y P
Anal Pain or Itching Y P
Hemorrhoids Y P

Bowel movements

How often? _____
Is this a change? _____
Blood in stool Y P
Mucous in stool Y P
Undigested food in stool Y P
Black stool Y P
Constipation Y P
Straining w/BM Y P
Diarrhea / Loose Stool Y P
Greasy/Fatty Stool Y P
Laxative Use Y P

Urinary

Pain on urination Y P
Increased frequency Y P
Increased urgency Y P
Wake to urinate? Y P
If Y, ____ # x /night
Inability to hold urine Y P
Bladder infections Y P
Kidney Stones Y P
Kidney Infections Y P
Blood In Urine Y P
Pelvic Pain Y P

Female Reproductive

Age menses began _____
Days period lasts _____
Days/cycle (e.g. 28) _____
Bleeding between periods Y P
Are cycles regular Y N
PMS Y P
Painful menses Y P
Excessive flow Y P
Diminished Flow Y P
Endometriosis Y P
Facial Hair Growth Y P
Ovarian Cysts Y P
Polycystic Ovaries Y P
# of pregnancies _____
# of live births _____
# of miscarriages _____
# of abortions _____
Difficulty conceiving Y P
Menopausal
symptoms Y P
Age at Menopause _____
Sexually active? Y N
Birth Control Y N
What type? _____
Practice safe sex? Y N
Pain w/ intercourse Y P
Sexual difficulties Y P
STDs Y P
Sexual preference:
Heterosexual _____
Bisexual _____
Homosexual _____

Breasts

Monthly Self Exams? Y N
Lumps Y P
Pain/tenderness Y P
Nipple Discharge Y P

Male Reproductive

Hernias Y P
Testicular masses Y P
Testicular pain Y P
Prostate problems Y P
Sexually active? Y N
Practice safe sex? Y N
Sexual difficulties Y P
STDs Y P
Discharge or sores Y P
Sexual Preference:
Heterosexual _____
Bisexual _____
Homosexual _____

Musculoskeletal

Joint pain or stiffness Y P
Arthritis:
Rhematoid Arthritis Y P
Osteoarthritis Y P
Muscle spasm/cramps Y P
Trauma / Accident Y P
Swelling Y P
Osteopenia/porosis Y P
Broken bones Y P
Sciatica Y P
Fibromyalgia Y P

Neurologic

Fainting Y P
Seizures Y P
Paralysis Y P
Muscle weakness Y P
Numbness or
tingling Y P
Loss of memory Y P
Vertigo Y P
Head Injury Y P
Headache Y P
Concussion Y P

Mental / Emotional

Depression Y P
Mood Swings Y P
Anxiety or
nervousness Y P
Panic Attacks Y P
Alcoholism Y P
Drug Dependency Y P
Eating disorder Y P
Mental Fog Y P
Attention deficit Y P
Take Vacations Y N
Watch TV (hours/day) _____
Read (hours/day) _____

Endocrine

Hypothyroid / ↓function Y P
Hyperthryoid / ↑function Y P
Heat or cold
intolerance Y P
Excessive thirst Y P
Excessive hunger Y P
Hormone Therapy Y P
Diabetes or pre-
Diabetes Y P
Hypoglycemia Y P

Blood / Immune

Anemia Y P
Easy bleeding or
bruising Y P
Blood Transfusions Y P
Swollen glands/ lymph
Nodes Y P
Tick Bites Y P
Lyme Disease Y P
Mono / Epstein-Barr Y P
Cancer Y P
HIV / AIDS Y P
Autoimmune Disease Y P

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Confidential Health Questionnaire

Lifestyle

Diet & Habits

How often do you consume the following? **Key: 0=never, 1=rarely (1-4x/month), 2=often (2-4x/week), 3=regularly (5-7x/week)**

Water	___ cups / day	Fast food (lighter choices)	0 1 2 3	Yogurt	0 1 2 3
Coffee	___ cups/day	White flour (bread, pastry)	0 1 2 3	Cheese	0 1 2 3
Tea (type:_____)	___ cups/day	White Rice	0 1 2 3	Eggs	0 1 2 3
Soda	0 1 2 3	Whole grains & Brown Rice	0 1 2 3	Chocolate	0 1 2 3
Fruit Juice	0 1 2 3	Fish	0 1 2 3	Sweets (candy, cookies, cake)	0 1 2 3
Fruit	0 1 2 3	Poultry	0 1 2 3	Salty snacks (chips, pretzels)	0 1 2 3
Vegetables	0 1 2 3	Red meat	0 1 2 3	Artificial sweeteners*	0 1 2 3
Legumes, beans	0 1 2 3	Unfermented soy (soy milk)	0 1 2 3	Alcohol	___ drinks/wk
Nuts / Seeds	0 1 2 3	Fermented soy (tofu, tempeh)	0 1 2 3	Cigarettes/tobacco	___ packs/day ___ # years
Fast food (fried)	0 1 2 3	Milk, cream	0 1 2 3	Recreational Drugs	Type:_____ Frequency:_____

** Artificial sweeteners include aspartame (nutrasweet), saccharin, and sucralose; they're found in diet sodas & other sugar-free foods.*

Are you a vegetarian or vegan? Y / N If Yes, what type and for how long? _____

Do you currently follow any 'named' diets (i.e. Atkin's, South Beach, etc)? Y / N If Yes, which one? _____

Do you avoid any foods or food groups (i.e. dairy, gluten-containing foods, etc)? Y / N If Yes, please list foods & reasons:

_____

List specific foods that you crave (♀-put a star next to foods craved premenstrually): _____

_____

Please list typical meals/foods consumed throughout the day:

Breakfast:	Dinner:
Lunch:	Snacks:

Do you feel that you have a healthy relationship with food? Y / N If No, Please Explain: _____

_____

Sleep

Average hours of sleep per night: ____ hours/night Typical bedtime: _____ Typical 'wake time':_____

***Please check all sleep issues that apply*:**

☐ trouble falling asleep initially	☐ pain or physical disorder prevents sleep	☐ partner complains that I snore
☐ waking up too early in am	☐ restless legs	☐ sensitive to noise/light/environmental stimuli (including snoring partners)
☐ waking unrefreshed & irritable	☐ grinding teeth	☐ racing thoughts preventing sleep
☐ very sleepy during day	☐ reflux or heartburn	☐ procrastinating going to sleep
☐ frequent waking during the night to urinate	☐ waking up gasping for air	

Exercise

Please list typical activities in a usual week:

Type of exercise:	# of days per week	Duration per session:	Indoors (I) or Outdoors (O)

Energy Level

What time of day is your energy best? _____ Worst? _____

Rate your stress level: *Circle:* 0 1 3 4 5 (most stress) Rate your energy level: *Circle:* 0 1 2 3 4 5 (most energy)

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Confidential Health Questionnaire

Social & Environmental History:

Work Occupation:_____ Employer: _____ Hrs/Week of Work (Avg):_____

Please check any of the following stressors that apply to your occupation:

□ chemical/toxin exposure □ heavy lifting □ prolonged standing/walking □ computer work □ high stress □ graveyard shift

□ long hours □ difficulties with coworkers □ other:_____

How do you feel about your job/career?_____

Environment

Have you had any toxic environmental exposures in your lifetime? Y N Maybe If Yes or Maybe, please explain:_____

_____

Do you buy any organic produce? □ never □ rarely □ often □ mostly □ always

Do you buy hormone-free & antibiotic-free meat, poultry, and dairy? □ never □ rarely □ often □ mostly □ always

Do you frequently encounter chemicals or toxins with any of your hobbies (i.e. insecticides w/ gardening, lead solder, etc)? Y / N

If yes, please explain:_____

Support & Emotional Health

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

_____

Are you content with your relationships and support system? _____

Are you: □ married □ separated □ divorced □ widowed □ significant partner □ single □ other:_____

Live with: □ spouse □ partner □ relatives □ friends □ parents □ kids □ alone □ pets:_____ □ other:_____

Please list any children and their ages: _____

Do you feel safe in your living environments (home, work, school, etc)? □ Yes □ No

Is there anyone in your life whom you are afraid of? □ Yes □ No

What are some of your main hobbies & interests? _____

What brings you joy in life? _____

What are some of your current challenges in life? _____

What do you do to relieve stress?_____

Please list any predominant emotions that you have felt lately: _____

Please list 5 important events in your life from most recent to most distant:

1.) _____ Date/Age: _____ / _____
2.) _____ Date/Age: _____ / _____
3.) _____ Date/Age: _____ / _____
4.) _____ Date/Age: _____ / _____
5.) _____ Date/Age: _____ / _____

Is there anything else that you want me to know about you? _____

_____

Thank you very much for taking the time to fill out this form! If possible, please return this form via fax, email, or regular mail 3 days prior to our appointment so that I may review it ahead of time. Otherwise, please bring your completed form with you to the pharmacy for your first appointment.

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personalized natural wellness

Amy K. Tyler, N.D
Naturopathic Doctor

Confidential Pediatric Health Questionnaire

Please fax (512.215.9495) or email (amy@amytylernd.com) your completed forms at least 24 hours prior to your appointment, if possible. Otherwise, please bring your completed forms with you to your appt.

Since Texas does not license Naturopathic Doctors, Amy Tyler, ND cannot prescribe pharmaceutical drugs, diagnose, or treat disease in the state of Texas. For this reason, if you choose to consult with Amy Tyler, ND, it is recommended that you also continue services with your primary care physician.

General Patient Information

Patient's Name: _____

Nickname / Preferred Name: _____

Date of Birth: _____ Age: _____

Today's Date: _____

Gender: _____ Ethnicity: _____

Pediatrician Name: _____

Pediatrician Phone #: _____

Date of last physical exam:_____

Parent/Guardian Name(s): _____

Address: _____

Phone: Home:_____ Cell:_____ Work:_____

Email address:_____

How do you prefer to be contacted? €Home €Cell €Work €Email

Is it okay to leave a message? €Home €Cell €Work

Please list any specialists that your child has seen:

Dr.'s Name: _____ Specialty: _____

Dr.'s Name: _____ Specialty: _____

Primary Health Concerns:	*If applicable, please list prior approaches related to your concerns:*		
	Prior Diagnoses	Prior Labs/Imaging	Prior Treatments

What expectations/goals do you have for your ***first visit*** to our clinic?_____

_____

What are your ***long-term*** goals while working with our clinic?_____

_____

Are there any lifestyle factors (i.e. food, sleep, stress, family dynamics, etc) that you believe may be contributing to your child's health issues? *(please list)*_____

_____

To what extent are you open to addressing & changing lifestyle factors that may be contributing to your child's symptoms? *circle:*

(least open) 1 2 3 4 5 (most open)

When did your child last seem completely well?_____

Any significant events in the 6 months prior to becoming unwell?*(mention anything, even if it seems unrelated)* _____

_____

Any ideas about what triggered or caused your child's symptoms?_____

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Medications & Supplements

Current Prescriptions, Over-the-Counter Medications, & Supplements ***(include oral, topical, and suppositories):***

Name of Product (Include brand for supplements)	Date Started (approximate)	Prescribed by (Dr.'s name or Self)	Reason for taking	Dosage ex. *drugs*: 100 mg *supplements*: 2 capsules, 1 tsp	Frequency Ex. 3 x/day	Has it helped?

Does your child have a history of extensive antibiotic use or steroid use? *If Yes, please explain:*_____
_____

Please ***circle*** the forms of supplements/medications that your child prefers, and ***put an 'X'*** through any that he/she definitely does not like: •No preference •Capsules •Tablets •Liquids •Powders •Tinctures (alcohol-based) •Teas • My child has difficulty taking supplements •Other:_____

Past Medical History

Allergies & Sensitivities *Please list all substances that your child reacts adversely to (even if the reaction is minor):*

	Substance & Type of Reaction (ex. peanuts → hives & breathing difficulty):
Food	
Medicines & Supplements	
Environmental (dust, trees, etc)	
Other	

Has your child ever experienced a life-threatening allergic reaction? Y / N *If Yes, Please explain:* _____
_____

Hospitalizations, Surgeries, & Major Illnesses

Age	Condition or Procedure	Any ongoing problems related to this?

Immunizations *Please check all vaccinations that your child has received:*

☐ mmr (measles, mumps, rubella) ☐ dpt (diphtheria, pertussis, tetanus) ☐ chicken pox (varicella) ☐ smallpox

☐ measles (isolated) ☐ diphtheria (isolated) ☐ H. Influenza ☐ hepatitis B

☐ mumps (isolated) ☐ tetanus (isolated) ☐ rubella (isolated) ☐ polio

☐ other

Did your child experience any adverse reactions to any of the above vaccines? ☐ yes ☐ no If yes, please list vaccine(s) and type of reaction:_____
_____

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Family History

Is your child adopted? € yes € no

Please check any health issues experienced by members of your family:

€ alcoholism/drug Addiction	€ autoimmune Disease	€ depression	€ learning disability
€ allergies	€ bleeding disorder	€ diabetes	€ mental illness
€ arthritis	€ cancer	€ heart disease	€ tuberculosis
€ asthma	€ celiac disease	€ high blood pressure	

Do any other significant medical conditions or symptoms run in, or are present in, your family? _____
_____

Please list the members of your household, including ages of any other children:

_____

Do you have any family pets? Please list:_____

Review of Symptoms

Please circle as follows: Y = condition your child has currently P = condition your child had in the past*

(*note: for past problems, only circle if they were significant. For ex., everyone has had a cough due to a cold, so you don't need to circle it unless it was recurrent or significant.)

General			***Nose / Sinuses / Mouth***			***Gastrointestinal***		
Weight	_____		Frequent colds	Y	P	Nausea/vomiting	Y	P
Height	_____		Nose bleeds	Y	P	Abdominal Pain / colic	Y	P
Fatigue	Y	P	Stuffiness	Y	P	Flatulence / belching	Y	P
Fever / Chills	Y	P	Sinus problems	Y	P	Jaundice	Y	P
Night Sweats	Y	P	Seasonal allergies			Anal itching	Y	P
Skin & Hair			(hayfever)	Y	P	Diaper Rash	Y	P
Eczema	Y	P	Frequent sore throat	Y	P	Constipation	Y	P
Psoriasis	Y	P	Teething Pain	Y	P	Loose Stools/Diarrhea	Y	P
Rashes / Hives	Y	P	Cold Sores	Y	P	Straining with BM	Y	P
Hair Loss	Y	P	Dental Cavities	Y	P	Blood or Mucous in stool	Y	P
Itching	Y	P	# of amalgam fillings	_____		# BM per day	_____	
Dandruff	Y	P	Thrush	Y	P	Excessive thirst / hunger	Y	P
Lice	Y	P	***Respiratory / Throat***			Loss of appetite	Y	P
White Spots on Nails	Y	P	Cough	Y	P	***Genitourinary***		
Ridges on Nails	Y	P	Wheezing	Y	P	Bed wetting	Y	P
Head / Eyes / Ears			Asthma	Y	P	Urinary tract infection	Y	P
Headaches	Y	P	Bronchitis	Y	P	Burning/difficult		
Head Injury	Y	P	Pneumonia	Y	P	urination	Y	P
Impaired Vision	Y	P	Croup	Y	P	Kidney disease	Y	P
Dark circles under eyes	Y	P	Strep throat	Y	P	Blood in urine	Y	P
Impaired Hearing	Y	P	Tonsillitis	Y	P	♀ Yeast infections	Y	P
Ear infections	Y	P	***Cardiovascular***			♂ Undescended testicles	Y	P
Excessive ear wax	Y	P	Heart murmur	Y	P	***Mental/Emotional***		
Ringing Ears	Y	P	Rheumatic Fever	Y	P	Insomnia / sleep issues	Y	P
Earaches	Y	P	***Miscellaneous:***			Anxiety	Y	P
Musculoskeletal			Scarlet fever	Y	P	Nightmares	Y	P
Joint pain/swelling	Y	P	Roseola	Y	P	Behavioral Disorder	Y	P
Broken Bones	Y	P	Chicken pox	Y	P	***Neurological***		
Muscle pain/cramps	Y	P	Anemia	Y	P	Dizzy spells	Y	P
Scoliosis	Y	P	Easy bruising	Y	P	Seizures	Y	P
Trauma /accident	Y	P	Bleeding tendency	Y	P	Motor Problems	Y	P

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Prenatal & Birth History

Prenatal History

Mother's age at child's birth: _____

Mother's health during pregnancy: *(check any health issues that were present)*

€ bleeding
€ illnesses: _____
€ strep B
€ diabetes
€ Rh incompatibility
€ nausea
€ high blood pressure
€ thyroid problems
€ physical or emotional trauma
€ stress and anxiety
€ cigarette, alcohol, drug consumption
€ medications:_____
€ other: _____

Birth History

Term: full / premature / late Height at birth: _____ Weight at birth:_____

Length of Labor:_____

Complications? _____ Please check: €vaginal birth €c-section

Did your child have any of the following after birth? *Please check*

€ rashes €blue baby €colic €birth injuries
€ cerebral palsy €seizures €fever €difficult feeding

Other: _____

Age began: sitting _____ crawling _____ talking _____ walking _____

Nutrition

Is/was your child: €breastfed €formula-fed €both What type of formula? €milk €soy €other:_____

At what age was food introduced? _____

Please list approximate age that your child started consuming the following foods (if applicable):

Vegetables _____	Meat, Poultry, Fish_____	Beans/legumes _____
Fruits _____	Dairy _____	Fruit Juice _____
Grains (rice, oats, etc) _____	Sweets _____	Soda _____

How often does your child consume the following? **Key: 0=never, 1=rarely (1-4x/month), 2=often (2-4x/week), 3=regularly (5-7x/week)**

Water	___ cups / day	White flour (bread, pastry)	0 1 2 3	Milk, cream	0 1 2 3
Soda	0 1 2 3	White Rice	0 1 2 3	Yogurt	0 1 2 3
Fruit Juice	0 1 2 3	Whole grains & Brown Rice	0 1 2 3	Cheese	0 1 2 3
Fruit	0 1 2 3	Fish	0 1 2 3	Eggs	0 1 2 3
Vegetables	0 1 2 3	Poultry	0 1 2 3	Chocolate	0 1 2 3
Legumes, beans	0 1 2 3	Red meat	0 1 2 3	Sweets (candy, cookies, cake)	0 1 2 3
Nuts / Seeds	0 1 2 3	Unfermented soy (soy milk)	0 1 2 3	Salty snacks (chips, pretzels)	0 1 2 3
Fast food (fried)	0 1 2 3	Fermented soy (tofu, tempeh)	0 1 2 3	Artificial sweeteners*	0 1 2 3
Fast food (lighter choices)	0 1 2 3				

Please list typical meals/foods consumed throughout the day:

Breakfast:	Dinner:
Lunch:	Snacks:

Food aversions: _____ **Food Cravings:** _____

How would you describe your child's personality/disposition? _____

_____

Is there anything else you would like me to know about your child? _____

_____

Thank you for taking the time to fill out this form!

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Amy K. Tyler, N.D
Naturopathic Doctor

DATE _____

RETURN VISIT QUESTIONNAIRE

Last Name: _____ First Name: _____

Phone Number that I may contact you at: _____

Email address that I may contact you at: _____

PRESENT HEALTH CONCERNS

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

What goals do you have for your visit today? _____

_____

Please list any severe or life-threatening allergies:_____

Explain:_____

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

1. _____ 2. _____ 3._____

4. _____ 5. _____ 6._____

4. _____ 5. _____ 6._____

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. _____ 2. _____ 3._____

4. _____ 5. _____ 6._____

7. _____ 8. _____ 9._____

4. _____ 5. _____ 6._____

Please list any other concerns or questions you would like to address during our visit: