Dr. Amy Haynes
Naturopathic Physician & Licensed Acupuncturist

521 S. 2ND Street W.
Missoula, MT. 59801
(406)721-2147
Fax: (406)543-1020

www.DrAmyHaynes.com
info@dramyhaynes.com

Patient Policy Form

Dear _____,

Welcome to the office of Dr. Amy Haynes. We are excited to provide you with our best efforts to serve your healthcare needs and feel blessed to work with you to achieve your optimal health goals.

Please review the information below. Enter your initials next to each line item below, and please sign and date the bottom of this form as acknowledgment of the patient policy contents listed below.

_____ I give permission for the staff of Dr. Amy Haynes to contact me via telephone or email and to leave me messages that may contain appointment or medical information.

_____ Payment for all services and products is due at the time of the visit.

_____ Cancellation Policy: Any appointment time changes or cancellations must be received 24 hours prior to appointment time. Patient will be billed for a consultation without a 24-hour cancellation notification. Cancellations must be received via phone at 406-721-2147.

As the patient, you are responsible for the total charges incurred for each visit. We accept Visa, American Express, Mastercard and Discover as well as checks and cash for payment. There will be a charge of $30.00 for each returned check.

We may recommend natural and alternative supplements, which may be purchased at Dr. Amy Haynes' clinic. Most insurance companies do not cover the supplemental items that we recommend and sell.

I have read and understand the above-stated policies and will comply with them in all aspects.

IF TREATMENT IS TERMINATED PRIOR TO PROGRAM COMPLETION, FINANCIAL RESPONSIBILITY TO THE PATIENT IS ASSESSED AT A PER-VISIT FEE IF PATIENT IS ON A LONGTERM PROGRAM OPTION. ANY PHONE CALLS OR EMAILS REGARDING ANY ADDITIONAL QUESTIONS OUTSIDE THE SCHEDULED CONSULT WOULD BE OF AN EXTRA CHARGE. ADMINISTRATIVE CHARGES ARE BASED ON 15 MINUTE INCREMENTS AT $25.00.

SIGNATURE X _____ DATE: _____

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Comprehensive Intake

Name:	Date:
Address:	City:
State:	Zip:
Home	Work
Cell Phone:	E-mail:

Date of Birth: / /		Gender:	Age:
Height:		Weight:	

Status:

- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Single
- ☐ Partnership

Live

- ☐ Spouse
- ☐ Parnter
- ☐ Parent
- ☐ Children
- ☐ Friends
- ☐ Alone

Education:
Occupation:
Employer:
Work Address:

In case of Emergency, who should we contact?

Name:	Relationship:
Address:	Phone:

Why are you coming to see Dr. Haynes? What do you need?

What is your major complaint? Please list when each symptom began; be as descriptive as possible.

What health problems do you want to discuss today?

The general state of your health has been?

___Excellent ___Good ___Fair ___Poor

What are your current medications?	Dosage	Condition Treated	Date Started

What are your current vitamins and/or supplements?	Dosage	Where do you get your supplements?

Please list your current and past health conditions and date of onset.	Date

Is there anything else in your medical history that you consider to be relevant? (Even from childhood.)

Have you ever worked in a dental office? Yes / No

What is your employment history? Please provide brief summary including dates if possible. Dates

Please list all present allergies, including allergies to medications. What type of allergic reaction occurs?

What sports did you participate in at school? Now?

What hobbies do you have? Past Hobbies?

Please list all hospitalizations and the condition each hospitalization was for, including dates. Dates

What immunizations have you had? Any adverse reactions? Explain.

Please explain your housing history.

Type of Home(s)	Location	When did you live here?

Mark 1 (mild), 2 (moderate), or 3 (severe) for any of the following that apply to you:

INTEGUMENT SYSTEMS

Now	Past		Now	Past	
____	____	warts, moles, cysts (circle)	____	____	hives
____	____	light or dark patches of skin (circle)	____	____	pimples
____	____	increased hair growth in unusual places	____	____	ridges, pits or spots on nails
____	____	premature gray hair	____	____	skin infections

HEMATOPOIETIC, LYMPH, IMMUNE SYSTEMS

____	____	swollen or painful lymph nodes	____	____	frequent colds or flu
____	____	wounds heal slowly	____	____	bruise easily
____	____	difficulty stopping bleeding	____	____	bleeding from unusual places
____	____	anemia	____	____	fluid retention

ENDOCRINE SYSTEM

____	____	prefer hot/cold (circle) weather	____	____	unexplained weight loss
____	____	can't stand the cold/heat (circle)	____	____	weakness

HEAD

____	____	severe headaches	____	____	double vision
____	____	seizures or fits			

EYES

____	____	poor eyesight (near or farsighted)	___	____	dry eyes

EARS

____	____	discharge from ears	____	____	pain in ears
____	____	hearing trouble	____	____	itching in ears

NOSE

____	____	nose bleeds	____	____	sinus problems
____	____	loss of smell	____	____	sores in nose

THROAT

____	____	persistent hoarseness	____	____	loss of voice
____	____	difficulty swallowing	____	____	pain

NECK

____	____	stiffness	____	____	injuries
____	____	swelling	____	____	pain

RESPIRATORY

Now	Past		Now	Past	
____	____	unexplained fever	____	____	night sweats
____	____	chest pain when breathing	____	____	sleep apnea
____	____	wheezing	____	____	daily cough
____	____	difficulty breathing at night (wakes you up)	____	____	asthma
			____	____	allergies

When was your last TB test? _____ Results _____ Have you ever been exposed to TB? Yes No

CARDIOVASCULAR

____	____	murmurs	____	____	leg vein trouble
____	____	palpitations (fluttering), skipping, rapid heartbeat	____	____	leg pain when walking
			____	____	low/high blood pressure

GASTROINTESTINAL

____	____	frequent or severe nausea	____	____	vomiting
____	____	blood in stools	____	____	diarrhea
____	____	constipation	____	____	hemorrhoids
____	____	anal itching	____	____	change in bowel movements
____	____	black stool	____	____	vomiting blood
____	____	distress from fats or greasy food	____	____	heartburn
____	____	bad breath/taste in mouth/body odor	____	____	GERD or acid reflux
____	____	history of alternating consitpation with diarrhea	____	____	indigestion
			____	____	yellow jaundice
____	____	symptoms aggravated by worry/tension	____	____	difficulty belching, stomach cramp
____	____	indigestion occurs immediately after eating	____	____	heavy, full feeling after eating
____	____	loss of appetite	____	____	sudden strong craving for sweets
____	____	indigestion occurs 2-3 hours after meals or alcohol	____	____	fullness, bloating, sourness
			____	____	stomach pain occurs 5-6 hrs after meal
____	____	wake up at night feeling hungry			
____	____	feel better mornings, worse afternoon	____	____	fatigue after eating
____	____	loss of appetite	____	____	sleepy during day
____	____	good appetite, but fail to gain or lose weight	____	____	ulcers
____	____	irritable if late for a meal, miss a meal or before breakfast	____	____	irritable bowel symptoms
			____	____	nervousness, shaky feeling,
____	____	headaches, relieved by eating			

How often do you have bowel movements? _____
Must you strain to have a bowel movement? Yes No

SPINE AND EXTREMITIES

Now	Past		Now	Past	
____	____	joint pain, swelling, stiffness	____	____	fibromyalgia
____	____	backaches	____	____	burning on soles of feet
____	____	poor coordination			

Have you ever had arthritis? Yes No When _____

URINARY

Now	Past		Now	Past	
____	____	night urination	____	____	painful urination
____	____	trouble holding urine	____	____	trouble starting urine
____	____	frequent bladder infection	____	____	blood in urine
____	____	weak urine stream			

MALE SYMPTOMS

Now	Past		Now	Past	
____	____	have you ever had prostate problems	____	____	painful erection
____	____	discharge from penis	____	____	lumps, swelling or pain in testicles
____	____	infertility	____	____	difficulty with ejaculation
____	____	difficulty maintaining or achieving an erection	____	____	history of a sexually transmitted disease (herpes, gonorrhea, warts)

FEMALE SYMPTOMS

Now	Past		Now	Past	
____	____	discharge from vagina	____	____	difficulty feeling sexually aroused
____	____	no lubrication when aroused	____	____	never or seldom have orgasms
____	____	sex is painful	____	____	pelvic pain
____	____	menstrual flow:excessive/absent (circle)	____	____	bleeding/spotting between period
____	____	pain before/during/after period (circle)	____	____	infertility
____	____	lumps in breasts	____	____	nipple discharge
____	____	irregular periods	____	____	decreased sex drive
____	____	premenstrual symptoms: cramping, water retention, breast tenderness, headaches, irritability	____	____	frequent yeast infections

Period every ____ days. Number of tampons or pads used per day ____. Date of last period _____

What form of contraception do you use? _____

Number of pregnancies ___ Number of births ___ Number of miscarriages ___ Number of abortions ___

Any complications during pregnancy? Yes No If yes, please explain _____

Did you have a normal puberty? _____ Have you ever had venereal disease? Yes No

NERVOUS

____	____	loss of balance	____	____	paralysis
____	____	convulsions (seizures)	____	____	lack of strength
____	____	tremor (shaking, trembling)	____	____	numbness
____	____	unusual sensations	____	____	fatigue

MENTAL STATUS

Now	Past		Now	Past	
____	____	feel pick-up from exercising	____	____	don't remember dreams
____	____	restlessness	____	____	nervousness
____	____	excessive worry	____	____	require sleep during day
____	____	panic attacks	____	____	low motivation
____	____	frequent nightmares	____	____	trouble concentrating
____	____	hard to express anger	____	____	crying spells
____	____	hears voices	____	____	see things others don't
____	____	always put other's interests before mine	____	____	fearful
____	____	trouble getting along with people	____	____	excess stress in life
____	____	loss of someone through death or separation	____	____	generally early for appointments
			____	____	generally late for appointments
____	____	don't know how to relieve stress	____	____	leave things undone until the last-minute
____	____	feel afraid at home			

Family History

Yes	No	Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
Yes	No	Does anyone in your family experience similar symptoms to yours?
Yes	No	Do you or anyone in your immediate family have any history of kidney dysfunction?
Yes	No	Do you or anyone in your immediate family member have a history of cancer?
Yes	No	Do you or anyone in your immediate family have any history of heart disease, myocardial infarction (heart attack), etc.?
Yes	No	Do you or anyone in your immediate family have a history of strokes?

Microbiome Health

Yes	No	Do you get foul or sulfur smelling gas (distention, bloating, belching, feeling full and a noisy gut) after eating carbohydrates (i.e. grains and vegetables) or fermented foods and/or probiotics?
Yes	No	Do you often have gas that has a sulfur or foul smell?
Yes	No	Are you sensitive to supplements?
Yes	No	Have you ever been vegan or vegetarian for any length of time?
Yes	No	Can you tolerate meat?
Yes	No	Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid?
Yes	No	Have you taken birth control or Hormone Replacement Therapy for any length of time?
Yes	No	If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving?
Yes	No	Have you been on antibiotics for any extended period of time or often as a child or adult?
Yes	No	Were you caesarian delivered?
Yes	No	Were you breast fed? If so, how long?_____
Yes	No	Does your gut temporarily feel better after a round of antibiotics?
		How many times a day are you having a bowel movement?_____

Mold

How old is the house you are living in?_____ How long have you lived there?_____
Have you noticed any new symptoms since moving in?_____ If so, what?_____

Yes No Do you see mold growing at home, work or school?
Yes No Have you ever had water damage at home, work or school?
Yes No Does your home, workplace or school have a damp or mildew smell?
Yes No Does spending time in your basement cause or worsen your symptoms?
Yes No Does your basement ever get wet?
Yes No Do you have a crawlspace?
Yes No Does your basement or crawl space have a sump pump?
Yes No Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?
Yes No Does your car have a mildew smell?
Yes No Does anyone in your family have chronic sinus infections or irritations?

General Toxicity

Yes No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.
Yes No Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)
Yes No Do you have your house sprayed with pesticides for pest control?
Yes No Do you spray herbicide (weed killers) in or around your home?
Yes No Do you use conventional insect repellents on yourself or family?
Yes No Do you use conventional sunscreen?
Yes No Do you use conventional perfume or cologne every day?
Yes No Do you get your hair colored? If so, is it on the scalp?
Yes No Do you use aerosol hairspray?
Yes No Do you get your nails done? If so, how often?_____
Yes No Do you use air freshener in your house, work or car?
Yes No Do you drink filtered water? If so, what type of filter do you have?_____
Yes No Do you drink bottle water? If so, what type of filter do you have?_____

Yes No Do you have a water filtration system for your entire house or shower filtration? If so, what type?_____
Yes No Does your spouse or other family members work around chemicals?
Yes No Can you think of any other toxic exposures you may have had?_____
Yes No Do you use non - green cleaning products?
Yes No Do you have any surgical implants? (e.g. breast, dental, chin, nose)

Lyme Disease

Yes No Have you ever been diagnosed with Lyme Disease?
Yes No Have you ever had dry sockets or infected tooth extractions?
Yes No Do you have small joint pain?
Yes No Have you ever been bitten by a tick or recluse spider?
Yes No Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?
Yes No Was your mother ever diagnosed with Lyme Disease?
Yes No Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

Mercury

Yes No Do you have amalgam (silver) fillings in your teeth? If yes, how many?_____
Yes No Have you ever had an amalgam removed? If yes, how many?_____
Yes No If you had amalgams removed, was it done by a biological dentist using a safe protocol?
Yes No Did your mother have amalgam when pregnant with you?
Yes No Have you ever worked in a dental office? If so, how long?_____
Yes No Have you had any dental crowns? If yes, how many?_____
Yes No Have you had any bridges?
Yes No Have you had any root canals?
Yes No Have you had any tooth extractions?
Yes No Do you have any dental implants or other metal in your mouth? Explain:_____
Yes No Did you wear contact lenses during the 1980's or early 1990's?
Yes No Did you take oral contraceptives during the 1980's or early 1990's?
Yes No Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
Yes No Have you noticed any adverse reactions to these shots?
Yes No Do you have any tattoos with red ink?
Yes No Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic salmon?

Lead

Yes No Does your occupation involve smoldering or metal salvage?
Yes No Have you done any old home repair or sandblasting? If so, when?_____
Yes No Do you do a lot of painting?
Yes No Was your home built before 1978?
Yes No Have you ever worn cosmetics containing kohl? (makeup with dark black or deep red pigment?
Yes No Are you around a lot of fake leather, or vinyl?
Yes No Do you get joint aches in the morning?
Yes No Do you dye your hair?
Yes No Have you ever made your own bullets or been exposed?

Rate each of the following symptoms to the best of your ability based upon your typical health over the last year.
If you cannot answer a question, simply leave it blank.

Point Scale

0 - Never had the symptom
1 - Occasionally have it, mild effect
2 - Occasionally have it, severe effect
3 - Frequently have it, mild effect
4 - Frequently have it, severe effect

Column #1

____ Anxiety
____ Mood Swings
____ Enraged behavior for no reason
____ Excessive shyness, timidity, social phobia (not typical to your personality)
____ Irritability (not normal for you)
____ Low body temperature (below 97.5)
____ Insomnia (Can't get to sleep or return to sleep
____ Dizziness
____ Sound in ears (ringing or hearing your heart beat)
____ Psychological symptoms, even thoughts of suicide
____ Sensitivity to sound
____Indecisiveness
____ Feeling of being overwhelmed or fearful
____ Metallic taste in your mouth
____ Bad breath
____ Bleeding gums
____ Sensitive teeth
____ Canker sores or other sores in mouth
____ Floaters, shadows or swimmers when you read or look into the sky
____Dyslexia or loss of place while reading even as a child
____ Swelling eyelids
____ Peeling on top layer of skin (hands and feet)
____ Heart pain (angina) and you are under 45 y/o
____ Depression
____Gout (arthritic pain, especially big toes
____ Pain in shoulders or upper back
____ Twitching eyelids
____ Anemia (low iron or hemoglobin on blood test)
____ Wrist/ankle drop or weak extensor muscles
____ Hair falls out (not normal male pattern baldness

Column #2

____ Sensitivity to light
____ Fatigue after exercising (feeling worse)
____ Bad night vision or seeing halos around lights
____ Shortness of breath, with very little effort
____ Excessive thirst and/or urination
____ Red eyes or tearing
____ Blurred vision at times
____Morning stiffness
____ Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
____ Non-restful sleep
____ Receive static shock more often and w/more dramatic effect than normal (door knobs, light-switch, people, etc.)
____ Trouble processing new information
____ Word reversal or trouble finding words
____ Sensitivity to touch
____ Short-term memory loss
____ Chronic sinus congestion
____Dry non-productive cough
____ Muscle twitching
____ Excessive sweating especially at night
____Joint pain not necessarily true arthritis can move from joint to joint
____ Difficulty losing weight regardless of diet or exercise
____ Persistent viral or fungal infection, including athletes foot, warts, jock itch, candidiasis
____ Frequent illness or prolonged illness or sick days
____ Numbness or weakness in arms or legs
____ Headaches
____ Trouble adding or dividing numbers
____ Fluctuating constipation and diarrhea
____ Stomach pain for no apparent reason
____Appetite swings
____ Frequent muscle aches, cramps, unusual sharp pains
____ Rashes or rosacea
____Cold extremities (hands and feet)

Total Columns 1 & 2 _____

Diet Journal

Name:_____
Beginning Date:_____

The Purpose of the Diet Journal is to provide your doctor with an unbiased record of your normal eating habits. Simply record your typical diet (including beverages) for six days in succession. Be sure to include amounts, and list any ingredients separately as needed. In the BM section, please list the times of bowel movements. Also indicate any BM irregularities, such as diarrhea or unusual color. In the Notes section, record the times of any symptoms such as mood swings, indigestion, headaches, fatigue, etc.

What time do you wake up in the morning? _____

What time do you leave your house for work/school/errands?_____

What is your favorite food?_____

What is your favorite restaurant?_____

Do you wake up hungry? _____

Please list how many days per week you are eating out (1-7) beside each meal time.
Give some examples of your most frequented spots.

Breakfast:_____ (Days per week.)
Restaurant(s):

Lunch: _____(Days Per week.)
Restaurant(s):

Dinner:_____ (Days Per week.)
Restaurant(s):

Day One

Breakfast	Lunch	Dinner

Snacks	BM Times	Notes

Day Two

Breakfast	Lunch	Dinner

Snacks	BM Times	Notes

Day Three

Breakfast	Lunch	Dinner

Snacks	BM Times	Notes

Day Four

Breakfast	Lunch	Dinner

Snacks	BM Times	Notes

Day Five

Breakfast	Lunch	Dinner

Snacks	BM Times	Notes

Day Six

Breakfast	Lunch	Dinner

Snacks	BM Times	Notes

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Body Temperature Log

Keep thermometer under tongue for no less than 4 minutes, 3 times per day, for 5 consecutive days.
When using a digital thermometer, please take consecutive readings until you get matching readings.

Date	*3 hours after waking*	*3 hours later*	*3 hours later*

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Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined as:

"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of Disease."

A Vitamin is not a drug. Neither is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, Mineral, Trace Element, Amino Acid, or Herb may have an effect on any disease process or symptom, this does not mean it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional or dietary advice is not intended as any primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice and adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical process of the human body.

By signing below, you are agreeing that you have read and understand the above information.

_____ _____

Signature Date

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NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), you have certain privacy rights concerning your health care information. Under this law, your health care provider generally cannot give your information to your employer, use or share our information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your healthcare.

It is important that you understand that our information can be used and shared in the following ways:

- To give you medical treatment or other types of health care, multiple providers may be involved inyour treatment, both directly and indirectly
- To bill you or a third party for payment for services provided to you
- To assist law enforcement officials in response to criminal activities and to avert a threat to an individual or to public health safety (as in outbreaks of communicable disease)
- In response to a court or administrative order
- We may share your health information with a person(s) that you have named to be involved with your health care. I hereby authorize privileged, confidential information about my treatment to be shared with the following people:

_____

Print name(s) of authorized people

You have the following rights relating to the medical records we keep about you:

- Right to inspect your health record and to receive a copy of your health record upon request
- Right to amend information in your health record you believe is inaccurate or incomplete
- Right to know to whom we have disclosed your health information
- Right to ask for limits on the health information data we give out about you
- Right to receive communication from us about our health information in alternate ways
- Right to receive a paper copy of the complete Notice of Privacy Practices

I acknowledge having received and read the above-stated policies of the office of Dr. Amy Haynes, N.D.

_____ _____

Print Name (or name of responsible party if patient is a minor) Date

_____ _____

Signature Date

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Request and Authorization to Release Confidential Medical Information

To:
Physician/Facility _____ Phone _____ Fax _____

_____
Address City/State Zip code

For:
Name of Patient _____ D.O.B.__/__/____ Social Security Number _____

_____
Address City/State Zip Code

☐ Health records (History, Physical Exams, Surgical Reports, Vaccination logs) ☐ Lab results

☐ Imaging (x-rays, CT, MRI, US) ☐ Other _____

For the Following Periods:

☐ Previous Month ☐ Previous ____ months ☐ All

Notes: _____

_____

_____

_____

By signing below I agree to release of the aforementioned health information. Unless otherwise revoked, this authorization will expire 6 months from the date of signing.

_____ _____
Signature Date