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: _____

Peoples Wellness Consultation Policies

- Please give 24 hours notice if you need to reschedule or cancel your appointment by calling us at 512-219-8600 (Central Scheduling). This will allow us to accommodate other clients.

- Consultation Fees (in person and phone):
  - Initial Consultation: 60-90 minutes, *depending on complexity*
  - Follow Up Consultation: *depending on complexity*

    No charge: < 5 minutes
    $ 30 for 15 minutes
    $ 85 for 30 minutes
    $ 125 for 45 minutes
    $ 145 for 60 minutes
    $ 195 for 90 minutes

- Email Policy: Email may be used for answering brief, clarifying questions about current protocols or recent visits, at my 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.

Peoples 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 "Notice of Privacy Policies" and "Wellness Consultation Policies".

Signature (*Patient or Patient's Representative*):_____

Date:_____

PEOPLES 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. Becky Andrews

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 non-economic 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 claim, if asserted in a civil action, would be barred by the applicable legal statue of limitations, or (2) the claimant 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	

Supplement / Medication Tracking

Patient Name:	DOB:
Problem List:	Allergies:
	PCP:
	Pharmacy:

Supplements	Dose	Date Began Taking	Date Discontinued	Helpful?	Recommended By
Prescription Medications					

Becky Andrews ND

NEW CLIENT REGISTRATION FORM

All information on this form is confidential. If you are uncomfortable or unsure about answering any questions, you may leave them blank and discuss them with your practitioner.

CLIENT INFORMATION / PROFILE

Name:	Date of Birth:	Gender: M F Other
☐ Single ☐ Partnered ☐ Divorced ☐ Other	Number of people in household:	children?
Occupation:	Employer / School:	
Education completed: ☐ High School ☐ Some College ☐ College ☐ Graduate Degree ☐ Other		
Travel Outside US? ☐ Yes ☐ No	Where / When?	
Emergency Contact :	home phone:	
Relationship to patient:	work phone:	
Are you currently under medical care? ☐ No ☐ Yes For:		
Who is your Primary Care Physician (PCP)?		
Clinic Name, Address and phone:		
Please list other health care professionals from whom you receive care (name, specialty, contact # if possible):		
Referring Physician or Patient Name:		
Have you ever consulted with a naturopathic physician, acupuncturist, chiropractor, or nutritionist before?	☐ Yes ☐ No (circle those that apply) When? Who?	

HEALTH CONCERNS (please list in order of importance to you)

1.	5.
2.	6.
3.	7.
4.	8.
Are you currently pregnant? ☐ No ☐ Yes Months?	
Is your condition injury or accident related? ☐ No ☐ Yes, auto accident ☐ Yes, work related	
What goals do you have from your visit today and overall?	
What expectations do you have of your naturopath?	

Client Name	Date of Birth:

HEALTH HISTORY

Allergies or Reactions to:	☐ Iodine	☐ Penicillin / antibiotics	☐ Sulfa Drugs	☐ Local anesthetics
	☐ Aspirin	☐ Nuts	☐ Scents	☐ Other:
History of serious illness, accidents, hospitalization or operations (description, date):				
Childhood Illnesses:	☐ Chicken Pox	☐ Measles	☐ Mumps	☐ Rubella
☐ German measles	☐ Rheumatic Fever	☐ Strep Throat	☐ Other:	
Have you ever been touched in a way that made you uncomfortable without your permission?			☐ Yes	☐ No
Have you ever been physically or emotionally abused?			☐ Yes	☐ No
Do you have concerns with abuse / violence in your life now?			☐ Yes	☐ No

REVIEW OF SYSTEMS: Please check if you have or have ever had:

Condition	Never	Past	Current	Physician's Notes
1. General				
Weight loss / gain	☐	☐	☐	Max weight: Min. wt: Current Wt:
Fever / Chills	☐	☐	☐	
Fatigue / Chronic Fatigue	☐	☐	☐	
Heat / Cold Intolerance	☐	☐	☐	
Cold Hands and Feet	☐	☐	☐	
Sweats / Night Sweats	☐	☐	☐	
Thirst	☐	☐	☐	
2. Skin				
Dryness	☐	☐	☐	
Eczema	☐	☐	☐	
Rashes / Itching	☐	☐	☐	
Sores	☐	☐	☐	
Moles	☐	☐	☐	
Hair or nail dryness / changes	☐	☐	☐	
Easy Bruising	☐	☐	☐	
Yellow / Jaundice	☐	☐	☐	
3. Head				
Headache	☐	☐	☐	
Trauma	☐	☐	☐	
4. Eyes				
Blurred Vision	☐	☐	☐	
Corrective Lenses / Contact Lenses	☐	☐	☐	
Double Vision	☐	☐	☐	
Dry Eyes	☐	☐	☐	
Eye Pain	☐	☐	☐	
Glaucoma	☐	☐	☐	
Floaters	☐	☐	☐	
Discharge	☐	☐	☐	
Poor night vision	☐	☐	☐	
5. Ears				
Earaches	☐	☐	☐	
Ringing of Ears	☐	☐	☐	
Hearing Problems	☐	☐	☐	
6. Nose				
Sinus congestion or infection	☐	☐	☐	
Bleeding	☐	☐	☐	
Discharge	☐	☐	☐	
Post Nasal Drip	☐	☐	☐	

Client Name:				Date of Birth:
7. Mouth / Throat	Never	Past	Current	**Physician's Notes (Con't)**
Sores	☐	☐	☐	
Bleeding gums	☐	☐	☐	
Cavities / Root canals / toothaches	☐	☐	☐	
Hoarseness	☐	☐	☐	
Sore Throat	☐	☐	☐	
Bitter or Metallic taste in mouth	☐	☐	☐	
8. Lungs				
Asthma	☐	☐	☐	
Difficulty Breathing / Shortness of Breath	☐	☐	☐	
Chest Pain / Tightness in chest	☐	☐	☐	
Cough: Persistent or Bloody	☐	☐	☐	
Wheezing	☐	☐	☐	
Bronchitis	☐	☐	☐	
Emphysema	☐	☐	☐	
Pneumonia	☐	☐	☐	
Tuberculosis	☐	☐	☐	
9. Cardiovascular				
Heart palpitations	☐	☐	☐	
Blood Clots in Legs or Lungs	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Low Blood Pressure	☐	☐	☐	
Swelling (Edema) of hands, feet, legs	☐	☐	☐	
Heart murmurs / Arrhythmias	☐	☐	☐	
Heart Disease	☐	☐	☐	
Heart Attack	☐	☐	☐	
Stroke	☐	☐	☐	
Circulatory Problems (raynauds, etc)	☐	☐	☐	
Varicose Veins	☐	☐	☐	
Pacemaker	☐	☐	☐	
10. Gastrointestinal				
Loss of / Excess Appetite	☐	☐	☐	
Nausea / Vomiting	☐	☐	☐	
Difficulty or pain with swallowing	☐	☐	☐	
Eating Disorders	☐	☐	☐	
Pain with Digestion	☐	☐	☐	
Indigestion / Reflux	☐	☐	☐	
Gas / Bloating	☐	☐	☐	
Constipation	☐	☐	☐	
Diarrhea (with or without blood?)	☐	☐	☐	
Colitis / Crohn's	☐	☐	☐	
Hernia	☐	☐	☐	
Hemorrhoids	☐	☐	☐	
Anal Discomfort	☐	☐	☐	
Blood or Mucus in Stool	☐	☐	☐	
Black tarry or "coffee ground" stools	☐	☐	☐	
Gallbladder Disease	☐	☐	☐	
Hepatitis (type _____)	☐	☐	☐	
High Cholesterol / Lipids	☐	☐	☐	
Liver Disease	☐	☐	☐	
Ulcer	☐	☐	☐	
11. Genitourinary				
Pain with Urination	☐	☐	☐	
Urgency to Urinate	☐	☐	☐	
Frequent Urination	☐	☐	☐	
Wake to Urinate	☐	☐	☐	
Blood in Urine	☐	☐	☐	
Difficulty holding urine (sneeze / cough)	☐	☐	☐	
Kidney disease / Stones	☐	☐	☐	

Client Name	Date of Birth:

12. Musculoskeletal	Never	Past	Current	
Muscle pain / spasm / strain	☐	☐	☐	
Joint pain / sprain	☐	☐	☐	
Arthritis (type:)	☐	☐	☐	
Back Problems (type:)	☐	☐	☐	
Broken Bones	☐	☐	☐	
Osteoporosis	☐	☐	☐	
Weakness	☐	☐	☐	
Trauma / Swelling	☐	☐	☐	
13. Endocrine				
Diabetes	☐	☐	☐	
Thyroid disease	☐	☐	☐	
Goiter	☐	☐	☐	
Tremor	☐	☐	☐	
Hormone Therapy	☐	☐	☐	
14. Blood / Lymphatic				
Anemia	☐	☐	☐	
Bleeding tendencies	☐	☐	☐	
Blood Transfusions	☐	☐	☐	
Swollen Lymph nodes	☐	☐	☐	
Blood / Lymph disease or cancer	☐	☐	☐	
15. Allergic / Immune				
HIV / AIDS	☐	☐	☐	
Cancer / Chemotherapy	☐	☐	☐	
Autoimmune (scleroderma, hashimotos, lupus, etc)	☐	☐	☐	
Hay fever / Asthma / Eczema	☐	☐	☐	
Drug Allergies	☐	☐	☐	
Food Allergies	☐	☐	☐	
Environmental / Animal allergies	☐	☐	☐	
16. Neurologic				
Epilepsy / Seizures / Convulsions	☐	☐	☐	
Fainting	☐	☐	☐	
Dizziness / Vertigo	☐	☐	☐	
Problems with speech	☐	☐	☐	
Problems with walking / coordination	☐	☐	☐	
Paralysis / weakness	☐	☐	☐	
Numbness	☐	☐	☐	
Multiple Sclerosis	☐	☐	☐	
17. Psychologic				
Anxiety	☐	☐	☐	
Depression	☐	☐	☐	
Chemical Dependency	☐	☐	☐	
Phobias	☐	☐	☐	
Memory Loss	☐	☐	☐	
Mood Changes	☐	☐	☐	
Psychiatric Care	☐	☐	☐	

Client Name	Date of Birth:

Sexual Health Information

Are you currently sexually active?	☐No	☐Yes	With:	☐Men	☐Women	☐Both	
Have you been sexually active with:	☐Men	☐Women	☐Both	☐Neither			
☐Current ☐Past	☐Bisexual	☐Bisexual	☐Prostitute	☐IV drug user			
Are you satisfied with your sex life?	☐No	☐Yes	Do you practice safer sex?	☐No	☐Yes		
Do you have need for birth control?	☐No	☐Yes					
Method of birth control currently used			Number of sexual partners this year?				
STDs ☐HIV	☐Herpes	☐HPV/ Warts	☐Gonorrhea	☐Chlamydia	☐Syphilis	☐Hepatitis	
Notes:							

Male Health Information

Condition	Never	Past	Current	Physician's Notes
Difficult Urination	☐	☐	☐	
Testicular Pain / Swelling	☐	☐	☐	
Impotence / Sexual difficulties	☐	☐	☐	
Prostate problems	☐	☐	☐	
Notes:				

Female Health Information

Menstrual History			Obstetric History		
Age at first period			Have you ever been pregnant	☐No	☐Yes
Date last menstrual period began			Age at first pregnancy		
Periods regular?	☐No	☐Yes	Number of pregnancies		
Days between periods			Number of living children		
Length of flow			Number of stillbirths		
Heaviness of flow			Number of miscarriages	When in pregnancy?	
Color of flow			Number of tubal pregnancies		
Clots (size? Sm, Med, Lg)	☐No	☐Yes	Number of abortions	When in pregnancy?	
Pain with ovulation?	☐No	☐Yes	Number of Cesarean sections		
Pain with Menses?	☐ No	☐Yes	Date of last pregnancy		
Menopause?	☐No	☐Yes	Difficulty conceiving	☐No	☐Yes
			Difficulty with pregnancy	☐No	☐Yes
PMS Symptoms: ☐None	☐Bloating/swelling		Difficulty with labor or delivery	☐No	☐Yes
☐Breast Tenderness ☐Acne	☐Mood Swings		Difficulty with breast feeding	☐No	☐Yes
☐Digestive changes ☐Fatigue	☐Headache		Future OB plans	☐No	☐Yes
☐Other					

Vaginitis Symptoms:	Never	Past	Current	Risk Factors		
Discharge	☐	☐	☐	History of Abnormal paps	☐No	☐Yes
Irritation / Itching	☐	☐	☐	Did your mother take DES?	☐No	☐Yes
Vaginal dryness	☐	☐	☐	Did your mother ever miscarry?	☐No	☐Yes
Odor	☐	☐	☐	Do you do self breast exams?	☐No	☐Yes
Pain with sex	☐	☐	☐	Long term Hormone Replacement?	☐No	☐Yes
Trichomoniasis	☐	☐	☐			
Bacteria (BV)	☐	☐	☐			
Yeast	☐	☐	☐			

Notes:

Client Name	Date of Birth:

Family History

Mother:	☐Living	☐Deceased	Cause	Age:
Father:	☐Living	☐Deceased	Cause	Age:
Siblings:	Number living:	Number deceased:	Causes / Ages:	
Children:	Number living:	Number deceased:	Causes / Ages:	

Has any family member had:	Yes	Which Relative(s) & Age of Onset	Physician's Notes
Diabetes	☐		
Severe allergies	☐		
Stroke	☐		
Heart Disease	☐		
Heart Attack	☐		
Blood clots in lungs or legs	☐		
High Blood Pressure	☐		
High Cholesterol	☐		
Kidney Disease	☐		
Osteoporosis	☐		
Hepatitis	☐		
Thyroid problems	☐		
Colitis / Crohn's	☐		
HIV / AIDS	☐		
Tuberculosis	☐		
Birth Defects	☐		
Drinking or Drug problems	☐		
Breast Cancer	☐		
Colon Cancer	☐		
Ovarian Cancer	☐		
Uterine Cancer	☐		
Other Cancer:	☐		
Mental Illness/Depression	☐		
Alzheimer's	☐		
Other:	☐		
	☐		

Social & Lifestyle

Habits	Yes	No	Details	Notes
Current Tobacco Use	☐	☐	Packs per day:	
Past Tobacco Use	☐	☐	Packs per day:	
Quit?	☐	☐	When?	
Alcohol consumption	☐	☐	Per day?	
Types:			Per week?	
Recreational Drug Use	☐	☐	Type:	
Ever been treated for drug or alcohol abuse	☐	☐	When?	
Seat Belt Use	☐	☐		
Caffeine Use (coffee, tea, cola)	☐	☐	Cups per day?	
			Type?	
Regular Exercise?	☐	☐	How much?	
Types:				
Health Hazards at home / work?	☐	☐		
Social				
Happy with relationship status?	☐	☐		
Do you have a good support network of family and friends?	☐	☐	Who?	
What is your predominant emotion?				
Lifestyle				
Do you enjoy your work?	☐	☐	Hours per week:	
Stress Level ☐Low ☐Medium ☐High				
Stress source ☐Money ☐Job ☐Family/ Relationship				
What do you do to relive stress?				

Client Name	Date of Birth:

Sleep	Yes	No	Details	
Problems falling asleep?	☐	☐		
Problems staying asleep?	☐	☐		
Do you wake rested in the am?	☐	☐		
Usual bed time / rising time:		Hours of sleep daily:		
Dreams?				
Diet				
Do you follow a particular Diet?				
Known food allergies / intolerances?				
What is a typical breakfast for you?				
Typical Lunch?				
Typical Dinner?				
Snacks?	Dessert / Treats?			
How much water do you drink per day?				

EXAM AND IMAGING HISTORY (Indicate date, doctor's name or place of most recent)

Physical Exam		HIV test	
Pap Smear		Chest X-ray	
Mammogram		EKG	
Colonoscopy		STD screen	
Prostate check		Cholesterol screen	
TB test		Bone density check	

IMMUNIZATION HISTORY

Immunization	Date	Boosters
Tetanus – Diphtheria		
Measles-Mumps-Rubella (MMR)		
Varicella		
Hepatitis A		
Hepatitis B		
Flu shot		
Other:		

_____ _____

Client Signature *Date*

_____ _____

Signature of Wellness Consultant *Date reviewed with Client*