



Natural Remedies
 Dr. Borislava Johnson, B.C.N.D.
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 832-588-8863
 www.naturalremedies.com

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|------|
| IN: |
| DOB: |

New Client Information Packet

Full Legal Name: _____ Date: _____

Preferred Name: _____ Email Address: _____

Gender: Female Male Marital Status: _____ Date of Birth: _____

Home Phone: _____ Cellular: _____ Work Phone: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ Zip: _____

Emergency Contact's Name: _____

Phone Number: _____ Relation to Client: _____

Client's Occupation: _____

How did you hear about us? _____

Due to the possibility of interactions among medications and/or supplements, please list **ALL** medications and vitamins/supplements (prescribed and over the counter) you are **CURRENTLY** taking:

| Name of Medication/Supplement | Dose | Last Taken |
|-------------------------------|------|------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

Do you take probiotics? (Such as yogurt or any other oral enzyme that restores bacteria to the body): Y / N

How do you take the probiotics? (pills, liquid, with food): _____

Name any allergies (medicines, environmental, food, etc.) you have, if any?

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Have you had a COVID-19 vaccine? Y / N

IN:
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If yes, which one did you receive? (Please check one and write down the date you received each dose)

- Johnson & Johnson 1st Dose _____
- Moderna 1st Dose _____ 2nd Dose _____
- Pfizer 1st Dose _____ 2nd Dose _____
- Other _____ 1st Dose _____ 2nd Dose _____

Please list current/recent physicians you are seeing:

| Name of Physician | Specialty | Phone Number | Last Seen |
|-------------------|-----------|--------------|-----------|
| | | | |
| | | | |
| | | | |
| | | | |

List **CURRENT** medical conditions and concerns:

1. _____
2. _____
3. _____
4. _____

What are your specific goals for today’s consultation? _____

Females only: What was the date of your last menstrual cycle? _____ Are you currently pregnant? Y / N
In the last year, what other conditions (not mentioned above) have you been treated for by a physician? _____

Please list any other past health problems/hospitalizations: _____

of bowel movements per day: _____ Do you experience gas/bloating on a regular basis: Y / N

Do you frequently use any of the following? (check ALL that apply to you)

- Aspirin Laxatives Antacids Diet pills Birth control pills/implants/injections

Alcohol – type _____ and amount: per day _____ per week _____

Tobacco (including vaping) – type _____ and amount: per day _____ per week _____

Caffeine – type _____ and amount: per day _____ per week _____

Recreational drugs (including vaping)– type _____ and frequency: _____

Do you get regular screening tests done by another doctor (pap, blood tests, etc.)? Y / N

Do you have any dietary restrictions? _____

Do you eat home cooked meals? Y / N # of times per week do you eat out: _____

IN:
DOB:

How many hours of sleep do you get at night? _____

Do you wake during the night? Y / N If yes, how often and reason? _____

Diet: Vegan Vegetarian Flexitarian Paleo Keto Other _____

Please list what you eat on a typical day:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Do you exercise regularly? Y / N If yes: what form of exercise, how often, and at what intensity? _____

How would you describe the emotional climate of your home? _____

How stressful is your work, and other aspects of your life? _____

Your stress levels? (Please check one) Low Medium High

How well do you handle these stresses? _____

Are you regularly exposed to toxins and other hazards (work, home, hobbies, etc.)? Please describe. _____

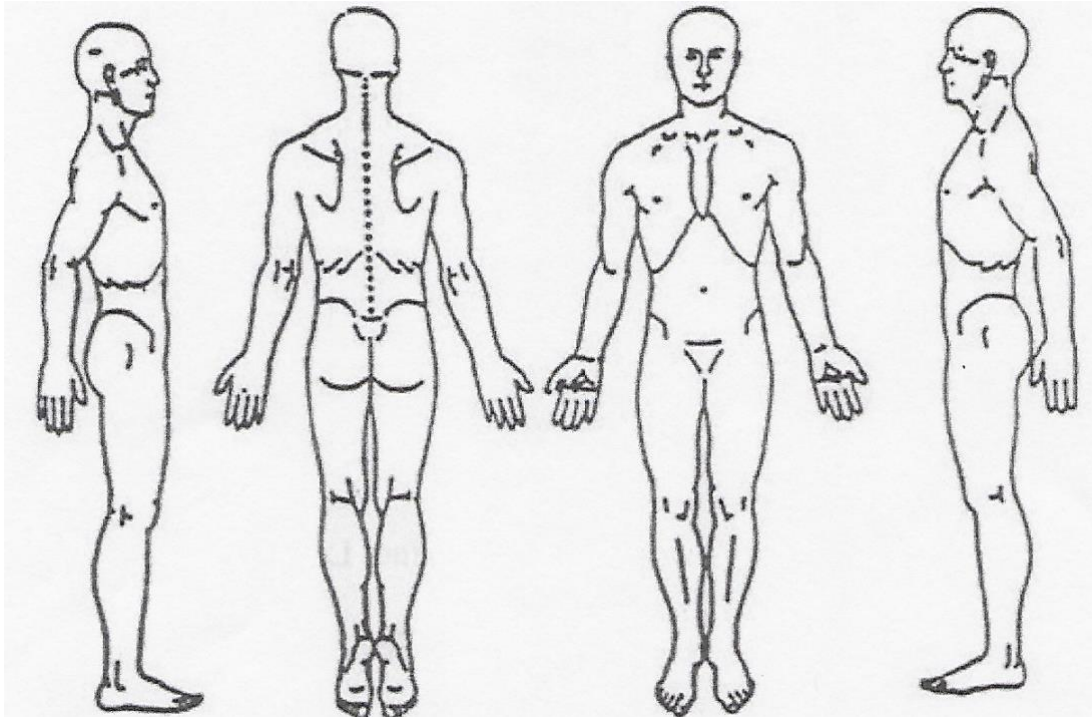
Family History:

Indicate if a close relative (parent/ child/ sibling) has had any of the following: Who?

| Condition: | Who? (example: parent, child, sibling, etc.) | Condition: | Who? (example: parent, child, sibling, etc.) |
|----------------------|--|-------------------|--|
| Allergies | | Arthritis | |
| Asthma | | Heart Disease | |
| Cancer | | Diabetes | |
| High Blood Pressure | | Thyroid condition | |
| Kidney Disease | | Depression | |
| Other mental illness | | Other | |
| Drug/alcohol abuse | | Other | |

IN:
DOB:

Please indicate below where you are experiencing concerns:



Please circle the number below, which indicates the level of pain:

(No Symptoms) 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 (Extreme Symptoms)

Check the following conditions that apply to you, past and present. Add comments for clarification if needed.

FULL BODY

- | | | |
|--|--|---|
| <input type="checkbox"/> Weight change | <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sweats/night sweats | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed/bruise easily | <input type="checkbox"/> Change in sleep | |

Comments: _____

EYES

- | | | |
|---|-----------------------------------|--|
| <input type="checkbox"/> Vision Glasses | <input type="checkbox"/> Blurring | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Dryness | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Styes | <input type="checkbox"/> Dark under Eyelid |

Comments: _____

EARS, NOSE, MOUTH, THROAT

- | | | |
|---|--|---|
| <input type="checkbox"/> Tinnitus (ringing) | <input type="checkbox"/> Diminishing Hearing | <input type="checkbox"/> Postnasal Drip |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Obstruction | <input type="checkbox"/> Mouth Sores |
| <input type="checkbox"/> Teeth Problem | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Taste Problem |
| <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Gum Disease |

Comments: _____

| |
|-------------|
| IN: DOB: |
|-------------|

NECK

- Stiffness Swollen Glands

Comments: _____

CARDIOVASCULAR

- Palpitations Pain Chest Pain
 Edema (Swelling) Hypertension Low BP
 Arrhythmias Rheumatic Fever

Comments: _____

RESPIRATORY

- Dyspnea (Breathlessness) Wheezing Cough
 Sputum (cough) Shortness of breath TB
 Bronchitis Pneumonia Asthma

Comments: _____

GASTROINTESTINAL

- Appetite Pain Indigestion
 Difficulty swallowing Jaundice Blood in Stool
 Constipation Anal Discomfort Nausea
 Vomiting Diarrhea Heartburn
 Bloating Pancreatitis Hemorrhoids
 Gall Bladder Disease Liver Disease

Comments: _____

GENITOURINARY (GENITAL & URINARY)

- Painful urination Night urinations Blood in urine
 Frequent Urination

Comments: _____

MUSCULOSKELETAL

- Trauma Swelling Pain
 Arthritis Tremors Stiffness

Comments: _____

NEUROLOGICAL

- Fainting Convulsions Sensations
 Coordination Speech Carpal tunnel
 Seizures Sciatica Paralysis

Comments: _____

PSYCHIATRIC

- Memory Loss Mood swings Sleep Pattern
 Anxiety Depression Phobia
 Drug/alcohol abuse Suicidal Anger/irritability

Comments: _____

IN:
DOB:

ENDOCRINE

- Goiter
- Tremor
- Hormone Therapy

- Heat/Cold Intolerance

Comments: _____

HEMATOLOGIC/LYMPHATIC

- Anemia
- Bleeding Tendency
- Transfusion

- Enlarged lymph nodes

Comments: _____

ALLERGIC/IMMUNOLOGIC

- Hives
- Hay Fever
- Seasonal Allergies

Comments: _____

HEAD

- Headaches
- Trauma/Head injury
- Migraine

- Hair Loss
- Dandruff
- Oily

Comments: _____

SKIN

- Itching
- Rash
- Psoriasis/eczema

- Cancer
- Color Change
- Lump

- Wart/Moles

Comments: _____

MALE

- Testicular pain/swelling
- Hernia
- Prostate Disease/Symptoms

Comments: _____

FEMALE

- Breast Masses
- Breast Pain
- Nipple Discharge

- Menstrual Cramping
- Any abnormal paps
- Dry vagina

- Vaginitis
- Heavy menstrual bleeding
- Menstrual Pain

- Pain w/ intercourse

Comments: _____

STI

- Syphilis
- Gonorrhea
- Sores/Discharge

- Chlamydia
- Herpes

Comments: _____

IN:
DOB:

Is there anything that you feel is important that has not been covered? _____

Which consultation will you prefer today? (Please check one)

- Office Visit (up to 30 mins + Wellness Scan) \$150.00** **Office Visit (Up to 1 ½ hrs + Wellness Scan) \$225.00**

Please check any **additional** ZYTO scans you would like today.

- Today's Immunity** **\$175.00**
The six main components to a healthy immune system consists of the gastrointestinal system, immune system, lymphatic system, respiratory system, mental/emotional stress, and sleep. These six components are measured more closely to help determine which areas of immunity may need the most support.
Estimated Time: 5 minutes
- Lifestyle** **\$250.00**
The four core systems of the body consist of the detoxification system, gastrointestinal system, hormonal/endocrine system, and the immune system. In order to maintain a healthy life, the four systems need to be balanced. The Lifestyle scan determines what categories need to be corrected to fulfill this goal.
Estimated Time: 25 minutes
- Digestive** **\$150.00**
The digestive system has a large influence on how the body and mind function. Because there are millions of neurons in the stomach lining, the stomach is often referred to as the body's "second brain." The Digestive Scan begins with scanning the primary digestive stressors in the body and can identify personalized data about your stomach's health.
Estimated Time: 15 minutes
- Wellness** **\$150.00**
A wellness scan is conducted to give us a general idea of what is going on in the body. It measures all biocommunications of the different components that make up our body, which provides insights into your personal wellness and helps determine a starting point to get the body aligned and balanced.
Estimated Time: 7 Minutes
- Foods for Wellness** **\$125.00**
One diet that is optimal for one, may not be optimal for another. This scan addresses everyone's bio-individuality and show what your body has a biological coherence or incoherence response to. It is NOT an allergy or toxin scan, but it can help guide your future diet and nutrition choices.
- Hormones** **\$100.00**
Hormones, in fact, not only control the reproductive system, but are necessary for the numerous other physical, mental, and emotional functions. The hormones scan addresses the most out of balance hormones, which will also help to improve or maintain your overall health.
- Vitamins & Minerals** **\$100.00**
Addresses the vitamins and minerals presently found in your body and which ones your body has a better response to.

Follow-up office visit: \$75.00

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The state of Texas does not allow ND's (naturopathic doctors) to prescribe pharmaceutical medications at this time, although it is legal in other states. In Texas, naturopathic doctors cannot legally "diagnose" or "treat" illness. We can, however, work with you to enhance your overall health and well-being. Due to the lack of licensure in Texas for naturopaths, most health insurances do not cover naturopathic/holistic services, homeopathic medications, and/or supplements. Please be aware if you choose to use a Flexible Spending Account or Health Savings Account, we are not responsible if they choose not to cover for naturopathic/holistic services, homeopathic medications, and/or supplements.

I, _____, understand that I cannot hold Natural Remedies accountable if I pay using my HSA or FSA for any services rendered and/or any purchases made at Natural Remedies.

Client's/Legal Guardian Signature

Date

HIPAA NOTICE OF PRIVACY PRACTICES

This notice is effective as of August 19, 2020.

Please be aware: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

Since 1996 certain laws have been enforced regarding medical record privacy (Health Insurance Portability and Accountability Act) or HIPAA. Under the law, we are now required to notify you of this, so here is a short version of these regulations for you, for your convenience. The privacy notice is available for you to read.

This Notice of Privacy Practices describes the ways we are allowed by law to use your protected health information (medical records) or PHI as we work with you to enhance your overall health and well-being, payment, and other health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. We are required to abide by these privacy rules.

According to privacy laws, your doctor or health care provider will use your PHI as he/she has always done to work with you to enhance your overall health and well-being, payment, or other health care operations. In addition, we may also disclose your PHI from time to time to other physicians or health care providers who become involved in taking care of you. Your PHI will be used, as needed, in order for us to obtain payments for our services. Should front desk sign in sheets be used where you will be asked to sign your name and we will call you by your name in the waiting room when your doctor is ready to see you. We may also use your PHI when necessary to contact you concerning your appointment. We will share your PHI with business associates who perform services for us. There could include billing services or transcribing services. They are also required to maintain confidentiality.

Your PHI could be used to provide you with information about alternative ways to improve your health or other health related benefits and services that may be of interest to you. Other uses or disclosures will be made only with your written authorization, unless otherwise allowed or required by law. You may revoke this authorization at any time, in writing.

Unless you object, we may reveal (with your signed consent) to a member of your family, close friend, or other person you choose, parts of your PHI that relate to that person's involvement in your health care. If you are unable to agree or object to this, as an emergency, your doctor will try to obtain your consent as soon as possible. Your PHI may be disclosed by us in order to comply with workman's compensation laws. If you are an inmate, we may disclose necessary information to the staff of the institution.

You have the right to inspect and copy your PHI except for certain federal law limitations. You may also ask us not to disclose your PHI or reason for seeing Dr. Johnson, payment, or health care operations, also that it not be disclosed to family members. This must be specific and in

writing. However, your doctor is not required to agree to such restrictions if he/she believes it is not in your best interest. You may ask for your PHI to be amended. You also have the right to know to whom we have revealed your information if it is other than for the care, payment, or health care operations.

You have the right to a paper copy of this notice upon request. 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. We will not retaliate against your filing such a complaint.

I HAVE READ AND UNDERSTOOD THE PRIVACY NOTICE

Client's Full Legal Name (Printed)

Client's/Legal Guardian Signature

Date

INDIVIDUAL/INDIVIDUALS LIST BELOW ARE AUTHORIZED TO RECEIVE MEDICAL INFORMATION CONCERNING THE ABOVE CLIENT:

Spouse: _____

Son / Daughter: _____

Mother / Father: _____

Other: _____

Client/Legal Guardian Signature

Date

Client Full Legal Name (Printed)

Client Health Information Consent Form

We want you to know how your Protected Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Protected Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing the consent.

1. The client understands and agrees to allow Natural Remedies to use their Protected Health Information (PHI) for the purpose of care, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this naturopathic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that Natural Remedies will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The client has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The client may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A client's written consent need only be obtained one time for all subsequent care given the client in this office.
4. The client may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of client record privacy, and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Clients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the client refuses to sign this consent for the purpose of care, payment and health care operations, Natural Remedies has the right to refuse to give care.
8. From time to time we may send you birthday cards or letters, use your name on a birthday list or use your name on a referral board in our office. By your signature below, you have given us permission to do so.
9. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

I have read and understand how my Protected Health Information will be used and I agree to these policies and procedures.

Client/Legal Guardian Signature

Date

Client Full Legal Name (Printed)

Natural Remedies

Dr. Borislava Johnson, B.S.N.D.

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www.naturalremedies.com

Supplement Pick-Up Authorization

Client Name: _____
(Please Print)

In order to protect the privacy of our clients, Natural Remedies will only release supplements to relatives, partners, or friends with your signed consent. If you wish to authorize someone to pick your supplements for any future date, please fill out the information below for our records.

Please list below the name of any individual(s) you wish to authorize to pick-up any supplement(s) recommended by Dr. Johnson:

1. _____
2. _____
3. _____
4. _____
5. _____

Client Signature: _____ Date: _____

Please note: This permission form only authorizes the release of supplements to another individual(s), not the release of your health information.