

DIRECTIONS TO NIHA

From Baltimore & Maryland

EASIEST

Take I-95 South to I-495 West heading toward Rockville.

From I-495, take Exit 34 and stay in the far right lane which forks and loops south onto Wisconsin Avenue, Route 355.

(Note: North of I-495 Rt. 355 is Rockville Pike, south of I-495 Rt. 355 is Wisconsin Avenue.)

Stay on Wisconsin Avenue for about 4-5 miles, crossing Western Avenue.

The next light is Jenifer Street. Take a left on to Jenifer Street.

Turn right down ramp into parking garage (same garage as Elizabeth Arden)

The elevators for the building are between the parking garage floors, accessible only via steps.

The office is on the 4th floor, Suite #401, turn left after exiting elevator.

FASTEST

Take I-95 South to I-495 West heading toward Rockville

Stay on I-495 until Connecticut Ave. (Exit 33)

Take Connecticut Ave. South toward Washington, DC

Go ½ way around Chevy Chase Circle and continue straight on Connecticut Ave.

Turn Right onto Military Road and continue for approximately ½ mile

Turn Left onto 43rd Street, go to the end of the block where you are forced to turn Right onto Jenifer Street.

Take an immediate Left turn down the ramp (before Wisconsin Ave.) into the parking garage (same garage as Elizabeth Arden)

The elevators for the building are between the parking garage floors, accessible only via steps

The office is on the 4th floor, Suite #401, turn left after exiting elevator

From Virginia

From I-95 take the Capital Beltway (I-495 North) toward Tysons Corner and Maryland

Take I-495 into Maryland, take River Road-East (Exit 39) toward Bethesda, MD & DC

Follow River Road for approximately 6 miles

Turn left at Western Avenue, follow for approximately ½ mile

Turn right onto Jenifer Street at Lord & Taylor

Follow Jenifer Street until it crosses Wisconsin Avenue

Turn right down ramp into parking garage (same garage as Elizabeth Arden)

The elevators for the building are between the parking garage floors, accessible only via steps

The office is on the 4th floor, Suite #401, turn left after exiting elevator

Via Metro

Take Red Line to Friendship Heights Metro Station

Exit the Station via the Jenifer Street Exit-via elevator

Upon leaving Metro Station, 5225 *Wisconsin Avenue* building is across the street

The office is on the 4th floor, Suite #401, turn left after exiting elevator

Handicap Access

The parking garage has handicap parking spaces near the elevators, but to get to the elevators, you must walk up or down 7 steps. If steps are difficult to use, we recommend that you park on the street in front of or behind the building and use those handicap accessible entrances to the building. If you need assistance, please advise us in advance and we will provide support and a wheel chair if needed. We apologize for the inconvenience.

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

National Integrated Health Associates

5225 Wisconsin Ave., NW., Suite 401

Washington, DC 20015

**FOR YOU:
START HERE**

DATE				1
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
E-MAIL ADDRESS				
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
DATE				
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO				

**FOR YOUR
CHILD:
START HERE**

INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH		
DATE EMPLOYED		
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH		
DATE EMPLOYED		
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY		STATE ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		CITY
BUSINESS PHONE NO.		EXT.
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		CITY
BUSINESS PHONE NO.		EXT.

GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT THIS OFFICE? NAME: RELATIONSHIP:		
REFERRED TO US BY:		
YOUR FORMER ADDRESS: CITY STATE ZIP		
PERSON TO CONTACT FOR EMERGENCY: NAME: PHONE NUMBER: ADDRESS: CITY STATE ZIP		
CLOSEST RELATIVE NOT LIVING WITH YOU: NAME: PHONE NUMBER: ADDRESS: CITY STATE ZIP		

AUTHORIZATION & ACKNOWLEDGEMENTS
—YEARLY UPDATE

National Integrated Health Associates (NIHA)
5225 Wisconsin Ave. ♦ Suite 401 ♦ Washington DC 20015
Tel: 202-237-7000 ♦ www.NIHAdc.com ♦ Fax: 202-237-0017

Treatment Authorization: I [print name] _____ authorize medical/dental treatment of myself or my minor child by physicians, dentists or medical assistants and staff at National Integrated Health Associates (NIHA).

Notice as to Nature of Services: I understand that care I receive at NIHA may be non-traditional or unconventional. Such services are commonly referred to as complementary or alternative or holistic medicine/dentistry, or innovative services. Many of these services may not be recognized as standard medical/dental practices, and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition than that for which it is prescribed for me. I understand my doctor may request laboratory evaluation that may include venipuncture, and analysis of stool, urine and saliva.

Notice That Services are Not Primary Care: I understand that no physician or any other practitioner I see at NIHA is acting as my primary care physician unless otherwise agreed to by a physician in writing. I understand that even though my physician(s) and NIHA practitioners may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is in my best interest to also have a primary care physician to ensure that I am fully appraised of all available conventional means to address any medical conditions I may have. This is also important because these practices are exclusively office-based and are not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children.

I also understand that it is my responsibility to inform NIHA who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physician and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed at NIHA in order to properly and safely coordinate my care. My primary care physician is:

Name _____ Address _____

City/State/Zip _____ Phone _____

I am also being treated for _____ by:

Name _____ Address _____

City/State/Zip _____ Phone _____

Medical/Dental Records Release Authorization: I authorize NIHA to release my medical/dental information to any physician or health practitioner to whom I am being referred for care and to any payer of my care including my insurance company, managed care program, or Medicare carrier upon their specific request. I also authorize any physician or health care provider I have seen to release my medical/dental records to NIHA.

Financial/Insurance Responsibility for All NIHA Services: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at each visit; NIHA does not accept assignment. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-payments, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical/dental expenses because differences between integrative and conventional medicine can lead to differences in views about medical necessity. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically or dentally necessary. I understand my responsibility to pay includes fees for laboratory or other clinical services requested by my treatment practitioner(s). NIHA will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for NIHA to take action to secure payment of an outstanding balance owed.

Notice to Medicare Patients: The doctors at NIHA have opted entirely out of the Medicare program, which means that Medicare will not cover any services or procedures performed at NIHA. I understand that I will not be able to submit any claims to Medicare and that if I have a secondary insurance carrier that carrier may or may not choose to reimburse claims. I understand that I will need to sign a contract (Medicare Private Contract Agreement) agreeing not to submit to Medicare, that Medicare limiting fees do not apply, and that I will be financially responsible for any services received. I understand that some services may be considered by Medicare to be non-covered, excluded, or considered not medically necessary due to their nature as complementary medical practices. I understand that Medicare will not be reviewing any claims, and that an opinion by Medicare that a service is not medically necessary in their view of care would not discharge my responsibility for services.

Claim Management: My treating practitioner(s) may respond to insurance requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I understand I may be charged for responding to requests for information. Insurance claim forms and information will be provided to patients at the time of visit or sent

to you upon the availability of the appropriate documentation. NIHA does not typically send information directly to insurance carriers due to problems we have experienced with carriers losing claims.

Notice about CareFirst: Because many of the services provided at NIHA incorporate complementary or alternative care services about which CareFirst's claim reviewers are unfamiliar, CareFirst is currently requesting NIHA practitioner's notes for dates of service submitted for reimbursement. Patients with CareFirst should take special note of the following information. Where records are submitted to CareFirst, they will be provided to patients for submission in approximately 1-3 weeks, depending upon the availability of lab results and other materials that need to be submitted.

Further Notice as to Policies Regarding Insurance for Certain NIHA Practitioners:

For Drs. Beals, Garzon, Mines, Rind and Solomon:

I understand that, for services provided by the above listed practitioners, services should be considered on a cash basis and insurance support services will not be provided. A bill describing services will be provided, but will only use procedural billing codes at the discretion of the practitioner. I understand that I may complete my insurance company's claim form and submit a request for coverage, but NIHA will not provide a claim form (HCFA 1500), nor will it respond to requests for additional information. Patients may request a copy of their records and personally respond to requests by their insurer for additional information.

All Other NIHA Practitioners except as noted above:

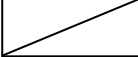
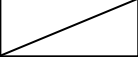
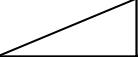
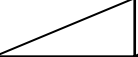
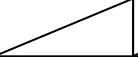
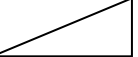
I understand that, for services provided by the above listed practitioners, NIHA will provide claim forms for submission to insurance; submission shall be the patient's responsibility. Claim submissions may or may not be for covered services and may or may not include procedural codes or other data sufficient to support my insurer's determination as to what services it will reimburse. NIHA may provide records requested by my insurance company. If possible, NIHA will advise whether my insurance will cover any particular expenses, but given the uncertainty that pervades insurance decisions, cannot be responsible for any information that turns out to be incorrect.







No Guarantees: I am aware that no practice of medicine or dentistry is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnosis or treatments that I receive at NIHA.

Revocation of Authorizations: The authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

Patient Acknowledgment: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical/dental care and for no other purpose. I do not represent any third party.

Annual Update Questions: Address, Telephone, email or Insurance Company Changes? If so, please update the information below.

_____/Date: _____      
Signature of Patient or Legal Guardian Must Review, Initial and Date Annually

_____/Date: _____      
Witness Must Review, Initial and Date Annually

Date: _____ New address/phone #/email _____
=====

Date: _____ New address/phone #/email _____
=====

Date: _____ New address/phone #/email _____
=====

Date: _____ New address/phone #/email _____
=====

National Integrated Health Associates, LLC (NIHA)

PAYMENT POLICY

ALL FEES ARE DUE IN FULL THE DATE TREATMENT IS STARTED

Thank you for choosing our office. If you have any questions regarding fees for our services, please discuss them with us promptly and frankly. We will make every effort to avoid misunderstandings and preserve our relationship. In all cases, it is our intent to fully explain and inform you of all procedures, options and fees in advance of treatment. If you ever have questions or feel uninformed, please ask.

Payment for services is due in full at the time service is rendered. Payment may be made with any combination of the following: cash, checks, MasterCard, Visa, American Express and Discover. For your convenience we are able to arrange an extended payment plan through the use of Unicorn Financial Services. Please feel free to request applications.

If you have insurance, we will provide you with the standard forms typically needed for filing a claim at the time of our visit. Please be advised, however, that many of the services provided are not covered by most insurance companies. We are sorry, but due to the time and difficulty involved in working with insurance companies, we do not file insurance claims. You are responsible for filing your own claim and following up as needed.

Missed or broken appointments waste valuable staff time and raise fees for everyone. A broken appointment without a 48 hour cancellation notice interferes with the practitioner's ability to properly complete the planned treatment and his/her schedule. Our broken appointment policy is strictly enforced and is intended to prevent ALL patients from having to pay higher fees due to the irresponsibility of a few. The fee for a broken appointment will range from \$25 to \$200 (up to 50% of the visit's fee). To avoid incurring a broken appointment fee, please adhere to the following notice requirements:

- One week notice is required to cancel an initial (new patient) appointment.
- 48-Hour notice is required to cancel an established patient appointment.

If we receive returned checks (due to insufficient funds or closed accounts) you will be charged \$25.00. If your account needs to be turned over to a third party for collection, there will be a charge of at least 50% of your total balance to cover attorney's fees and other collection costs.

If you have any questions about the above information, PLEASE do not hesitate to ask us. We are here to help you.

I, _____, have read, understand and agree to comply with the above payment policy.

	/Date:	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 16.6%;"></td><td style="width: 16.6%;"></td><td style="width: 16.6%;"></td><td style="width: 16.6%;"></td><td style="width: 16.6%;"></td><td style="width: 16.6%;"></td></tr></table>						
Signature of Patient or Legal Guardian		Renewal: Initial and Date						
	/Date:	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 16.6%;"></td><td style="width: 16.6%;"></td><td style="width: 16.6%;"></td><td style="width: 16.6%;"></td><td style="width: 16.6%;"></td><td style="width: 16.6%;"></td></tr></table>						
Witness		Renewal: Initial and Date						

NATIONAL INTEGRATED HEALTH ASSOCIATES

Limited Liability Company Working for Your Health
5225 Wisconsin Ave., NW ♦ Suite 401 ♦ Washington DC 20015
Tel: 202-237-7000 ♦ Fax: 202-237-0017

Privacy Notice

As you are no doubt aware, major changes in Federal privacy requirements - the HIPAA privacy regulations - obligate most physician practices to provide notice about privacy rights and detailed policies designed to protect your privacy. These requirements were put in place because so much patient information is now being shared in digital format over computer networks. Because NIHA does not participate in insurance plans and has opted out of Medicare in order to privately contract directly with patients, this office does not share any patient information in digital format. Because NIHA does not submit claims electronically, it is not subject to the detailed provisions of the HIPAA privacy regulations. In addition to assisting us in keeping the cost of our services reasonable, this will also allow us to collect less personal information.

NIHA remains committed to protecting patient confidentiality. You should understand the following with regard to how we treat your personal health information, which includes medical and dental information:

- 1) When you register as a new patient, you will sign an authorization form that includes a release of information allowing us to provide personal health information to your insurance company for the purpose of assisting you in obtaining payment and to any health care practitioner to which a NIHA practitioner refers you for care. The authorization also allows us to request and obtain records from practitioners that you have seen for the purpose of assisting us in your treatment. If you wish records sent to a health provider you have not yet seen, a family member, an attorney, or other party outside of this list, you must first sign a release of information before we can forward your information.
- 2) We cannot release information to family members, other than parents or legal guardians, even if they are involved in your care, without your written permission.
- 3) In order to ensure quality of care, NIHA records are occasionally reviewed both internally and by outside consultants in legal, clinical, record keeping and other concerns that effect the quality of the services we provide. Only necessary information is accessed, and any such review is performed by professional staff working under the condition of confidentiality.
- 4) If you wish to limit the nature of information that is released, or the parties noted above to whom information may be provided, please ask to meet with NIHA's privacy coordinator to discuss these limitations. In some instances, NIHA may not be in a legal position to honor requested limitations, or there may be consequences that you need to be aware of, such as limitations upon receipt of insurance payment or upon the quality of care delivered. It is best to discuss any such concerns in advance.
- 5) You may revoke authorization for the future release of information in writing. We may in that

event, however, decline to provide further treatment.

6) We may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.

7) Because NIHA is not subject to HIPAA, NIHA will continue long established and useful business practices, such as providing you with appointment reminders, notifying you of lab results, or using sign up sheets, but will take steps to do so in a fashion that takes your privacy expectations into account.

8) NIHA reserves the right to charge \$25 for the copying and forwarding of your health record.

9) While the records of the care we provide are NIHA's property, we will make them available for your inspection and provide copies at a reasonable fee. If you have any concerns about your health records, please see NIHA's privacy coordinator.

NIHA's Privacy Coordinator:
John Rose
202-237-7000 x 107

Please acknowledge receipt and review of this notice by signing below.

Name of Patient (printed)

Date

Signature

**National Integrated Health Associates
Dental History**

Patient Name: _____ Date: _____

What is the reason for today's visit? _____

Date of last dental visit _____ Reason _____

Date of last cleaning _____ Date of last X-rays _____

Previous dentist's name _____

Address _____

City / State / ZIP _____

How often do you have dental check-ups? _____

How often do you brush? _____ floss? _____

What dental aids do you use? _____

What dental problems do you have now? _____

Are any of your teeth sensitive to: (please circle)

Hot or cold? Yes No

Sweets? Yes No

Biting or chewing? Yes No

Do you get cold sores or other oral lesions? Yes No

Do you notice mouth odors or bad tastes? Yes No

Do your gums bleed or hurt? Yes No

Do you notice any loose teeth or change in your bite? Yes No

Does food tend to get caught in your teeth? Yes No

Do you smoke or chew tobacco? Yes No

Do you clench or grind while awake or asleep? Yes No

Do you mouth breathe while awake or asleep? Yes No

Have you noticed clicking or popping of the jaw? Yes No

Do you have difficulty opening or closing? Yes No

Do you have pain or difficulty chewing? Yes No

Do you have tired jaws, especially in the morning? Yes No

Are you satisfied with the appearance of your teeth? Yes No

Rate your smile (on a scale of one to ten) _____

Would you like to keep all of your teeth for life? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal Treatment? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

Your teeth ground or bite adjusted? Yes No

Pain in jaw, joint, ear or side of face? Yes No

Do you feel nervous about today's appointment? _____

What is your biggest concern? _____

What did you like best at your last dental office? _____

What did you like least? _____

Have you ever had an upsetting dental experience? Yes No

If so, what was it? _____

Is there anything else we should know? Yes No

Please rank the following in the order in which they would

KEEP YOU from having treatment:

Fear of pain ____ Cost of treatment ____ Lack of concern ____

Missing time from work __ Embarrassed by dental condition __

National Integrated Health Associates Patient Report of Health History

Thank you for your careful answers to these questions. This will help our Integrative Medicine approach to your health care. If more space is needed for any item, please continue on the last page.

Who referred you to NIHA? _____

Please list the main health issues you would like addressed today, and list symptoms related to these issues. Please rate your symptoms by degree of severity, on a scale of 1 – 5 [1 = mild, 5 = very severe]

Health Issues	Symptoms	Rate 1-5	Physician Comments
1.			
2.			
3.			
4.			
5.			

Patient Name: _____

Date: _____

Current Medications	Dose + Frequency + Response
Current Supplements	Dose + Frequency + Response

Current Supplements (cont.)	Dose + Frequency + Response

Do you? Please √	If so, how much?	Over what time period?	Do you? Please √	If so, how much?	Over what time period?
<input type="checkbox"/> Smoke Tobacco			<input type="checkbox"/> Use Caffeine		
<input type="checkbox"/> Chew Tobacco			<input type="checkbox"/> Drink Sodas		

Do you? Please √	If so, how much?	Over what time period?	Do you have any other addictions?	How much?	Over what time period?
<input type="checkbox"/> Drink Alcohol			<input type="checkbox"/> _____		
<input type="checkbox"/> Use Drugs			<input type="checkbox"/> _____		

List Drug Allergies	What kind of reaction to drug?	Supplement Allergies	Food Allergy	Inhalant Allergy	Chemical Allergy
			<input type="checkbox"/> Milk Products	<input type="checkbox"/> Dust	<input type="checkbox"/> Chlorine, Formaldehyde
			<input type="checkbox"/> Wheat, Grains	<input type="checkbox"/> Grass, Trees, Pollen	<input type="checkbox"/> Cosmetics, Perfumes
			<input type="checkbox"/> Soy	<input type="checkbox"/> Mold	<input type="checkbox"/> Detergents, Cleaners
				<input type="checkbox"/> Animal Danders	<input type="checkbox"/> Gas, glues, paint, dyes
					<input type="checkbox"/> Newsprint, petrochem

Types of Traditional & Complementary (Alternative) Health Care Utilized (Past & Current). Indicate positive results with √.

Medical Specialties	Results	Medical Specialties	Results	Complementary	Results	Complementary	Results
<input type="checkbox"/> Primary Care		<input type="checkbox"/> Oncology		<input type="checkbox"/> Acupuncture		<input type="checkbox"/> Naturopathy	
<input type="checkbox"/> Cardiology		<input type="checkbox"/> Orthopedic/Phys. Therapy		<input type="checkbox"/> Ayurvedic		<input type="checkbox"/> Nutritional/ Herbs	
<input type="checkbox"/> Endocrinology		<input type="checkbox"/> Psychiatry/Psychology		<input type="checkbox"/> Chiropractic		<input type="checkbox"/> Osteopathy	
<input type="checkbox"/> Gastroenterology		<input type="checkbox"/> Rheumatology		<input type="checkbox"/> Homeopathy		<input type="checkbox"/> Reflexology/Reiki	
<input type="checkbox"/> Internal Medicine		<input type="checkbox"/> Urology		<input type="checkbox"/> Hypnotherapy		<input type="checkbox"/> Spritual/Energy	
<input type="checkbox"/> Neurology		<input type="checkbox"/> Other:		<input type="checkbox"/> Massage		<input type="checkbox"/> Other:	

Are you receiving disability payments?	Yes / No	Are you in litigation over any health problems?	Yes / No
Is this a Workers' Comp. case?	Yes / No	Are you here on behalf of a third party?	Yes / No

If need additional space, please attach a separate sheet

FAMILY HISTORY

Condition	You	Family Members
Alcohol [include frequency]		
Anemia		
Anxiety		
Arthritis		
Asthma Bronchitis		
Autoimmune Disease		
Bladder / Kidney		
Bleed Easily		
Bone Loss (Osteoporosis)		
Cancer		
Depression		
Diabetes		
Digestive / Intestinal Prob.		
Ear / Eye Problems		
Eating Disorders		
Genetic Condition		
Gout		
Headaches		
Heart Disease		
High Blood Pressure		
HIV/AIDS		

Condition	You	Family Members
Hormonal Problems		
Hyperactivity / ADHD		
Learning Disability/PDD		
Muscle Problems		
Neurological Problems		
Psychological Problems		
Rheumatic Fever		
Seizure Disorders		
Sex Transmitted Disease		
Sinus / Respiratory		
Skin Prob / Eczema / Acne		
Stroke		
Swallowing Disorder		
Thyroid Disease		
TMJ		
Tuberculosis		
Viral Disorder		
Weight Loss or Gain		
OTHER:		

Your Birth (forceps, etc.) _____	Serious Infections/Diseases _____	Age _____	Dental Interventions _____	Age _____
Number of siblings _____ Your place in birth order _____				
Surgery _____		Age _____		
	Typical childhood vaccinations? <input type="checkbox"/> yes <input type="checkbox"/> no			
	Long periods on prescription/street drugs, alcohol, tobacco, caffeine _____	Age _____		
Hospitalizations _____		Age _____		
Injuries/Accidents without Stitches _____	Toxic Exposure, past or present _____	Age _____		
Injuries/Accidents with Stitches _____	Major Psychological Trauma _____	Age _____	Pregnancies/Births/IUD/BC pills/ Abortion: Spont., Planned _____	Age _____

Daily Food Intake

Types of fats & oils (butter, margarine, etc) _____

Types of protein (meat, eggs, dairy, fish, soy, etc) _____

How often do you eat flour products (bread, pasta, etc) _____

Fruits & vegetables – which ones and how much? _____

Are there any foods you are sensitive to? _____

What do you drink? _____

Types of snacks or sweets _____

Do you skip meals? (If so, how often?) _____

Are you trying to gain weight _____ lose weight _____ Have you dieted in the past _____

Do you want nutritional a consultation? _____

Patient Name: _____

Date: _____

Review of Systems

For "Past" [over 6 mo ago] ✓ if it applies For "Now" - Rate 1-5 1 = mild 3 = Moderate 5 = Severe

Symptoms	Past	Now	Comments	Symptoms	Past	Now	Comments
GENERAL IMMUNE				EARS			
Frequent Fatigue				Ear Infections			
Weight Gain/Loss >10				Hearing Loss			
Hot/Heat Intolerant				Itching			
Cold/Cold Intolerant				Hard Ear Wax			
Perspire Easily				Discharge			
Lack of Perspiration				Dizziness			
Frequent Infections				Ringing/Tinnitus			
Immune/Auto-Immune				NASAL			
Hx of Mono or EBV				Bleeds			
Swollen Glands				Burning/Dry/Crusting			
Measles				Sinusitis			
Whooping Cough				Sense of Smell Loss			
Scarlet Fever				Obstruction			
Tonsillitis				MOUTH/THROAT			
Chicken Pox				Bleeding Gums			
ENDOCRINE				Bone Loss			
Fever, Chills				Bruxism (Grinding)			
Low body Temp.				Face/Jaw Pain/TMJ			
Cold Extremities				Fillings: Amalgam			
Thyroid Disorder				Lip Cracks			
Dizzy on Standing				Mouth Ulcers			
Polyuria				Swallowing Probs.			
Polydipsia				Taste Loss			
Tremors				Tongue Coated			
Night Sweats				Tongue Fissured			
SKIN / NAILS				Voice Hoarse			
Acne,Eczema,Dermatitis				DIGESTIVE			
Brown Spots				Poor Appetite			
Hives/Rashes				Indigestion			
Itching, Burning, Dry				Abdominal Pain			
Oily				Jaundice			
Pale				Belching,Bloating,Gas			
White Spots				Colitis/Irritable Bowel			
Yellow Tone				Constipation			
Nails: Brittle, Peeling				Diarrhea			
Ridges, white lines				Gastritis, Pain, Ulcer			
HEAD & NECK				Heartburn, Reflux			
Headaches				Hemorrhoids/Bleeding			
Migraines				Liver/Gallbladder			
Head Injury				Nausea/Vomiting			
Face / Jaw Pain				Hematemesis			
Neck Pain, Stiff Neck				Change in Bowel Habits			
Syncope				Stool: ○Brown			
Hair: Brittle, Dry				"Black "Dk Green			
Hair Loss of Color				" Yellow "Mucus			
Hair Loss							

Patient Name: _____

Date: _____

Review of Systems

For "Past" [over 6 mo ago] ✓ if it applies For "Now" - Rate 1-5 1 = mild 3 = Moderate 5 = Severe

Symptoms	Past	Now	Comments	Symptoms	Past	Now	Comments
EYES				RESPIRATORY			
Wear Glasses/Contacts				Asthma / Bronchitis			
Blurred Vision				Cancer – Lungs			
Blood Shot				Chemically Induced			
Burning / Dry / Itching				Colds/Flu (how often?)			
Cataracts				Cough – Chronic			
Floater (seeing spots)				Emphysema			
Glaucoma/Retina prob.				Exercise Induced prob			
Lids Crusty				Shortness of Breath			
Light Sensitive				Pneumonia			
Night Blindness				Influenza			
Diplopia				Expectoration			
Photophobia				Coughing Blood			
CARDIOVASCULAR				MALE			
High Blood Pressure				Discharge			
Low Blood Pressure				Impotence			
Pleurisy				Pain – Testicular			
Chest Pain				Prostate Problems			
Dizzy Spells				Weak Urine Stream			
Leg Pain w/Walking				STD's			
Palpitations/Tachycardia				FEMALE			
Stroke				Breasts: Cancer			
Edema				Fibrocystic			
Orthopnea				Sore			
Nocturnal Dyspnea				Endometriosis			
Intermittent Claudifications				Fibroids/Cysts			
Gangrene				Hormone Replacement			
Varicosities				Hot Flashes			
MUSCULOSKELETAL				Cramps			
Arthritis/Joint Pain				Heavy Flow			
Back Pain/Disc Problems				Irregular			
Bursitis/Tendonitis				Infertility			
Muscle Aches/Pains				Peri-Menopausal			
Muscle Cramps/Spasms				Menopausal: Natural			
Muscle Weakness				Surgical			
Paralysis				Night Sweats			
NEUROLOGICAL				Osteoporosis			
Clumsy				Ovary/Uterine Cancer			
Convulsions/Seizures				Painful intercourse			
Fainting Spells				Pap Smears-Abnormal			
Neuralgia/Tingling				Pre-Menstrual Tension			
Numbness				Pregnancy: Incomplete			
Raynaud's				Full Term			
Spastic Motion/Tremors				Sex-transmitted Dz.			
				Vaginal: Dryness			
				Infection			
				Inflammation			
				Yeast			

Patient Name: _____

Date: _____

Review of Systems

For "Past" [over 6 mo ago] ✓ if it applies For "Now" - Rate 1-5 1 = mild 3 = Moderate 5 = Severe

Symptoms	Past	Now	Comments	Symptoms	Past	Now	Comments
URINARY				GLUCOSE CONTROL			
Kidney Disease				Afternoon drowsiness			
Bladder infect: Frequent				Crave: Butter/Fats			
Blood in Urine				Foods (list)			
Frequent Urination				Ice			
Incontinence				Fatigue After Eating			
Kidney Stones				Hunger Headaches			
Pain, Burning				Hunger Irritability			
Discharge				Skin Crawling feeling			
Excessive Night Urination				Symptoms from Foods			
Flank Pain							
BEHAVIOR/PSYCH.				Best time of the day			
Addictions (list)				Worst time of the day			
Anxiety				Best season for you			
Attention Deficit (ADD)				Worst season for you			
Bizarre Behavior							
Depression				OTHER			
Developmental delay							
Eating Disorder (list)							
Fearful/Worrier							
Hyperactivity / Manic							
Insomnia							
Lack of Dream Recall							
Learning Problems							
Memory Problems							
Mood Swings							
Narcolepsy-Oversleeping							
Obsessive/Compulsive							
Phobias							
Schizophrenia							
Suicidal							
Concentration/focus							

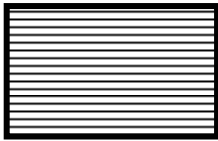
Reviewed By: _____ Date: _____

Your Current Problem Areas

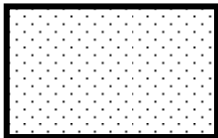
Name: _____ Date: _____

Using the symbols below, mark the areas on your body where you feel the described sensations.

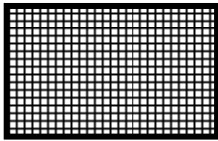
Numbness



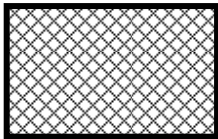
Pins & Needles



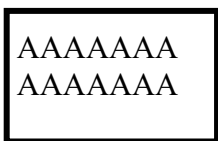
Burning Pain



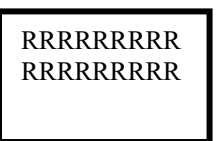
Stabbing Pain



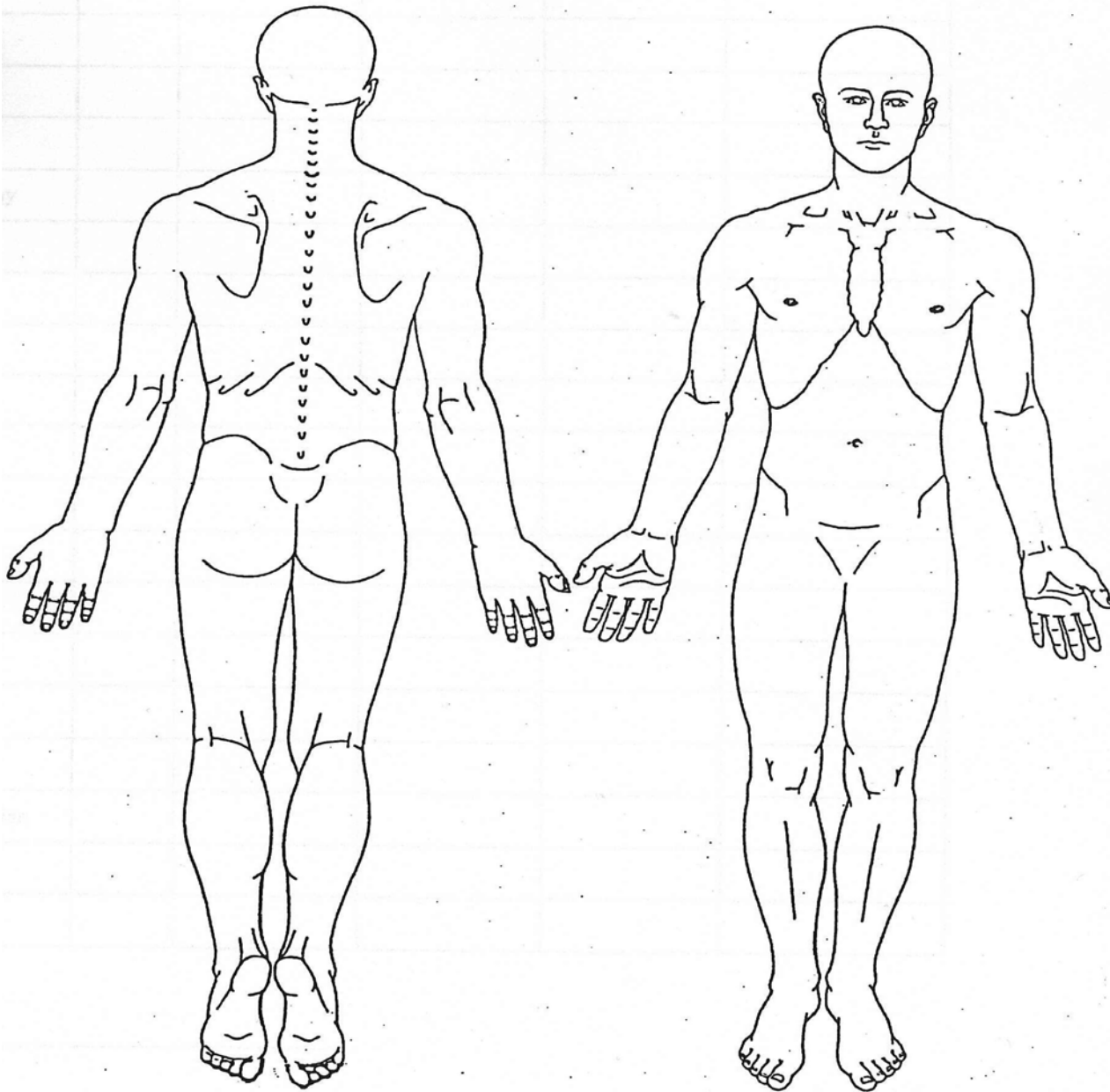
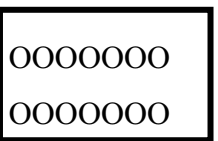
Aching Pain



Radiating Pain



Other



Pain Assessment

What do you believe is the cause of the pain? _____

Where is the pain more intense? _____

What makes the pain better / worse? _____

Rate your pain on following scale: 1= minimal 10= severe

1 2 3 4 5 6 7 8 9 10

If more than one area of pain, please write number on diagram.

Name: _____ Date: _____

Instructions to Patient: Please list the date of the most recent of the following:

Exam/Test/ Intervention	Date	Exam/Test/ Intervention	Date
Complete Physical		MEN:	
EKG (electrocardiogram)		Prostatic Exam	
Cardiac Stress Test		PSA Blood Test	
MRI, CT		Bone Density Test	
X-Rays		WOMEN:	
Dental		Pap Smear	
Cholesterol Test		Mammogram	
Stool Blood Test		Breast Exam by physician	
Colonoscopy		Bone Density Test	
Flexible Sigmoidoscopy		Last Menses	
Vision Test			
Tetanus Booster			
Hepatitis B Vaccine			

√	What is your activity level?	Rate 0 - 3	Stressors Affecting Your Life
	Sedentary: Inactive by choice.		Difficulties with work or lifestyle
	Sedentary: Inactive due to inability		Recent change in marital status
	Light: Light daily work, no regular exercise		Death or serious illness among family/friends
	Moderate 1: Sedentary work & exercise 3 times/week		Dysfunctional family <input type="checkbox"/> past <input type="checkbox"/> present
	Moderate 2: Light daily work & exercise 3 times/week		Personal illness and coping with illness
	Sustained: Moderate daily work & exercise 5 times/week		Lack of love or fulfilling relationships
	High: Heavy work & heavy exercise 5 times/week		Feeling lonely, disconnected from others
	Heavy: Elite athlete. Heavy workouts 20 hrs/week		Lack of prayer, spirituality, inner peace

Notes: You may write additional information on this page.