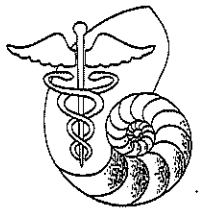
"We look forward to meeting you!"



The Art of Health
Dr. Amy Anderson, DO

20696 Bond Rd. NE
Suite #210
Poulsbo, WA 98370

Phone: 360-692-7919
Fax: 360-692-7960

Located on the corner of
Bond Rd. & HWY 305
in the North Kitsap Medical Center

The Art of Health, PLLC
Amy M Anderson, D.O.
20696 Bond Rd NE #210
Poulsbo, WA 98370
Ph: (360)692-7919 Fax: (360) 692-7960

Welcome to The Art of Health

Phone calls. During office hours we receive a very large volume of phone calls. Our first priority is life threatening emergencies, followed by scheduled patient appointments. We do not have extra staff to answer phones, so when you call you will be able to leave a message. Messages are checked daily, but triaged and handled in the order of medical necessity. We respond to all messages, but may take up to 72 hours.
*If you call and do not choose the appropriate option, this will lag in the timeliness of our returned call. Please do not leave multiple messages.

Prescription refills. Plan ahead. Allow 7 days to refill. When you get to your last refill, it is time to schedule a follow up appointment.

Referrals. Please be patient. Most specialists are about 1 to 3 months booked out. It does require a good amount of work on our part to send a patient referral. Please allow up to 2 weeks for the referral process to be completed before calling our office or the specialist's office.

Labs/Imaging. All imaging and lab results require a scheduled appointment to review.

You are responsible for knowing your insurance and lab coverage. We have nothing to do with the cost of labs or your bills. Dr. Anderson always uses as many appropriate codes as possible. For problems please call the lab or your insurance company directly.

Paperwork. All paperwork, forms, letters, ect. require an appointment to be completed.

- Please do not walk in to the office for medical questions. This greatly interrupts work flow and is not fair to patients who have a scheduled appointments or left messages.

Please be aware, it is our office policy that your first initial appointment is an

Establish Care appointment.

This is where Dr. Anderson will get to know your medical past, so she can plan for what you need for future appointments.

This appointment is

NOT a Preventative Care/Physical appointment

GENERAL INFORMATION

Name: *First* *Middle* *Last*

Preferred Name:

Date of Birth: Age:

Gender: O Male O Female

Genetic Background: O African O European O Native American O Mediterranean
O Asian O Ashkenazi O Middle Eastern

Highest Education Level: O High School O Under-Graduate O Post-Graduate

Job Title:

Nature of Business:

Primary Address: *Number, Street:* *Apt. No.*

City *State* *Zip*

Primary Address: *Number, Street:* *Apt. No.*

City *State* *Zip*

Home Phone 1:

Home Phone 2:

Work Phone:

Cell Phone:

Fax:

E-mail:

Emergency Contact: *Name* *Phone Number:*

Address *Apt. No.*

City *State* *Zip*

Physician's Name:

Phone Number Fax

Referred by:
OGoogle (which words)_____ OMedia_____
OFamily Member_____ OFriend_____
OOther_____

PATIENT REGISTRATION FORM
DISCLOSURES AND CONSENTS

Patient Name: _____ DOB: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to The Art of Health, PLLC for services rendered to my dependents or me. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that The Art of Health, PLLC is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to The Art of Health, PLLC on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Patient Information Privacy Policy. I hereby authorize The Art of Health, PLLC to release any of my or my dependent's medical or incidental non-public personal information that may be necessary to medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO CALL OR MAIL:

I certify that I understand the privacy risks of phone calls or the mail. I hereby authorize a representative or The Art of Health, PLLC to call or mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying The Art of Health, PLLC to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes labs, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by The Art of Health, PLLC.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____

GUARANTOR NAME (Please Print): _____

MEDICATIONS

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

PREVIOUS MEDICATIONS *(LIST TO GET A COMPLETE HISTORY)*

MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

NUTRITIONAL SUPPLEMENTS *(VITAMINS/MINERALS/HERBS/HOMEOPATHY)*

SUPPLMENT AND BRAND	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

Have your medications or supplements ever caused you unusual side effects or problems? ○ Yes ○ No
Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ○ Yes ○ No

Have you had prolonged or regular use of Tylenol? ○ Yes ○ No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ○ Yes ○ No

Frequent antibiotics > 3 times/year ○ Yes ○ No

Long term antibiotics ○ Yes ○ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ○ Yes ○ No

Use of oral contraceptives ○ Yes ○ No

PHARMACY INFORMATION

Primary Pharmacy: *Name* *Phone Number:*

Address

City *State* *Zip*

E-mail *Fax**

** It is extremely important that you list the pharmacy's fax number.*

Compounding/Supplement Pharmacy:

Name *Phone Number:*

Address

City *State* *Zip*

E-mail *Fax**

** It is extremely important that you list the pharmacy's fax number.*

ALLERGIES

Medication/ Supplement/Food: _____

_____

Reaction: _____

_____

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us?_____

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____

2. _____

3. _____

When was the last time you felt well?_____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Please list current and ongoing problems in order of priority:

Describe Problem:	Mild	Moderate	Severe
Example: Post Nasal Drip		X	

Prior Treatment/Approach	Excellent	Good	Fair
Example: Elimination Diet	X		

MEDICAL HISTORY DISEASES/DIAGNOSIS/CONDITIONS

Check appropriate box and provide date of onset

GASTROINTESTINAL

- ☐ Irritable Bowel Syndrome _____
- ☐ Inflammatory Bowel Disease _____
- ☐ Crohn's _____
- ☐ Ulcerative Colitis _____
- ☐ Gastritis or Peptic Ulcer Disease _____
- ☐ GERD (reflux) _____
- ☐ Celiac Disease _____
- ☐ Other _____

CARDIOVASCULAR

- ☐ Heart Attack _____
- ☐ Other Heart Disease _____
- ☐ Stroke _____
- ☐ Elevated Cholesterol _____
- ☐ Arrythmia (irregular heart rate) _____
- ☐ Hypertension (high blood pressure) _____
- ☐ Rheumatic Fever _____
- ☐ Mitral Valve Prolapse _____
- ☐ Other _____

METABOLIC/ENDOCRINE

- ☐ Type 1 Diabetes _____
- ☐ Type 2 Diabetes _____
- ☐ Hypoglycemia _____
- ☐ Metabolic Syndrome _____
- ☐ (Insulin Resistance or Pre-Diabetes)
- ☐ Hypothyroidism (low thyroid) _____
- ☐ Hyperthyroidism (overactive thyroid)_____
- ☐ Endocrine Problems_____
- ☐ Polycystic Ovarian Syndrome (PCOS) _____
- ☐ Infertility_____
- ☐ Weight Gain_____
- ☐ Weight Loss _____
- ☐ Frequent Weight Fluctuations_____
- ☐ Bulimia _____
- ☐ Anorexia _____
- ☐ Binge Eating Disorder_____
- ☐ Night Eating Syndrome_____
- ☐ Eating Disorder (non-specific _____
- ☐ Other_____

CANCER

- ☐ Lung Cancer _____
- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ Ovarian Cancer _____
- ☐ Prostate Cancer _____
- ☐ Skin Cancer _____

GENITAL AND URINARY SYSTEMS

- ☐ Kidney Stones _____
- ☐ Gout _____
- ☐ Interstitial Cystitis _____
- ☐ Frequent Urinary Tract Infections _____
- ☐ Frequent Yeast Infections _____
- ☐ Erectile Dysfunction or Sexual Dysfunction _
- ☐ Other _____

MUSCULOSKELETAL/PAIN

- ☐ Osteoarthritis _____
- ☐ Fibromyalgia _____
- ☐ Chronic Pain _____
- ☐ Other _____

INFLAMMATORY/AUTOIMMUNE

- ☐ Chronic Fatigue Syndrome _____
- ☐ Autoimmune Disease _____
- ☐ Rheumatoid Arthritis _____
- ☐ Lupus SLE_ _____
- ☐ Immune Deficiency Disease _____
- ☐ Herpes-Genital _____
- ☐ Severe Infectious Disease _____
- ☐ Poor Immune Function _____
- ☐ (frequent infections)
- ☐ Food Allergies _____
- ☐ Environmental Allergies _____
- ☐ Multiple Chemical Sensitivities _____
- ☐ Latex Allergy _____
- ☐ Other _____

MEDICAL HISTORY *(CONTINUED)*

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

RESPIRATORY DISEASES

- ☐ Asthma _____
- ☐ Chronic Sinusitis _____
- ☐ Bronchitis _____
- ☐ Emphysema _____
- ☐ Pneumonia _____
- ☐ Tuberculosis _____
- ☐ Sleep Apnea _____
- ☐ Other _____

SKIN DISEASES

- ☐ Eczema _____
- ☐ Psoriasis _____
- ☐ Acne _____
- ☐ Melanoma _____
- ☐ Skin Cancer _____
- ☐ Other _____

NEUROLOGIC/MOOD

- ☐ Depression _____
- ☐ Anxiety _____
- ☐ Bipolar Disorder _____
- ☐ Schizophrenia _____
- ☐ Headaches _____
- ☐ Migraines _____
- ☐ ADD/ADHD _____
- ☐ Autism _____
- ☐ Mild Cognitive Impairment _____
- ☐ Memory Problems _____
- ☐ Parkinson's Disease _____
- ☐ Multiple Sclerosis _____
- ☐ ALS _____
- ☐ Seizures _____
- ☐ Other Neurological Problems _____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam _____
- ☐ Bone Density _____
- ☐ Colonoscopy _____
- ☐ Cardiac Stress Test _____
- ☐ EBT Heart Scan _____
- ☐ EKG _____
- ☐ Hemoccult Test-*stool test for blood* _____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____
- ☐ Ultrasound _____

INJURIES

Check box if yes: ☐ Back Injury ☐ Head Injury ☐ Neck Injury ☐ Broken Bones

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy _____
- ☐ Hysterectomy +/- Ovaries _____
- ☐ Gall Bladder _____
- ☐ Hernia _____
- ☐ Tonsillectomy _____
- ☐ Dental Surgery _____
- ☐ Joint Replacement –Knee/Hip _____
- ☐ Heart Surgery–Bypass Valve _____
- ☐ Angioplasty or Stent _____
- ☐ Pacemaker _____
- ☐ Other _____
- ☐ None _____

BLOOD TYPE

☐A ☐B ☐AB ☐O ☐Rh+ ☐Unknown

HOSPITALIZATIONS

☐ None

Date:	Reason:

GYNECOLOGIC HISTORY *(FOR WOMEN ONLY)*

OBSTETRIC HISTORY *(Check box if yes and provide number)*

☐ Pregnancies_____ ☐ Caesarean_____ ☐ Vaginal deliveries_____
☐ Miscarriage_____ ☐ Abortion_____ ☐ Living Children_____
☐ Post PartumDepression ☐ Toxemia ☐ Gestational Diabetes Baby Over 8 Pounds
☐ Breast Feeding For how long?_____

MENSTRUAL HISTORY

Age at First Period:_____ Menses Frequency:_____ Length:_____ Pain: ○ Yes ○ No Clotting: ○ Yes ○ No
Has your period ever skipped?_____ For how long?_____
Last Menstrual Period:_____
Use of hormonal contraception such as: ☐ Birth Control Pills ☐Patch ☐Nuva Ring
How long?_____
Do you use contraception? ○ Yes ○ No
☐Condom ☐Diaphragm ☐ IUD ☐Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐Fibrocystic Breasts ☐Endometriosis ☐ Fibroids ☐Infertility
☐Painful Periods ☐Heavy periods ☐PMS
Last Mammogram:_____ Breast Biopsy/Date:_____
Last PAP Test:_____ ☐ Normal ☐ Abnormal
Last Bone Density:_____ Results: ☐ High ☐ Low ☐ Within Normal Range
Are you in menopause? ☐ Yes ☐ No
Age at Menopause_____
☐Hot Flashes ☐Mood Swings ☐Concentration/Memory Problems
☐Vaginal Dryness ☐ Decreased Libido

WOMEN'S DISORDERS/HORMONAL IMBALANCES *(CONTINUED)*

☐ Heavy Bleeding ☐Joint Pains ☐Headaches ☐ Weight Gain
☐Loss of Control of Urine ☐Palpitations
☐ Use of hormone replacement therapy How long?_____

MEN'S HISTORY *(FOR MEN ONLY)*

Have you had a PSA done? ○ Yes ○ No
PSA Level: □0-2 □2-4 □4-10 □>10
□Prostate Enlargement □Prostate infection □Change in Libido □Impotence
□Difficulty Obtaining an Erection □Difficulty Maintaining an Erection
□Nocturia (urination at night) How many times at night? _____
□ Urgency/Hesitancy/Change in Urinary Stream □ Loss of Control of Urine

GI HISTORY

Foreign Travel? ○ Yes ○ No Where? _____
Wilderness Camping? ○ Yes ○ No Where? _____
Have you ever had severe: ○ Gastroenteritis ○ Diarrhea
Do you feel like you digest your food well? ○ Yes ○ No
Do you feel bloated after meals? ○ Yes ○ No

PATIENT BIRTH HISTORY

○ Term ○ Premature
Pregnancy Complications: _____
Birth Complications: _____
□ Breast Fed. How long?_____ □ Bottle-fed
Age at introduction of: Solid Foods:_____ Dairy:_____Wheat:_____
Did you eat a lot of candy or sugar as a child? ○ Yes ○ No

DENTAL HISTORY

□ Silver Mercury Fillings How many? _____
□ Gold Fillings
□ Root Canals How many? _____
□ Implants
□ Tooth Pain
□ Bleeding Gums
□ Gingivitis
□ Problems with Chewing

Do you floss regularly? ○ Yes ○ No

SMOKING

Currently Smoking? ○ Yes ○ No
How many years? _____ Packs per day: _____ Attempts to quit: _____
Previous Smoking: How many years? _____ Packs per day? _____
Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits*
□ None □ 1-3 □4-6 □ 7-10 □> 10 *If "None," skip to Other Substances*
Previous alcohol intake? ○ Yes (○ Mild ○ Moderate ○ High) ○ None
Have you ever been told you should cut down your alcohol intake? ○ Yes ○ No
Do you get annoyed when people ask you about your drinking? ○ Yes ○ No
Do you ever feel guilty about your alcohol consumption? ○ Yes ○ No
Do you ever take an eye-opener? ○ Yes ○ No
Do you notice a tolerance to alcohol (can you "hold" more than others)? ○ Yes ○ No
Have you ever been unable to remember what you did during a drinking episode? ○ Yes ○ No
Do you get into arguments or physical fights when you have been drinking? ○ Yes ○ No
Have you ever been arrested or hospitalized because of drinking? ○ Yes ○ No
Have you ever thought about getting help to control or stop your drinking? ○ Yes ○ No

OTHER SUBSTANCES

Caffeine Intake: ○ Yes ○ No
Coffee cups/day: □1 □2-4 □> 4 | Tea cups/day: □1 □2-4 □> 4
Caffeinated Sodas or Diet Sodas Intake: ○ Yes ○ No
12-ounce can/bottle □1 □2-4 □> 4 per day
List favorite type (Ex. Diet Coke, Pepsi, etc.): _____
Are you currently using any recreational drugs? ○ Yes ○ No
Type _____
Have you ever used IV or inhaled recreational drugs? ○ Yes ○ No

EXERCISE

Current Exercise Program: *(List type of activity, number of sessions/week, and duration)*

Activity	Type	Frequency per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? ○ Low ○ Medium ○ High
List problems that limit activity:

_____

_____

Do you feel unusually fatigued after exercise? ○ Yes ○ No
If yes, please describe:

_____

_____

Do you usually sweat when exercising? ○Yes ○ No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ○ Yes ○ No
Are you happy? ○ Yes ○ No
Do you feel your life has meaning and purpose? ○ Yes ○ No
Do you believe stress is presently reducing the quality of your life? ○ Yes ○ No
Do you like the work you do? ○ Yes ○ No
Have you ever experienced major losses in your life? ○ Yes ○ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations? ○ Yes ○ No
Would you describe your experience as a child in your family as happy and secure? ○ Yes ○ No

STRESS/COPING

Have you ever sought counseling? ○ Yes ○ No
Are you currently in therapy? ○ Yes ○ No
Describe: _____
Do you feel you have an excessive amount of stress in your life? ○ Yes ○ No
Do you feel you can easily handle the stress in your life? ○ Yes ○ No
Daily Stressors: Rate on scale of 1-10
Work_____ Family_____ Social_____ Finances_____ Health_____ Other_____
Do you practice meditation or relaxation techniques? ○ Yes ○ No How often? _____
Check all that apply: □Yoga □Meditation □Imagery □Breathing □Tai Chi □Prayer
□Other: _____
Have you ever been abused, a victim of a crime, or experienced a significant trauma?
○Yes ○ No

SLEEP/REST

Average number of hours you sleep per night: □>10 □8-10 □6-8 □< 6
Do you have trouble falling asleep? ○ Yes ○ No
Do you feel rested upon awakening? ○ Yes ○ No
Do you have problems with insomnia? ○ Yes ○ No
Do you snore? ○ Yes ○ No
Do you use sleeping aids? ○ Yes ○ No
Explain: _____

FAMILY HISTORY

Check family members that apply.	MOTHER	FATHER	BROTHER(S)	SISTER(S)	CHILDREN	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	AUNTS	UNCLES	OTHER
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Thyroid Problems Lupus												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Other:												

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? ○ Yes ○ No
Have you made any changes in your eating habits because of your health? ○ Yes ○ No
Describe: _____
Do you currently follow a special diet or nutritional program? ○ Yes ○ No

Check all that apply:
□ Low Fat □ Low Carbohydrate □ High Protein □ Low Sodium □ Diabetic □ No Dairy
□ No Wheat □ Gluten Restricted □ Vegetarian □ Vegan
□ Specific Program for Weight Loss/Maintenance Type: _____
□ Other _____

Height (feet/inches) _____ Current Weight _____
Usual Weight Range +/- 5 lbs _____ Desired Weight Range +/- 5 lbs _____
Highest adult weight _____ Lowest adult weight _____
Weight Fluctuations (> 10 lbs.) ○ Yes ○ No Body Fat % _____

How often do you weigh yourself? ○ Daily ○ Weekly ○ Monthly ○ Rarely ○ Never
Have you ever had your metabolism (resting metabolic rate) checked? ○ Yes ○ No
If yes, what was it? _____
Do you avoid any particular foods? ○ Yes ○ No
If yes, types and reason _____
_____
If you could only eat a few foods a week, what would they be?
_____
Do you grocery shop? ○ Yes ○ No
If no, who does the shopping? _____
Do you read food labels? ○ Yes ○ No
Do you cook? ○ Yes ○ No If no, who does the cooking? _____
How many meals do you eat out per week? □ 0-1 □ 1-3 □ 3-5 □ >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:
□ Fast eater
□ Erratic eating pattern
□ Eat too much
□ Late night eating
□ Dislike healthy food
□ Time constraints
□ Eat more than 50% meals away from home
□ Travel frequently
□ Non-availability of healthy foods
□ Do not plan meals or menus
□ Reliance on convenience items
□ Poor snack choices
□ Significant other or family members don't like healthy foods
□ Significant other or family members have special dietary needs or food preferences
□ Love to eat
□ Eat because I have to
□ Have a negative relationship to food
□ Struggle with eating issues
□ Emotional eater (eat when sad, lonely depressed, bored)
□ Eat too much under stress
□ Eat too little under stress
□ Don't care to cook
□ Eating in the middle of the night
□ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is:

ROLES/RELATIONSHIP

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long Term Partnership ☐ Widow
List Children: Child's Name Age Gender

_____ _____ _____

_____ _____ _____

Who is Living in Household? Number: _____

Names:_____ _____ _____

_____ _____ _____

Their Employment/Occupations: _____ _____

_____ _____ _____

Resources for emotional support?

Circle all that apply:

*Spouse *Family *Friends *Religious/Spiritual *Pets *Other: _____

Are you satisfied with your sex life? ☐ Yes ☐ No

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No

If yes, describe symptoms:

_____

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If yes, list all:

_____

Do you have an adverse reaction to caffeine? ☐ Yes ☐ No

When you drink caffeine do you feel: ☐Irritable or wired ☐Aches & Pains

Do you adversely react to (Circle all that apply):

*Monosodium glutamate (MSG) *Aspartame (Nutrasweet) *Caffeine *Bananas *Garlic *Onion *Cheese *Citrus Foods *Chocolate *Alcohol *Red Wine *Sulfite Containing Foods (wine, dried fruit, salad bars) *Preservatives (ex. sodium benzoate)

Other: _____

Which of these significantly affect you? Circle all that apply:

*Cigarette Smoke *Perfumes/Colognes *Auto Exhaust Fumes

*Other: _____

In your work or home environment, are you exposed to:

*Chemicals *Electromagnetic Radiation *Mold

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No

Have you ever been told you have Gilbert's syndrome or a liver disorder? ☐ Yes ☐ No

Explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

*Herbicides *Insecticides (frequent visits of exterminator) *Pesticides £Organic Solvents *Heavy Metals

*Other_____

Chemical Name, Date, Length of Exposure: _____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? ☐ Yes ☐ No

Do you have any pets or farm animals? ☐ Yes ☐ No

SYMPTOM REVIEW

Please check all current symptoms or those present in during the past the 6 months.

GENERAL
- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

HEAD, EYES & EARS
- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MUSCULOSKELETAL
- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness

Muscle Twitches:
- ☐ Around Eyes
- ☐ Arms or Legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES
- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression

Difficulty:
- ☐ Concentrating
- ☐ With Balance
- ☐ With Thinking
- ☐ With Judgment
- ☐ With Speech
- ☐ With Memory

- ☐ Dizziness (Spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

EATING
- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (breads, pastas)
- ☐ Sweet Cravings (candy, cookies, cakes)
  - ☐ Chocolate Cravings
  - ☐ Caffeine Dependency

DIGESTION
- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums

Bloating of:
- ☐ Lower Abdomen
- ☐ Whole Abdomen
- ☐ Bloating After Meals

- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting

Intolerance to:
- ☐ Lactose
- ☐ All Dairy Products ☐ Wheat
- ☐ Gluten (Wheat, Rye, Barley)
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast

- ☐ Liver Disease/Jaundice (Yellow Eyes or Skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in St

SKIN PROBLEMS
- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack Of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN
- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

SKIN, DRYNESS OF
- ☐ Eyes
- ☐ Feet
  - ☐ Cracking?
  - ☐ Peeling?
- ☐ Hair ☐ Unmanageable?
- ☐Hands
  - ☐Cracking? ☐Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - ☐ Dandruff?
- ☐ Skin In General

LYMPH NODES
- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

NAILS
- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft

Thickening of:
- ☐ Fingernails
- ☐ Toenails
- ☐ White Spots/Lines

RESPIRATORY
- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat

Hay Fever:
  - ☐ Spring
  - ☐ Summer
  - ☐ Fall
  - ☐ Change Of Season
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR
- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

URINARY
- ☐ Bed Wetting
- ☐ Hesitancy
  (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

MALE REPRODUCTIVE
- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps In Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE
- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:
- ☐ Bloating Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual:
- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):
In order to improve your health, how willing are you to:
Significantly modify your diet..... O 5 O 4 O 3 O 2 O 1
Take several nutritional supplements each day..... O 5 O 4 O 3 O 2 O 1
Keep a record of everything you eat each day..... O 5 O 4 O 3 O 2 O 1
Modify your lifestyle (e.g., work demands, sleep habits) ..... O 5 O 4 O 3 O 2 O 1
Practice a relaxation technique ..... O 5 O 4 O 3 O 2 O 1
Engage in regular exercise ..... O 5 O 4 O 3 O 2 O 1
Have periodic lab tests to assess your progress..... O 5 O 4 O 3 O 2 O 1

Comments _____
_____
_____

Rate on a scale of 5 (very confident) to 1 (not confident at all):
How confident are you of your ability to organize and follow through on the above health related activities? O 5 O 4 O 3 O 2 O 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?

_____
_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):
At the present time, how supportive do you think the people in your household will be to your implementing the above changes? O 5 O 4 O 3 O 2 O 1

Comments: _____
_____
_____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):
How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?
O 5 O 4 O 3 O 2 O 1

Comments: _____
_____
_____

The Art of Health, PLLC
Amy M. Anderson D.O.
20696 Bond RD NE
Poulsbo, WA 98370
Ph: (360)692-7919 Fax: (360) 692-7960

Cancellation Policy/No Show Policy

1. Cancellation/ No Show Policy For Doctor Appointment

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed care.

Effective **July 15, 2018** any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a **$50.00 fee**.

The charge is **Non-Negotiable**. If you dispute this fee, Dr. Amy Anderson DO, reserves the right to terminate the doctor-patient relationship.

No Show fees will be billed to the patient. This fee is not covered by insurance. All no show fees MUST be paid prior to the next appointment in order to be seen.
Dr. Amy Anderson, DO reserves the right to terminate the doctor-patient relationship of established patients due to no-shows.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and the doctor on time. If you are 10 minutes past your scheduled time we will have to reschedule the appointment.

I have read and understand the following policy. By signing below I agree to the above terms and conditions.

_____	_____	___/___/___
Print Name Patient	**Signature Patient/Guardian**	**Date**

The Art of Health, PLLC
Amy M Anderson, D.O.
20696 Bond Rd NE #210
Poulsbo, WA 98370
Ph: (360)692-7919 Fax: (360) 692-7960

Medication Policy

Please be advised you are responsible to keep your medications up to date and active.

If you have no refills left it means it is time to follow up with the doctor. Please call and set an appointment.

If you are on a controlled substance you are required to follow up every three months. It is best to make those follow up appointments after your last appointment to insure you do not have a lapses in care.

Medication refills need to be requested through your pharmacy, as they will send us the requests.

Please allow 72 business hours for completion of your refill.

There will be no expedited appointments or refills if you do not comply.

Please sign and date below

Signature

Date

INFORMED CONSENT FOR TELEHEALTH

1. I understand that Amy Anderson D.O. might recommend engaging in telehealth services with me to provide treatment.

2. To maintain confidentiality, I will not share my telehealth appointment with anyone not authorized to attend the session.

3. I understand that telehealth treatment has potential benefits including, but not limited to, easier access to care.

4. I understand that telehealth has been found to be effective in treating a wide range of disorders, and there are potential benefits including, but not limited to easier access to care. I understand; however, there is no guarantee that all treatment of all patients will be effective.

5. I understand that it is my obligation to notify my The Art of Health of my contact information prior to each treatment session. If for some reason, I change contact information it is my obligation to notify The Art of Health of the change in information.

6. I understand that either I or Amy Anderson D.O. can discontinue the telehealth services if those services do not appear to benefit me therapeutically or for other reasons which will be explained to me

7. I agree that I will not record either through audio or video any of the session, unless I notify my Amy Anderson D.O. and this is agreed upon.

8. I understand there are potential risks to using telehealth technology, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand some of these technological challenges include issues with software, hardware, and internet connection which may result in interruption.

9. I understand that The Art of Health is not responsible for any technological problems of which Amy Anderson D.O. Has no control over. I further understand that The Art of Health does not guarantee that technology will be available or work as expected.

10. I understand that I am responsible for information security on my device, including but not limited to, computer, tablet, or phone, and in my own location.

11. I understand that Amy Anderson D.O. or I can discontinue the telehealth consult/visit if it is determined by either me or Amy Anderson D.O. that the telehealth connections or protections are not adequate for the situation.

(See Other Side)

By signing this document, I acknowledge:

1. The Art of Health is **NOT** an emergency service. In the event of an emergency, I will use a phone to call 9-1-1 and/or other appropriate emergency contact.

2. I recognize The Art of Health and Amy Anderson D.O. may need to notify emergency personnel in the event he/she feels there is a safety concern, including but not limited to, a risk to self/others or Amy Anderson D.O. is concerned that immediate medical attention is needed.

3. Though The Art of Health and Amy Anderson D.O. and I may be in contact through telehealth services, neither The Art of Health nor Amy Anderson D.O. provides any medical or emergency or urgent healthcare services or advice. I understand should medical services be required, I will contact my physician. If emergency services are needed, I understand I should call 9-1-1.

4. I understand that the same fee rates apply for telehealth as apply for in-person treatment. It is my obligation to contact my insurer before engaging in telehealth to determine if there are applicable co-pays or fees which I am responsible for. Insurance or other managed care providers may not cover telehealth sessions. I understand that if my insurance, does not cover the telehealth sessions, I will be solely responsible for the entire fee of the session.

I have read and understand the information provided above regarding telehealth, have discussed it with The Art of Health, and I hereby give informed consent to the use of telehealth.

_____
Signature of patient (or guardian/conservator)

_____
Printed name

_____
Date

THE ART OF HEALTH, PLLC
AMY M. ANDERSON, DO

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing our Patient Registration Disclosures and Consents form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing our Patient Registration Disclosures and Consents form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Signature: _____