CYNTHIA PRESTON
NATUROPATHIC DOCTOR
16601 PCH
Sunset Beach, CA 90742

Adult New Patient Intake

Practice Polices for Patients

Congratulations on taking the first step towards your journey of Health. Dr. Preston's goal is to provide you with the highest level of personalized care. She is committed to helping you on your path to health and healing.

It is important to read all the enclosed information carefully. You may mail or fax completed forms prior to your appointment. This will allow Dr. Preston to help solve your problems more efficiently and enhance the quality of your care. Alternatively you may bring the forms in with you to your first appointment.

Appointment Scheduling

The charge for Late Cancelled Appointments and NO show appointments are **charged 50% for appointment of your scheduled visit time.** This means that we will charge you 50% of your scheduled fee, so if you had a 30 minute consults booked you would be billed 40 dollars (visit is 80). Due to the overwhelming requests for consultations, there is a 24-hour cancellation policy. We encourage patient responsibility with their appointment schedule. Scheduling reminder calls are a courtesy and are NOT meant to replace your management of our appointment schedule. Please don't depend on the reminder calls as your only means of arriving at your appointment. 24 hours advance notice is required and cancellation for a next day appointment left on voicemail after business hours will be charged as a late cancellation. If you are cancelling a Monday appointment you are required to call on Friday. You may cancel your appointment by calling Cynthia Preston ,ND at (562)794-9027 If calling after hours, please leave a message. Initial appointment is 275, 2nd follow up appointment is 180 and visits after this are anywhere from 85-120 depending on time and lab review and are required at time of visit.

I acknowledge 24 hour cancellation and payment policies:
PATIENT INITIALS _____Date_____

Phone and Email Policy

For your safety all questions or emails to Dr. Preston will be charged. Should you have **one brief question regarding clarification of treatment from previous visit** the message must be left with staff and Dr. Preston is available to return answers to staff during those clinic hours when she is not actively providing direct patient care. Any other questions must be scheduled with Dr. Preston as a phone/email or office consult, unless you are a concierge patient. Considerable effort

is made to respond to phone messages within 24 hours of their receipt; however, with a busy schedule and the only doctor on staff, telephone time is limited. It is preferable and safe that the evaluation and treatment of medical questions or recommendations be conducted during a scheduled office visit with Dr. Preston where you can receive adequate care and attention. We appreciate your understanding and consideration in this regard. Our phone and email policy is below:

- **1-10 minute phone call - $45**
- **Emails –$65 per email.**
- **Concierge patients – NO CHARGE!**

PATIENT INITIALS _____ Date_____

Insurance and Payment Information

Cynthia Preston, ND, **does not accept insurance or** Medicare and we cannot assure you that services (office visits, phone consultations or lab tests) will be reimbursed or paid. You will be provided with diagnosis and procedure codes to assist you with possible insurance reimbursement. You can request a bill of services rendered that you can submit to your insurance provider who may reimburse you for some or the entire fee at their discretion. Please note that phone visits and supplements will not be reimbursed by your insurance carrier.

Payment for the office visit or phone appointment is expected at time of service and can be in the form of check, cash or credit card payments. All credit card payments will be processed the same day of the visit or phone call.
You will receive an invoice receipt and superbill with the medical codes at the completion of your visit.
Dr. Preston does not accept insurance or Medicare. If you are using a health savings account all supplements and visits can be used towards this. Please save your superbill for tax filing purposes.

Please be prepared to pay for your visit in full. Please be aware that any conversation regarding your health treatment

PATIENT INITIALS _____ Date_____

LAB TESTS

After your initial or follow–up consultations, lab tests and/or diagnostic tests may be ordered.
Testing recommendations and cost(s) per test will be reviewed at time of visit. Fees for such tests are billed directly by the lab to the patient, meaning that payment must always be sent with test kits at time of administration. In many cases, the lab will work directly with the patient's insurance care provider. We cannot guarantee that your labs will always be covered and will not reimburse your fees for any reason.
With specialty testing kits there is a $**35 – 75** dollar fee depending on each test for shipping and processing of the test kits. This must be paid at time of visit when kit is given.
All specialty lab tests take up to 3 weeks to be finalized and sent to the office. Your appointment will be scheduled at 3 weeks for this reason.

Dr. Preston does provide phlebotomy services at Cynthia Preston, ND. This is a convenient service we offer for patients that includes a **$15 draw fee.** Specialty Kits include interpretation and processing fees of **$35 -85 .**

PATIENT INITIALS _____Date_____

REFILL AUTHORIZATION POLICY

If you are undergoing natural hormone replacement you are required to come in every three months or pay $80 dollars every three months to receive your refills. THIS DOES NOT COVER the cost of your medications. This is to help cover the time and administrative work of filing paperwork and refills every three months. We apologize for the inconvenience but the FDA is putting much demand and regulation on compounding pharmacies and medical community that requires more paperwork and supervision.

I _____understand that I will be required to pay $80 dollars every three month for refills or $110 for visits every three months and under go biyearly testing and visits to monitor my hormone therapies.

PATIENT INITIALS _____DATE_____

Patient Contact Information

Name of Patient _____ Date of First Visit ___

Name of Parent(s)/Guardian(s) (if applicable)_____ _____

Relationship to patient _____

Address_____

City _____ State _____ Zip Code

_____

Telephone # (cell) _____

(home) _____

(work) _____

Email address_____

Age _____ Date of Birth _____ Gender: Female ___Male

Married _____ Separated _____ Divorced___ Widowed ___ Single _____ Partnership

Live with: Spouse _____ Partner____ Parents ___ Children_ Friends ____ Alone _____

Occupation _____ Hours per week _____ Retired

Employer _____

(Work address) _____

How did you hear about our clinic?_____

Next of Kin or other to reach in an emergency

_____

Relationship _____ Phone_____

Address_____

I authorize employees or agents of Cynergetics to leave a detailed message for me on a voice message device associated with the phone number listed below regarding my:

Laboratory reports ___Yes (initials) _____No (initials)
Protected Health Information ___Yes (initials) _____No (initials)

If you answered yes please list number to call:

562-794-9027

Consent To Treat

I understand that the treatment provided is determined by the professional discretion of my naturopathic doctor. Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children or those with multiple medications. It is very important that you inform Dr. Preston immediately of any disease process that you are suffering from or if you are taking any medications. If you are pregnant or you are breast-feeding please inform me as well. It is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements because they may be toxic when taken in large doses. I will immediately notify the doctor if I become aware that I am pregnant.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to temporary aggravation of pre-existing symptoms, allergic reactions to herbs or supplements, bruising and bleeding from injection therapies.

I will immediately inform the doctor if I experience any gastrointestinal upset, allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur.

I have read, or have had read to me, the above information and I consent to receiving naturopathic medical care from the above mentioned naturopathic doctor I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment. Signing below means I consent to treatment

PATIENT INITIALS _____Date_____

Notice of Privacy Practices

This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996(HIPAA). Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. To correctional institutions or law enforcement officials, if you are an inmate

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care
3. You have the right to inspect and obtain a copy of the health information that, but not including psychotherapy notes.

I have also read and understand the attached NOTICE OF PRIVACY PRACTICES**,** which discusses my rights under the Health Insurance Portability and Accountability Act of 1996

REPRESENTATIVE or PATIENT INITIALS _____

ARBITRATION AGREEMENT

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 California 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 deputes 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to. sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2). and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). 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 statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

PATIENT SIGNATURE X

(Or patient Representative) **(Indicate relationship if signing for patient)**

OFFICE SIGNATURE X

Article 5: Revocation: This agreement may be revoked by written notice delivered to the hearth 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 X
(Or patient Representative) **(Indicate relationship if signing for patient)**

OFFICE SIGNATURE X

Consent Regarding E-mail Use or Disclosure of Health Information

Cynthia Preston, ND provides patients with the opportunity to communicate by e-mail. Transmitting confidential health information by e-mail however, has a number of risks:

1. Risks:
    a. e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily copy information
2. It is the policy of Cynthia Preston, ND that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of that's patients protected personal health information. We cannot guarantee the security and confidentiality of e-mail or internet communication.
3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks with the following conditions:
    a. All e-mails to or from patients concerning diagnosis and/or treatment will be made part of the protected personal health information. As a part of the protected personal health information, other individuals, such as Cynergetics staff, insurance coordinators and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
    b. Cynthia Preston, ND will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore e-mail must not be used in a medical emergency.
    c. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmittable or communicable diseases such as syphilis, gonorrhea and the like; behavioral health, mental health; or alcohol and drug abuse.
    d. Cynthia Preston, ND cannot guarantee that electronic communications will be private. Dr. Preston, ND is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct and is not liable for breaches of confidentiality caused by the patient.

I understand that my consent to the use of e-mail may be withdrawn at any time be e-mail or written communication to Cynthia Preston, ND. I have read this form carefully and understand the risks and responsibility associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail

PATIENT INITIALS_____ Date_____

Release of Records

REQUESTING PARTY: Today's Date_____

Printed Legal Name _____ Date of Birth_____

I, the undersigned, hereby authorize:

Name of Agency or doctor _____

Address_____

City, State, Zip_____

Phone_____ Fax_____

TO RELEASE MY INFORMATION TO:

Dr. Cynthia Preston, ND
16601 Pacific Coast Hwy
Sunset Beach, Ca 90742

Tel: (562)794-9027
Fax: (949)528-2526

Information to be released:

_____ALL MEDICAL RECORDS
_____OTHER_____

Initial next to "Yes" or "No" for the following protected information to be released:

Drug/Alcohol Information	Yes_____	No_____
Mental Health Information	Yes_____	No_____
AIDS/HIV Testing & Results	Yes_____	No_____
Sexually Transmitted Diseases Testing & Results	Yes_____	No_____
Communicable Diseases	Yes _____	No_____
Genetic Testing	Yes_____	No_____

and is limited to the time period from _____ to_____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise specified, this authorization will automatically expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or receive copies of the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. A copy of this authorization shall be as valid as the original.

SIGNATURES: _____

Requesting Party_____ Date_____

For_____ Relationship_____

_____

Patient name (Last, First)

HEALTH HISTORY QUESTIONNAIRE

Successful health care and preventive medicine are made possible when Dr. Preston has a comprehensive understanding of her patients. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything you don't understand with a question mark. If a section or question does not apply to you or your child skip it and proceed to the next question.

Y = a condition you have now **N** = have never had **P** = a condition you have had in the past

Are you currently receiving healthcare? Y N

If yes, where and from whom?_____
If no, when and where did you last receive medical or health care?
_____

What was the reason? _____
What are your most important health problems? List as many as you can in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Do you have any known contagious diseases at this time? Y N If yes, what?_____
Current Medications
Please list any **prescription** or **over-the-counter medications** you are taking, with dosages.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please list any **vitamins** or other **supplements** you are taking, with dosages.

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Allergies - Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental? _____

Patient name (Last, First)

CHILDHOOD ILLNESS

Scarlet fever	Y N	Diphtheria	Y N	Rheumatic fever	Y N
Mumps	Y N	Measles	Y N	German measles	Y N

HOSPITALIZATION AND SURGERY

What hospitalizations or surgeries have you had?

_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

X-RAYS AND SPECIAL STUDIES

X-rays, CAT scans, or other studies you have had:

_____
_____
_____

IMMUNIZATIONS

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Any reactions to vaccinations?	Y N

FAMILY HISTORY

	FATHER	MOTHER	CHILD	SPOUSE	SISTERS	BROTHERS
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=good P=poor)	_____	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____	_____
Check (√) those applicable						
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hayfever/Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

Patient name (Last, First)

Weight:_____ lbs. Weight 1 year ago:_____ lbs.

Maximum Weight: _____ When? _____Height: _____

MENTAL/ EMOTIONAL

Treated for emotional problems?	Y P N	Depression?	Y P N
Mood Swings?	Y P N	Anxiety or nervousness?	Y P N
Memory problems?	Y P N	Tension?	Y P N
Poor concentration?	Y P N	Seasonal depression?	Y P N

ENDOCRINE

Hypothyroid?	Y P N	Heat or cold intolerance?	Y P N
Hypoglycemia?	Y P N	Diabetes?	Y P N
Excessive thirst?	Y P N	Excessive hunger?	Y P N
Fatigue?	Y P N		

IMMUNE

Chronic Fatigue Syndrome?	Y P N	Chronic infections?	Y P N
Chronically swollen glands?	Y P N	Slow wound healing?	Y P N

NEUROLOGIC

Seizures?	Y P N	Paralysis?	Y P N
Muscle weakness?	Y P N	Numbness or tingling?	Y P N
Loss of memory?	Y P N	Loss of balance?	Y P N
Vertigo or dizziness?	Y P N		

SKIN

Rashes?	Y P N	Eczema, Hives?	Y P N
Acne, Boils?	Y P N	Itching?	Y P N
Color Change?	Y P N	Perpetual Hair Loss?	Y P N
Lumps?	Y P N		

HEAD

Headaches?	Y P N	Head Injury?	Y P N
Migraines?	Y P N	Jaw/TMJ problems	Y P N

EYES

Spots in Eyes?	Y P N	Cataracts?	Y P N
Impaired vision?	Y P N	Glasses or contacts?	Y P N
Blurriness?	Y P N	Eye pain/strain?	Y P N
Color blindness?	Y P N	Tearing or dryness?	Y P N
Double Vision?	Y P N	Glaucoma?	Y P N

EARS

Impaired hearing?	Y P N	Ringing?	Y P N
Earaches?	Y P N	Dizziness?	Y P N

Patient name (Last, First)

NOSE AND SINUSES

Frequent colds?	Y P N	Nose Bleeds?	Y P N
Stuffiness?	Y P N	Hayfever?	Y P N
Sinus problems?	Y P N	Loss of smell?	Y P N

MOUTH AND THROAT

Frequent sore throat?	Y P N	Copious saliva?	Y P N
Teeth grinding?	Y P N	Sore tongue/lips?	Y P N
Gum problems?	Y P N	Hoarseness?	Y P N
Dental cavities?	Y P N	Jaw clicks?	Y P N

NECK

Lumps?	Y P N	Swollen glands?	Y P N
Goiter (enlarged thyroid)?	Y P N	Pain or stiffness?	Y P N

RESPIRATORY

Cough?	Y P N	Sputum?	Y P N
Spitting up blood?	Y P N	Wheezing?	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Tuberculosis?	Y P N
Emphysema?	Y P N	Difficulty breathing?	Y P N
Pain on breathing?	Y P N	Shortness of breath (SOB)?	Y P N
Shortness of breath at night (SOB)?	Y P N	SOB lying down?	Y P N

CARDIOVASCULAR

Heart disease?	Y P N	Angina?	Y P N
High/Low Blood Pressure?	Y P N	Murmurs?	Y P N
Blood clots?	Y P N	Fainting?	Y P N
Phlebitis?	Y P N	Palpitations/Fluttering?	Y P N
Rheumatic Fever?	Y P N	Chest pain?	Y P N
Swelling in ankles?	Y P N		

GASTROINTESTINAL

Trouble swallowing?	Y P N	Heartburn?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea?	Y P N	Vomiting?	Y P N
Vomiting blood?	Y P N	Bowel Movements: How often? _____	
Blood in stool?	Y P N	Is this a change?_____	
Pain or cramps?	Y P N	Constipation?	Y P N
Belching or passing gas?	Y P N	Diarrhea?	Y P N
Black stools?	Y P N	Gall Bladder disease?	Y P N
Jaundice (yellow skin)?	Y P N	Ulcer?	Y P N
Liver Disease?	Y P N	Hemorrhoids?	Y P N

Patient name (Last, First)

URINARY

Pain on urination?	Y	P	N	Increased frequency?	Y P N
Frequency at night?	Y	P	N	Inability to hold urine?	Y P N
Frequent infections?	Y	P	N	Kidney stones?	Y P N

MALE REPRODUCTION

Hernias?	Y	P	N	Testicular masses?	Y P N
Testicular pain?	Y	P	N	Prostate disease?	Y P N
Discharge or sores?	Y	P	N	Sexually transmitted infections?	Y P N
Are you sexually active?	Y		N	Birth control? Type?_____	
Impotence?	Y	P	N	Genital warts?	Y P N
Premature ejaculation?	Y	P	N	Herpes?	Y P N

FEMALE REPRODUCTION / BREASTS

Age of first menses? _____

First day of last menses? _____

# of days in between menses? _____ days

# of days your menses lasts? _____ days

Painful menses?	Y	P	N	Are cycles regular?	Y N
Heavy or excessive flow?	Y	P	N	Bleeding between cycles?	Y P N
Are you sexually active?	Y		N		
Pain during intercourse?	Y	P	N	Clotting?	Y P N
PMS?	Y	P	N	Discharge?	Y P N
If yes, what are your symptoms?				Sexual difficulties?	Y P N
_____				Birth control?	Y P N
_____				What type?_____	
				Difficulty conceiving?	Y P N
				Number of pregnancies _____	
				Number of live births _____	
Endometriosis?	Y	P	N	Ovarian cysts?	Y P N
Menopausal symptoms?	Y	P	N	Abnormal PAP?	Y P N
Sexually transmitted infection?	Y	P	N	Genital warts?	Y P N
Herpes?	Y	P	N		
Do you do breast self exams?	Y	P	N	Breast lumps?	Y P N
Breast pain/tenderness?	Y	P	N	Nipple discharge?	Y P N

MUSCULOSKELETAL

Joint pain or stiffness?	Y	P	N	Arthritis?	Y P N
Broken bones?	Y	P	N	Weakness?	Y P N
Muscle spasms or cramps?	Y	P	N	Sciatica?	Y P N

BLOOD / PERIPHERAL VASCULAR

Easy bleeding or bruising?	Y	P	N	Anemia?	Y P N
Deep leg pain?	Y	P	N	Cold hands/feet?	Y P N
Varicose veins?	Y	P	N		

_____

Patient name (Last, First)

DIETARY

Typical Food That you Eat

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks/drinks_____

Do you drink black or green tea?	Y	N	Number servings *per week*
Do you drink cola or other sodas?	Y	N	Fish_____
Do you eat refined sugar?	Y	N	Red meat_____
Do you add salt?	Y	N	Chicken_____
Do you go on diets often?	Y	N	Alcohol_____
Do you eat three meals a day?	Y	N	Number servings *per day*
Do you drink coffee?	Y	N	Vegetables_____
Do you eat out often?	Y	N	Fruit_____
Bowel Movements/day _____			Caffeine_____
			Water_____

GENERAL

When during the day is your energy the best? _____ Worst? _____

Main interests and hobbies?_____

Do you exercise?	Y	N
If yes, what kind? _____ How often? _____		
Average 6-8 hrs. sleep?	Y	N
Sleep well?	Y	N
Awaken rested?	Y	N
Spend time outside?	Y	N
Do you use tobacco?	Y	N
Smoked previously?	Y	N

How many years? _____ How many packs per day? _____

What is your commitment towards make life changes? A little Moderate Completely

Please write any additional information (use back if necessary)

_____

_____

_____

_____

_____

_____