"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
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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): ____

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.***

PEDIATRIC MEDICAL QUESTIONNAIRE

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 help your child in three ways, what would they be?

1. ______________________
2. ______________________
3. ______________________

When was the last time you feel your child was well? ______________________

____

Did something trigger your child's change in health? ______________________

____

Is there anything that makes your child feel worse? ______________________

____

Is there anything that makes your child feel better? ______________________

____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	**Prior Treatment/Approach**	Excellent	Good	Fair
Example: Difficulty Maintaining Attention		*X*		*Elimination Diet*	*X*		

MEDICAL HISTORY

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

Past	Current	GASTROINTESTINAL
☐	☐	Irritable Bowel Syndrome ________________
☐	☐	Inflammatory Bowel Disease ________________
☐	☐	Crohn's ________________
☐	☐	Ulcerative Colitis ________________
☐	☐	Gastritis or Peptic Ulcer Disease ________________
☐	☐	GERD (reflux) ________________
☐	☐	Celiac Disease ________________
☐	☐	Other ________________

Past	Current	CARDIOVASCULAR
☐	☐	Heart Disease ________________
☐	☐	Elevated Cholesterol ________________
☐	☐	Hypertension (high blood pressure) ________________
☐	☐	Rheumatic Fever ________________
☐	☐	Mitral Valve Prolapse ________________
☐	☐	Other ________________

Past	Current	METABOLIC/ ENDOCRINE
☐	☐	Type 1 Diabetes ________________
☐	☐	Type 2 Diabetes ________________
☐	☐	Hypoglycemia ________________
☐	☐	Metabolic Syndrome (Pre-Diabetes) ________________
☐	☐	Hypothyroidism (low thyroid) ________________
☐	☐	Hyperthyroidism (overactive thyroid) ________________
☐	☐	Endocrine Problems ________________
☐	☐	Polycystic Ovarian Syndrom (PCOS) ________________
☐	☐	Weight Gain ________________
☐	☐	Weight Loss ________________
☐	☐	Frequent Weight Fluctuations ________________
☐	☐	Bulimia ________________
☐	☐	Anorexia ________________
☐	☐	Binge Eating Disorder ________________
☐	☐	Night Eating Syndrome ________________
☐	☐	Eating Disorder (non-specific) ________________
☐	☐	Other ________________

Past	Current	CANCER
☐	☐	________________

Past	Current	GENITAL AND URINARY
☐	☐	Kidney Stones ________________
☐	☐	Urinary Tract Infection ________________
☐	☐	Yeast Infections ________________
☐	☐	Other ________________

Past	Current	MUSCULOSKELETAL/ PAIN
☐	☐	Arthritis ________________
☐	☐	Fibromyalgia ________________
☐	☐	Chronic Pain ________________
☐	☐	Other ________________

Past	Current	INFLAMMATION/
☐	☐	Chronic Fatigue Syndrome ________________
☐	☐	Autoimmune Disease ________________
☐	☐	Rheumatoid Arthritis ________________
☐	☐	Lupus SLE ________________
☐	☐	Immune Deficiency Disease ________________
☐	☐	Severe Infectious Disease ________________
☐	☐	Poor Immune Function ________________
☐	☐	(frequent infection)
☐	☐	Food Allergies ________________
☐	☐	Environmental Allergies ________________
☐	☐	Multiple Chemical Sensitivities ________________
☐	☐	Latex Allergy ________________
☐	☐	Other ________________

Past	Current	RESPIRATORY DISEASES
☐	☐	Frequent Ear Infections ________________
☐	☐	Frequent Upper Respiratory Infections ________________
☐	☐	Asthma ________________
☐	☐	Chronic Sinusitis ________________
☐	☐	Bronchitis ________________
☐	☐	Sleep Apnea ________________
☐	☐	Other ________________

Past	Current	SKIN DISEASES
☐	☐	Eczema ________________
☐	☐	Psoriasis ________________
☐	☐	Acne ________________
☐	☐	Other ________________

MEDICAL HISTORY (CONTINUED)

NEUROLOGIC/ MOOD

Past	Current	Condition
☐	☐	Depression ______
☐	☐	Anxiety ______
☐	☐	Bipolar Disorder ______
☐	☐	Schizophrenia ______
☐	☐	Headaches ______
☐	☐	Migranes ______
☐	☐	ADD/ ADHD ______
☐	☐	Sensory Integrative Disorder ______
☐	☐	Autism ______
☐	☐	Mild Cognitive Impairment ______
☐	☐	ALS ______
☐	☐	Seizures ______
☐	☐	Arthritis ______
☐	☐	Other Neurological Problems ______

PREVIOUS EVALUATIONS

Check box if yes and provide date

- ☐ Full Physical Exam ______
- ☐ Psychological Evaluations______
- ☐ Wechsler Preschool & Primary Scale of Intelligence ______
- ☐ Speech and Language Evaluations ______
- ☐ Genetic Evaluation ______
- ☐ Neurological Evaluations ______
- ☐ Gastroenterology Evaluations ______
- ☐ Celiac/Gluten testing ______
- ☐ Allergy Evaluation ______
- ☐ Nutritional Evaluation ______
- ☐ Auditory Evaluation ______
- ☐ Vision Evaluation ______
- ☐ Osteopathic ______
- ☐ Acupuncture ______
- ☐ Occupational Therapy ______
- ☐ Sensory Integration Therapy ______
- ☐ Language Classes ______
- ☐ Sign Language ______
- ☐ Homeopathic ______
- ☐ Naturopathic ______
- ☐ Craniosacral ______
- ☐ Chiropractic ______
- ☐ MRI ______
- ☐ CT Scan ______
- ☐ Upper Endoscopy ______
- ☐ Upper GI Series ______
- ☐ Ultrasound ______

INJURIES

Check box if yes and provide date

- ☐ Back Injury ______
- ☐ Neck Injury ______
- ☐ Head Injury ______
- ☐ Broken Bones ______
- ☐ Other ______
- ☐ Head Injury ______
- ☐ Broken Bones ______
- ☐ Other ______

SURGERIES

Check box if yes and provide date

- ☐ Appendectomy ______
- ☐ Circumcision ______
- ☐ Hernia ______
- ☐ Tonsils ______
- ☐ Adenoids ______
- ☐ Dental Surgery ______
- ☐ Tubes in Ears ______
- ☐ Other ______

BLOOD TYPE: O A O B O AB O O O Rh+ O Unknown

HOSPITALIZATIONS ☐ None

Date	Reason

IMMUNIZATIONS

Is your child up to date with immunizations? O Yes O No

Do you feel immunizations have had an impact on your child's health? O Yes O No

If relevant, attach a copy of your child's immunization record or see addendum.

PSYCHOSOCIAL

Has your child experienced any major life changes that may have impacted his/her health? O Yes O No

Has your child ever experienced any major losses? O Yes O No

STRESS/COPING

Have you ever sought counseling for your child? O Yes O No

Is your child or family currently in therapy? O Yes O No Describe: ______

Does your child have a favorite toy or object? O Yes O No

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other: ______

Has your child ever been abused, a victim of a crime, or experienced a significant trauma? O Yes O No

SLEEP/REST

Average number of hours your child sleeps at night: O >12 O 10-12 O 8-10 O <8

Does your child have trouble falling asleep? O Yes O No

Does your child feel rested upon awakening? O Yes O No

Does your child snore? O Yes O No

ROLES/RELATIONSHIP

List Family Members:

Family Member and Relationship	Age	Gender

Who are the main people who care for your child? ______

Their Employment/Occupation: ______

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: ______

GYNECOLOGIC HISTORY *(for women only)*

MENSTRUAL HISTORY

Age at first period: _____ Menses Frequency: _____ Length: _____ Pain: O Yes O No Clotting: O Yes O 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? O Yes O No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

GI HISTORY

Has your child traveled to foreign countries? O Yes O No Where? ____________

Wilderness Camping? O Yes O No Where? ____________

Ever had severe: O Gastroenteritis O Diarrhea

DENTAL HISTORY

☐ Silver Mercury Fillings How many? ________

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Problems with Chewing

Do you floss regularly? O Yes O No

PATIENT BIRTH HISTORY

MOTHER'S PAST PREGNANCIES

Number of: Pregnancies ________ Live births: ________ Miscarriages: ________

MOTHER'S PREGNANCY

Check box if yes and provide date

- ☐ Difficulty getting pregnant(more than 6 months) ______
- ☐ Infertility drugs used Specify: ____________
- ☐ In vitro fertilization ____________
- ☐ Drink alcohol ____________
- ☐ Smoke tobacco ____________
- ☐ Take Progesterone ____________
- ☐ Take prenatal vitamins ____________
- ☐ Take antibiotics ☐ During Labor? ____________
- ☐ Take other drugs Specify: ____________
- ☐ Excessive vomiting, nausea (more than 3 weeks) ______
- ☐ Have a viral infection ____________
- ☐ Have a yeast infection ____________
- ☐ Have amalgam fillings put in teeth ____________
- ☐ Have amalgam fillings removed from teeth ____________
- ☐ Number of fillings in teeth when pregnant? ____________
- ☐ Have bleeding (which months?) ____________
- ☐ Have birth problems ____________
- ☐ Group B step infection ____________
- ☐ Have c-section because of ____________
- ☐ Use induction for labor (such as Pitocin) ____________
- ☐ Have anaesthesia – what was used? ____________
- ☐ Use oxygen during labor ____________
- ☐ Have Rhogam, if so how many shots ____________
  How many when pregnant? ____________
- ☐ Gestational Diabetes ____________
- ☐ High blood pressure(pre-eclampsia) ____________
- ☐ High blood pressure/toxemia ____________
- ☐ Have chemical exposure ____________
- ☐ Father have chemical exposure ____________
- ☐ Move to newly built house ____________
- ☐ House painted indoors ____________
- ☐ House painted outdoors ____________
- ☐ House exterminated for insects ____________

PREGNANCY

Total weight gain during pregnancy: ______lb Total weight loss during pregnancy: ______lb

Please describe diet during pregnancy:

____

____

____

Please describe labor:

____

____

____

PATIENT BIRTH HISTORY (CONTINUED)

PERINATAL

Pregnancy duration: *X following the week of gestation*

O 24 O 25 O 26 O 27 O 28 O 29 O 30 O 31 O 32 O 33 O 34 O 35

O 36 O 37 O 38 O 39 O 40(full term) O 41 O 42 O 43 O 44 Weeks

Very active before birth? O Yes O No

Hospital/Birthing Center? O Yes O No

Needed Newborn Special Care? O Yes O No

Appeared healthy? O Yes O No

Easily consoled during first month? O Yes O No

Antibiotics first month? O Yes O No

Experienced no complications first month of life? O Yes O No

BIRTH WEIGHT AND APGAR

Weight at birth: ______lbs Apgar score at one minute: _______ Apgar score at 5 mins: _______

EARLY CHILDHOOD ILLNESSES

Number of earaches in the first two years: _________

Number of other infections in the first two years: __________

Number of times you had antibiotics in the first two years of life: __________

Number of courses of prophylactic antibiotics in first 2 years of life: __________

First antibiotic at _______ months.

First illness at ________ months.

DESCRIPTION OF DEVELOPMENTAL PROBLEMS

If your child has developmental problems, at what age did they occur?

O 0-1 months O 2-6 months O 6-15 months O 16-24 months O After 24 months

Is this impression shared among parents and others caring for the child? O Yes O No

Does this impression, as the timing of onset, differ among parents and others caring for the child? O Yes O No

Is the impression, as to the timing of onset, weak? O Yes O No

Or is this impression strong? O Yes O No

DEVELOPMENTAL HISTORY

Please indicate the approximate age in months for the following milestones(example: walking 14 months):

Sitting up	__________months	O Never	Dry at night	__________months	O Never
Crawl	__________months	O Never	First words("mama, dada" etc)	_____months	O Never
Pulled to stand	__________months	O Never	Spoke clearly	__________months	O Never
Potty trained	__________months	O Never	Lost language	__________months	O Never
Walked alone	__________months	O Never	Lost eye contact	__________months	O Never

MEDICATIONS

CURRENT MEDICATIONS

Medications	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS: *Last 10 years*

Medications	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplication and Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? O Yes O No

Describe: ______________________________

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

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

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

Frequent antibiotics > 3 times/year O Yes O No

Long term antibiotics O Yes O No

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

Use of oral contraceptives O Yes O No

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 diseased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis(Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases(such as 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												

NUTRITION HISTORY

Has your child ever had a nutrition consultation? O Yes O No

Have you made any changes in your child's diet because of health problems? O Yes O No Describe ________

Does your child follow a special diet or nutritional program? O Yes O No

Check all that apply

☐ Yeast Free ☐ Feingold ☐ Weight Management ☐ Diabetic ☐ Dairy Free ☐ Wheat Free ☐ Ketogenic ☐ Specific Carbohydrate ☐ Gluten Free/Casein Free ☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Low Oxalate

☐ Food Allergy (*Ex. Peanuts, Eggs, etc.):*

____

Height (feet/inches) ____________ Current Weight ________________

Longest Weight Fluctuations O Yes O No

Does your child avoid any particular foods? O Yes O No If yes, types and reason: ____________________

____

If your child could eat only a few foods daily, what would they be? ____________________

____

Who does the shopping in your household? ____________________

Who does the cooking in your household? ____________________

How many meals does your child eat out per week? O 0-1 O 1-3 O 3-5 O > 5 meals per week

Check all the factors that apply to your child's current lifestyle and eating habits:

- ☐ Fast eater
- ☐ Erratic eating pattern
- ☐ Eat too much
- ☐ Dislike healthy food
- ☐ Time constraints
- ☐ Eat more than 50% meals away from home
- ☐ Poor snack choices
- ☐ Sensory issues with food
- ☐ Picky eater
- ☐ Limited variety of foods < 5/day
- ☐ Prefers cold food
- ☐ Prefers hot food
- ☐ Every meal is a struggle
- ☐ Most family meals together
- ☐ Use food as a bribe or reward
- ☐ Erratic mealtimes
- ☐ Most meals eaten at the table
- ☐ High juice intake
- ☐ Low fruit/vegetable intake
- ☐ High sugar/sweet intake
- ☐ Gestational Diabetes____________________
- ☐ High blood pressure(pre-eclampsia)____________________
- ☐ High blood pressure/toxemia____________________
- ☐ Have chemical exposure ____________________

BREASTFED HISTORY

Breastfed? O Yes O No   Type of formula: O Soy O Cow's Milk O Low Allergy

Introduction of cow's milk at __________ months. Introduction of solid foods at ___________ months.

First foods introduced at _________ months. Introductin of wheat or other grain at __________ months.

Choke/ Gas/ Vomit on milk? O Yes O Now   Refused to chew solids? O Yes O No

List mother's known food allergies or sensitivities: ______________________________

Please describe any other eating concerns you have regarded with your child: ______________________________

____

ACTIVITY

List type and amount of activity daily.

Type	Amount Daily

How much time does your child spend watching TV? ______________________________

How much time does your child spend on the computer or playing video games? ______________________________

ENVIRONMENTAL HISTORY

Please check appropriate box.

Past	Current	EXPOSURES
☐	☐	Mold in bathroom
☐	☐	Damp cellar
☐	☐	Pest extermination – Inside
☐	☐	Pest extermination – Outside
☐	☐	Forced hot air heat
☐	☐	Had water in basement
☐	☐	Mold visible on exterior of house
☐	☐	Heavily wooded or damp surroundings
☐	☐	Mold in cellar, crawl space, or basement
☐	☐	Moldy, musty school/daycare
☐	☐	Tobacco smoke
☐	☐	Well water
☐	☐	Carpet in bedroom
☐	☐	Carpet in most parts of the house
☐	☐	Feather or down bedding

SOME THINGS ABOUT YOUR PARENTS

When were your parents married? ____________________ If separated, when? ____________

If divorced, when? ____________________ If remarried, when? ____________________

Custody arrangements: ______________________________

MOTHER – PERSONAL

Age at your birth ____________________

Education ____________________

Ethnicity ____________________

Blood type ____________________

FATHER – PERSONAL

Age at your birth ____________________

Education ____________________

Ethnicity ____________________

Blood type ____________________

SYMPTOM REVIEW

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

STRENGTHS

- ☐ Especially attractive
- ☐ Accepts new clothes
- ☐ Cuddly
- ☐ Physically coordinated
- ☐ Happy
- ☐ Pleasant/ easy to care for
- ☐ Sensitive/ affectionate
- ☐ Wants to be liked
- ☐ Responsible
- ☐ Draws accurate pictures
- ☐ Sensitive to people's feelings
- ☐ Okay if parents leave
- ☐ Answers parent
- ☐ Follows instructions
- ☐ Pronounces words well
- ☐ Good with math
- ☐ Good with computers
- ☐ Good with fine work
- ☐ Good throwing and catching
- ☐ Good climbing
- ☐ Strong desire to do things
- ☐ Swimming
- ☐ Bold, free of fear
- ☐ Likes to be held
- ☐ Like to be swaddled

SLEEP

- ☐ Sleeps in own bed
- ☐ Sleeps with parent(s)
- ☐ Awakens screaming/ crying
- ☐ Awakes at night
- ☐ Difficulty falling asleep
- ☐ Early waking
- ☐ Insomnia
- ☐ Sleeps less than normal
- ☐ Daytime sleepiness
- ☐ Jerks during sleep
- ☐ Nightmares
- ☐ Sleeps more than normal

PHYSICAL

- ☐ Looks sick
- ☐ Glazed look
- ☐ Overweight
- ☐ Underweight
- ☐ Pupils usually large
- ☐ Unusually long eyelashes
- ☐ Pupils unusually small
- ☐ Dark circles under eyes
- ☐ Red lips
- ☐ Red fingers
- ☐ Red toes
- ☐ Webbed toes
- ☐ Red ears
- ☐ Double jointed
- ☐ Lymph nodes enlarged in neck
- ☐ Head warms
- ☐ Head sweats
- ☐ Night sweats
- ☐ Abnormal fatigue
- ☐ Failure to thrive
- ☐ Cold all over
- ☐ Cold hands and feet
- ☐ Cold intolerance
- ☐ Hands/ feet – very sweaty
- ☐ Perspiration – odd odor

SKIN

- ☐ Paleness, severe
- ☐ Fungus/ fingernails
- ☐ Fungus/ toenails
- ☐ Dandruff
- ☐ Chicken skin
- ☐ Oily skin
- ☐ Patchy dullness
- ☐ Seborrhea on face
- ☐ Thick calluses
- ☐ Athletes foot
- ☐ Feet – stinky
- ☐ Diaper rash
- ☐ Odd body odor
- ☐ Strong body odor
- ☐ Acne
- ☐ Dark circles under eyes
- ☐ Ears get red
- ☐ Eczema
- ☐ Flushing
- ☐ Red face
- ☐ Sensitive to insect bites
- ☐ Stretch marks
- ☐ Blotchy skin
- ☐ Bugs love to bite you
- ☐ Cradle cap
- ☐ Dry hair
- ☐ Dry scalp
- ☐ Hair unmanageable
- ☐ Bites nails
- ☐ Nails brittle
- ☐ Nails frayed
- ☐ Nails pitted
- ☐ Nails soft
- ☐ Skin pale
- ☐ Dark birth mark(s)
- ☐ Easy bruising
- ☐ Inability to tan
- ☐ Light birth mark(s)
- ☐ Ragged cuticles
- ☐ Thickening fingernails
- ☐ Thickening toenails
- ☐ Vitiligo
- ☐ White spots of lines in nails
- ☐ Dry skin in general
- ☐ Feet cracking
- ☐ Hand peeling
- ☐ Lower legs dry
- ☐ Skin lackluster
- ☐ Itchy skin in general
- ☐ Itchy scalp
- ☐ Itchy ear canals
- ☐ Itchy eyes
- ☐ Itchy nose
- ☐ Itchy roof of mouth
- ☐ Itchy arms
- ☐ Itchy hands
- ☐ Itchy feet
- ☐ Itchy anus
- ☐ Itchy penis
- ☐ Itchy vagina

DIGESTIVE

- ☐ Breath bad
- ☐ Increased salivation
- ☐ Drooling
- ☐ Cracking lip corners
- ☐ Cold sores on lips, face
- ☐ Geographic tongue (map-like)
- ☐ Sore tongue
- ☐ Tongue coated
- ☐ Cancer sores in mouth
- ☐ Gums bleed
- ☐ Teeth grinding
- ☐ Tooth cavities
- ☐ Tooth with amalgam fillings
- ☐ Mouth thrush (yeast infection)
- ☐ Sore throat
- ☐ Fecal belching
- ☐ Burping
- ☐ Nausea
- ☐ Reflux
- ☐ Spitting up
- ☐ Vomiting
- ☐ Abdominal bloating
- ☐ Lower abdominal bloating
- ☐ Colic
- ☐ Abdomen distended
- ☐ Abdominal pain
- ☐ Intestinal parasites
- ☐ Pinworms
- ☐ Cramping pain with pooping
- ☐ Constipation

- ☐ Diarrhea
- ☐ Farting – regular
- ☐ Farting – stinky
- ☐ Anal fissures
- ☐ Red ring around anus
- ☐ Stools bulky
- ☐ Stools light color
- ☐ Stools very stinky
- ☐ Stools with blood
- ☐ Stools with mucous
- ☐ Stools with undigested food
- ☐ Flatulence
- ☐ Stool odor foul
- ☐ Stool odor yeasty
- ☐ Stools pale
- ☐ Stools slimy
- ☐ Stools watery

EATING

- ☐ Poor appetite
- ☐ Thirst
- ☐ Extreme water drinking
- ☐ Bingeing
- ☐ Bread craving
- ☐ Craving for carbohydrates
- ☐ Craving for juice
- ☐ Craving for salt
- ☐ Diet soda craving
- ☐ Pica (eating non-edibles)
- ☐ Abnormal food cravings
- ☐ Carbohydrate intolerance
- ☐ Starch/ disaccharide intolerance
- ☐ Sugar intolerance
- ☐ Salicylate intolerance
- ☐ Oxalate intolerance
- ☐ Phenolics intolerance
- ☐ MSG intolerance
- ☐ Food coloring intolerance
- ☐ Gluten intolerance
- ☐ Casein intolerance
- ☐ Specific food(s) intolerance
- ☐ Lactose intolerance
- ☐ Behavior worse with food
- ☐ Behavior better when fasting

BEHAVIOR

- ☐ Behavior purposeless
- ☐ Unusual play
- ☐ Uses adults hand for activity
- ☐ Aloof, indifferent, remote
- ☐ Doesn't do for self
- ☐ Extremely cautious
- ☐ Hides skill/ knowledge
- ☐ Lacks initiative
- ☐ Lost in thought, unreachable
- ☐ No purpose to play
- ☐ Poor focus, attention
- ☐ Sits long time staring
- ☐ Uninterested in live pet
- ☐ Watches TV for a long time
- ☐ Won't attempt/ can't do
- ☐ Poor sharing
- ☐ Rejects help
- ☐ Curious/ gets into things
- ☐ Erratic
- ☐ Unable to predict actions
- ☐ Destructive
- ☐ Hyperactive
- ☐ Constant movement
- ☐ Melts down
- ☐ Tantrums
- ☐ Self mutilation
- ☐ Runs away
- ☐ Jumps when pleased
- ☐ Whirls self like a top
- ☐ Climbs to high places
- ☐ Insists on what wanted
- ☐ Tries to control others
- ☐ Head banging
- ☐ Falls, gets hurt running climbing
- ☐ Does opposite of asked
- ☐ Silly
- ☐ Shrieks
- ☐ Holds hands in strange pose
- ☐ Spends time with pointless task
- ☐ Stares at own hands
- ☐ Toe walking
- ☐ Arched back with bright lights
- ☐ Imitates others
- ☐ Finger flicking
- ☐ Flaps hands
- ☐ Licking
- ☐ Likes spinning objects
- ☐ Likes to flick finger in eye
- ☐ Likes to spin things
- ☐ Rhythmic rocking
- ☐ Slapping books
- ☐ Tooth tapping
- ☐ Visual stims
- ☐ Wiggle finger front of face
- ☐ Wiggle finder side of face
- ☐ Bites or chews fingers
- ☐ Bites wrist or back of hands
- ☐ Chews on things

MOOD

- ☐ Apathy
- ☐ Blank look
- ☐ Depression
- ☐ Detached
- ☐ Disinterest
- ☐ Eye contact poor
- ☐ Isolates
- ☐ Negative fright without cause
- ☐ Always frightened
- ☐ Anguish
- ☐ Disconnected
- ☐ Does not want to be touched
- ☐ Inconsolable crying
- ☐ Irritable
- ☐ Looks like in pain
- ☐ Moaning, groaning
- ☐ Phobias
- ☐ Restless
- ☐ Severe mood swings
- ☐ Unhappy
- ☐ Agitated
- ☐ Anxious

SENSORY

- ☐ Bothered by certain sounds
- ☐ Covers ears with sound
- ☐ Ear pain
- ☐ Ear ringing
- ☐ Hearing acute
- ☐ Hearing loss
- ☐ Likes certain sounds
- ☐ Sensitive to loud noise
- ☐ Sounds seem painful
- ☐ Tinnitus
- ☐ Acute sense of smell
- ☐ Examines by smell
- ☐ Intensely aware of odors
- ☐ Blinking
- ☐ Bother by bright lights
- ☐ Distorted vision
- ☐ Conjuctivitis
- ☐ Eye crusting
- ☐ Eye problem
- ☐ Lid margin redness
- ☐ Examines by sight
- ☐ Fails to blink at bright light
- ☐ Likes fans
- ☐ Likes flickering lights
- ☐ Looks out of the corner of eye
- ☐ Poor vision
- ☐ Puts eye to bright light or sun
- ☐ Strabismus (crossed eye)
- ☐ Fearful of harmless object
- ☐ Fearful of unusual events
- ☐ Unaware of danger
- ☐ Unaware of peoples' feelings
- ☐ Unaware of self as person
- ☐ Upset if things change
- ☐ Upset if things aren't right
- ☐ Adopts complicated rituals
- ☐ Car, truck, train obsession
- ☐ Collects particular things
- ☐ Draws only certain things
- ☐ Fixated on one topic
- ☐ Lines objects precisely
- ☐ Repeats old phrases
- ☐ Repetitive play/ objects
- ☐ Finger tip squeezing
- ☐ Hates wearing shoes
- ☐ Insensitive to pain
- ☐ Likes head burrowed
- ☐ Likes head pressed hard
- ☐ Likes head rubbed
- ☐ Likes head under blanket
- ☐ Likes to be help upside down
- ☐ Likes to be swung in the air
- ☐ Very insensitive to pain
- ☐ Very sensitive to pain

NEUROMUSCULAR

- ☐ Clumsiness
- ☐ Coordination

- ☐ Fine motor poor
- ☐ Gross motor poor
- ☐ Holds bizarre posture
- ☐ Hyperactivity
- ☐ Physically awkward
- ☐ Rocking
- ☐ Stiffens body when held
- ☐ Calf cramps
- ☐ Foot cramps
- ☐ Muscle pain
- ☐ Muscle tone tense
- ☐ Muscle twitches
- ☐ Fist clenching
- ☐ Jaw clenching
- ☐ Poor muscle tone/ limp
- ☐ Tics
- ☐ Muscle tone low trunk
- ☐ Muscle weakness, atophy
- ☐ Muscle tone low all over
- ☐ Tremors
- ☐ Cognitive delays
- ☐ Memory poor
- ☐ Poor attention, focus
- ☐ Slow and sluggish
- ☐ Expressive language delay

SPEECH

- ☐ Never spoke
- ☐ Occasional words when excited
- ☐ Expressive language poor
- ☐ No answers simple questions
- ☐ Points to objects/ can't name
- ☐ Speech apraxia
- ☐ Does not ask questions
- ☐ Babbling
- ☐ Asks using "you" not "I"
- ☐ Answers by repeating question
- ☐ Receptive language poor
- ☐ Says "I"
- ☐ Says "no"
- ☐ Says "yes"
- ☐ Lost language at 12-24 months
- ☐ Lost language after 24 months
- ☐ Scripting
- ☐ Stuttering
- ☐ Talks to self
- ☐ Poor auditory processing
- ☐ Unusual sound of cry
- ☐ Uses one word for another
- ☐ Rigid behaviors
- ☐ Poor confidence
- ☐ Timid
- ☐ Corrects imperfections

RESPIRATORY

- ☐ Pneumonia
- ☐ Bad odor in nose
- ☐ Breath holding
- ☐ Bronchitis
- ☐ Congestion change with season
- ☐ Congestion in the fall
- ☐ Congestion in the spring
- ☐ Congestion in the summer
- ☐ Congestion in the winter
- ☐ Cough
- ☐ Post nasal drip
- ☐ Runny nose
- ☐ Sighing
- ☐ Sinus fullness
- ☐ Wheezing
- ☐ Yawning

REPRODUCTIVE

- ☐ Girls: Early first period
- ☐ Boys: Large testicles
- ☐ Early breast development
- ☐ Early pubic hair
- ☐ Girls: Vaginal odor

URINARY

- ☐ Frequent urination
- ☐ Bed wetting after age 4
- ☐ Odd urinary odor
- ☐ Urinary hesitancy
- ☐ Urinary tract infections
- ☐ Urinary urgency
- ☐ Dry at night
- ☐ Seizures – focal
- ☐ Seizures – generalized
- ☐ Seizures – grand mal
- ☐ Seizures – petit mal
- ☐ Usual fast heart beat
- ☐ Heart murmur
- ☐ Headaches
- ☐ Joint pains
- ☐ Leg pains
- ☐ Muscle pains

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your child's heath, how willing is the patient in:

Significantly modifying diet: O 5 O 4 O 3 O 2 O1

Taking several nutritional supplements each day: O 5 O 4 O 3 O 2 O1

Keeping a record of everything eaten each day: O 5 O 4 O 3 O 2 O1

Modifying lifestyle (e.g., work demands, sleep habits): O 5 O 4 O 3 O 2 O1

Practicing a relaxation techniques: O 5 O 4 O 3 O 2 O1

Engaging in regular exercise: O 5 O 4 O 3 O 2 O1

Have periodic lab tests to assess progress: O 5 O 4 O 3 O 2 O1

Comments: ____

____

____

Rate on a scale of 5 (very confident) to 1 (not confident)

Your ability to organize and follow through on the above health related activities: O 5 O 4 O 3 O 2 O1

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 O1

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 child's health program? O 5 O 4 O 3 O 2 O1

Comments: ____

____

____

The Art of Health, PLLC
Amy M. Anderson D.O.
20696 Bond RD NE
Poulsbo, WA 98383
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.**

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: ____