IN:
DOB:

Natural Remedes
Dr. Borislava Johnson, B.C.N.D.
11078 Regency Green
Cypress, TX 77429
832-588-8863
www.naturalremedes.com

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.		

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 tested positive for COVID-19? **Y / N** If so, when, what were your symptoms, and how severe were the symptoms?

_____

_____

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

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? _____

_____

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

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	

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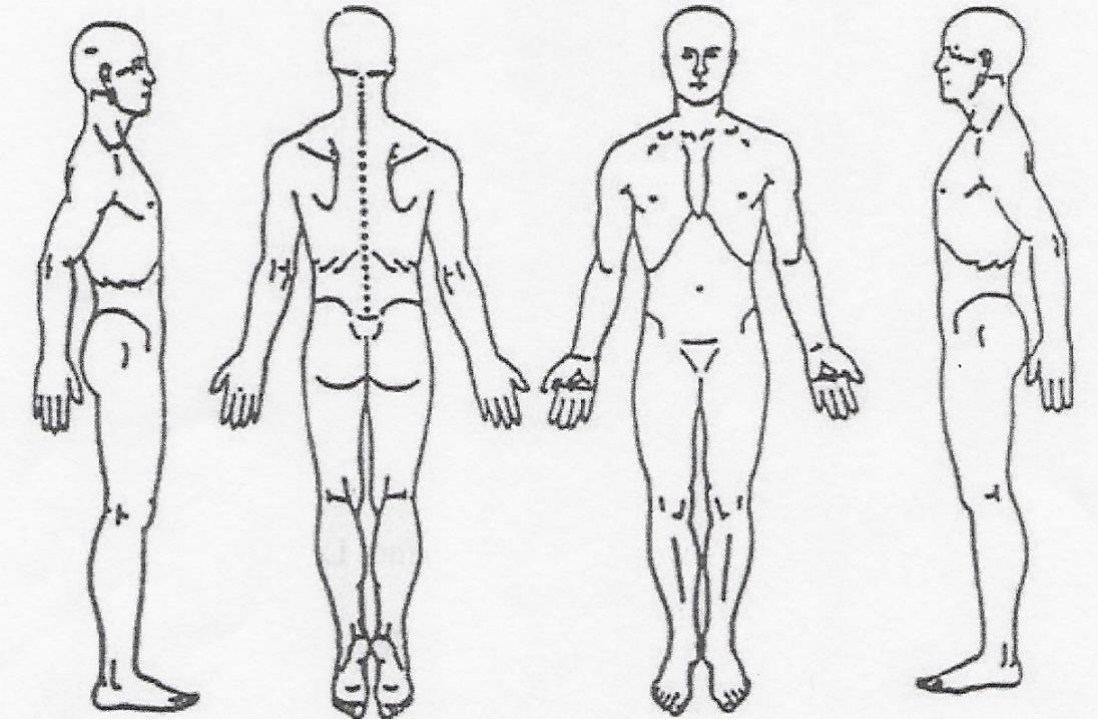
Please indicate below where you are experiencing concerns:



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

□ Weight change	□ Fever/chills	□ Weakness
□ Fatigue	□ Sweats/night sweats	□ Change in appetite
□ Bleed/bruise easily	□ Change in sleep	

Comments: _____

_____

EYES

□ Vision Glasses	□ Blurring	□ Pain
□ Discharge	□ Dryness	□ Glaucoma
□ Cataracts	□ Styes	□ Dark under Eyelid

Comments: _____

_____

EARS, NOSE, MOUTH, THROAT

□ Tinnitus (ringing)	□ Diminishing Hearing	□ Postnasal Drip
□ Bleeding	□ Obstruction	□ Mouth Sores
□ Teeth Problem	□ Hoarseness	□ Taste Problem
□ Nasal Polyps	□ Sore Throat	□ Gum Disease

Comments: _____

_____

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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:
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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 Pap smears □ Dry vagina
□ Vaginitis □ Heavy menstrual bleeding □ Menstrual Pain
□ Pain w/ intercourse
Comments: _____

STI

□ Syphilis □ Gonorrhea □ Sores/Discharge
□ Chlamydia □ Herpes
Comments: _____

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

_____

_____

Health Saving and Flexible Spending Accounts Disclaimer
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 no 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 Remedes accountable if I pay using my HSA or FSA for any services rendered and/or any purchases made at Natural Remedes.

_____

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 your 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 used 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 Remedes 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 Remedes 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 Remedes 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 Remedes
Dr. Borislava Johnson, B.C.N.D.
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www.naturalremedes.com

Supplement Pick-Up Authorization

Client Name: _____
(Please Print)

In order to protect the privacy of our clients, Natural Remedes 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.