



**NATUROPATHIC
MEDICINE**
of Southern Arizona



CONFIDENTIAL PATIENT INFORMATION

Please print or write legibly.

Today's Date: _____

Full Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Phone: Home (_____) _____ Cell (_____) _____

Fax (_____) _____ Email: _____

May we subscribe you to our clinic's email newsletter? Yes No

Referred by: Friend _____ Website
 Family _____ Other _____

Gender: Male Female Pregnant? Yes No # of children _____

Could you possibly be pregnant now? Yes No

Age _____ Birthdate (Month/Day/Year) ____/____/____

Height (feet) _____ Weight (pounds) _____

Marital Status: Married Single Widowed Divorced

Circle one or more: FT Employment PT Employment FT Student PT Student

Occupation _____ Employer _____

Work Phone (_____) _____

Person to be notified in case of an emergency:

Name _____

Address _____

Telephone _____ Relationship _____

Reason for appointment & related health issues/problems?	Date Began?	Had Previously?	Injury Related?

Name of your Primary Care Physician (PCP) _____

* Please note that Dr. Smith chooses to not be a Primary Care Physician.

PCP Telephone (_____) _____ Date of last visit _____

Date of last check up or physical _____

Diagnosis of current health issue(s) if available _____

Are you willing to change your habits in order to improve your health? Yes Maybe No

Are you currently utilizing any other therapies or practitioners for these issues? Yes No

If yes, what practitioner(s)/therapy(ies)? _____

MEDICAL HISTORY

Serious illnesses (type, duration, year): _____

Surgeries (type, year performed): _____

Known Allergies, Hypersensitivities or Intolerances: _____

Current Supplements: _____

Current Medications (include over the counter): _____

CONSTITUTIONAL

Hours of sleep per night: _____ Do you exercise regularly? Yes No

Type of exercise: _____

Are you currently or were you previously on a restrictive diet? Yes No

Do you smoke tobacco? Yes No Now? _____ Past? _____ Packs per week _____

Do you drink alcohol? Yes No Drinks per week: _____

History of treatment for addiction? Yes No Tobacco / Alcohol / Drugs / Other

Do you have a history of extensive travel to foreign countries? Yes No

If yes, which countries and for how long? _____

FAMILY HISTORY

Please indicate, to the best of your knowledge, whether any of your biological family members have any of the following conditions:

Mother (M) Father (F) Brother (B) Sister (S) Grandparent (G) Your Children (C)

	M	F	B	S	G	C		M	F	B	S	G	C
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/Mental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REVIEW OF BODY SYSTEMS

Check any of the boxes below that apply to

1. *symptoms* that you have experienced in the past 3 months

2. *diagnoses* you have received during your lifetime

GENERAL

- Recent weight loss
Amount? _____
Time period? _____
- Recent weight gain
Amount? _____
Time period? _____
- Inability to lose/gain weight (circle one)
- Eating Disorder
- Body Odor
- Appetite Change
- Tiredness/Weakness
- Sudden energy drop
Time of day? _____
- Fever
- Sweating at night
- Sweating when tired
- Trouble falling asleep
- Trouble staying asleep
- Wake up not rested
- Strong thirst
- Cravings

HEMATOLOGIC (BLOOD-RELATED)

- Blood type _____
- Anemia
- Bleeding Tendency
- Coagulation disorder
- Bruise easily
- Cuts heal slowly
- Blood clots
- Stroke

HEAD, EYE, EAR, NOSE, THROAT

- Disturbances of vision
- Red or itchy eyes
- Glaucoma
- Macular degeneration
- Eyeglasses/contacts

- Loss of hearing
- Ringing in ears
- Pain in ears
- Disturbances of speech
- Trouble swallowing
- Sore or dry throat
- Lip or mouth sores
- Nosebleeds
- Nose or sinus problems
- TMJ pain/problems
- Loss of taste or smell
- Headache(s)
Type(s) _____

MOUTH

- Halitosis (bad breath)
- Bleeding gums
- Mercury/amalgam (dark) fillings
- Problems with teeth or dentures
- Implants
- Other _____

RESPIRATORY (LUNGS)

- Wet Cough
- Dry cough
- Whooping Cough
- Excessive Sneezing
- Asthma
- Nasal or sinus problems
- Poor sense of smell
- Chest Pain or tightness
- Shortness of Breath
- Congestion
- Wheezing Rib Pain
- Tuberculosis
- Emphysema

- Bronchitis
- Pneumonia
- Pleurisy

GASTRO-INTESTINAL SYSTEM

- Constipation
- Loose stool or Diarrhea
- Diarrhea & Constipation
- Gripping/cramping
- Red Blood in stool
- Food visible in stool
- Very Dark Stool
- Light colored stool
- Frothy/bubbly stool
- Hard stool
- Symptoms with fatty foods
- Rectal pain
- Itching or burning
- Celiac Sprue
- Crohn's Disease
- IBS/IBD
- Diverticulosis/-itis
- Hemorrhoids
- Ulcerative colitis
- Parasite infection
- Nausea
- Vomiting
- Heartburn/Acid Reflux/GERD
- Fatigue after eating
- Constantly hungry
- Lack of appetite
- Lactose intolerant
- Hiatal hernia
- Ulcers
- Indigestion
- Candida or other GI fungus

- Abdominal pain
- Gas/flatulence
- Belching
- Bloating
- Jaundice (yellowing of skin and eyes)
- Hepatitis
- Cirrhosis
- Gallbladder problems
of bowel movements:
per day _____
per week _____
 Other _____

GENITO-URINARY SYSTEM

- Lower Abdominal Pain
- Kidney/Renal problem
- Renal insufficiency
- Water retention
- Abdominal Hernia
- Sexually Transmitted Disease
- Infertility
- Difficulty with urination
- Pain with urination
- Interstitial cystitis
- Inability to hold urine (incontinence)
- Blood in urine
- Dark urine
- Urethral discharge
- Bladder infection

FEMALE ISSUES

- Painful periods
- Menstrual cramps
- PMS
- Irregular periods
- Excessive bleeding

- Abnormal lack of menses
- Endometriosis
- Hot flashes
- Vaginal Dryness
- Miscarriage/Abortion
- Menopause: peri- or post- (please circle)
- Sexual difficulties
- Painful breasts
- Lumps in breasts
- Birth Control Pills
- Uterine: fibroids/cysts/tumors
- Pregnancy # _____
- Children # _____

MALE ISSUES

- Prostate problems
- Sexual difficulties
- Testicular pain/swelling

MUSCULO-SKELETAL SYSTEM

- Arthritis
Type(s): _____
- Osteopenia/osteomalacia/Osteoporosis
- Gout
- Shingles
- Fibromyalgia/Chronic Fatigue Syndrome
- Joint pain /swelling
- Scoliosis
- Flat feet
- Pins & needles sensation

- Numbness or lack of sensation
- Accident, injury, or trauma—Which body part(s) was involved?

CARDIOVASCULAR (HEART) SYSTEM

- Palpitations (sudden, episodic, strong heart beats)
- High blood pressure
- Low blood pressure
- Dizziness upon standing/rising
- High cholesterol
- Chest pain or angina
- Edema
- History of heart murmur(s)
- Swollen ankles or feet
- Cold hands or feet
- Heart attack # _____
- Stroke/CVA/TIA # _____
- Heart disease
- Slow heart rate
- Fast heart rate
- Poor circulation
- Blood clots
- Poor blood clotting/coagulation
- Sweaty hands or feet
- Anemia
- Pacemaker
- Vascular (blood vessel) disease

- Phlebitis
- Aneurysm
- Varicose Veins

CENTRAL NERVOUS SYSTEM

- Fainting
- Tinnitus (ear ringing)
- Convulsions/Epilepsy
- Multiple Sclerosis
- Weakness or paralysis
- Loss of feeling or function in body part(s)
- Balance difficulties
- Dizziness
- Vertigo
- Light-headedness
- Neuritis (nerve inflammation)
- Parkinson's Disease
- Bell's Palsy

ENDOCRINE (HORMONE) SYSTEM

- Diabetes (Type I or Type II, please circle)
- Syndrome X, Metabolic Syndrome
- Hypoglycemia (low blood sugar)
- Thyroid problems
- Hormone therapy

EMOTIONAL

- Worry
- Moodiness

- Anxiety
- Irritability
- Nervousness
- Depression
- Grief
- Problems in relationships

DERMATOLOGIC (SKIN) AND HAIR

- Rash/Itching
- Oozing skin sores
- Psoriasis/Eczema
- Rosacea
- Loss of hair
- Toenail fungus
- Skin fungal infection

IMMUNE SYSTEM

- Seasonal allergies
- Chemical sensitivity
- Cancer
- Benign tumor
- Epstein-Barr Virus (EBV)
- HIV / AIDS
- Lupus
- Rheumatoid Arthritis
- Thrush
- Herpes
- Polio
- Mumps
- Rubella
- Chicken Pox
- Malaria
- Measles



**NATUROPATHIC
MEDICINE**
of Southern Arizona



INFORMED CONSENT FOR NATUROPATHIC PATIENTS

Please read and sign the following in order to completely understand the risks and benefits of Naturopathic Medical Care.

I _____, hereby authorize this medical office to perform the following specific procedures as necessary to facilitate my diagnosis and treatments:

- **Minor office procedures:** e.g. dressing a wound, ear cleansing.
- **Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
- **Botanical medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters or suppositories.
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
- **Lifestyle counseling and hygiene:** diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
- **Physical Medicine:** manual therapy, therapeutic exercise, and energetic medicine.
- **Psychological counseling.**

I recognize the potential benefits and risks of the procedures as described below:

- **Potential benefits:** restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
- **Potential risks:** allergic reactions to prescribed herbs and supplements, side effects of natural medication, inconvenience of lifestyle changes, injury from injections, venipuncture, or procedures.
- **Notice to pregnant women:** all female patients must alert the doctor if they know or suspect that they are pregnant. Some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by this medical office regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I accept responsibility for the medical charges incurred by myself or the patient that I am guardian over. I agree to pay all bills at the time of service in full, unless other arrangements are made with the Clinic Director.

I realize that I play an integral role in my healing process and that in order to produce results I must take responsibility for my health.

By making this appointment and visiting with a provider of this medical office you are making an investment in your health.

Name of patient (please print) _____

Patient's signature _____ Date _____

Guardian or Spouse authorizing care _____ Date _____

CANCELLATION POLICY

As a courtesy to this medical office and other patients, we ask that you **agree to give a minimum of twenty-four hours notice to reschedule or cancel any appointment.** In the event of multiple missed appointments this office may, at our discretion, require a non-refundable deposit in order to hold future appointment times.

We strive to stay on time, scheduling appointments on the half-hour. In consideration of other patients' time, we ask that you are on time for your appointments. If you arrive late, we will do our best to accommodate you, which may necessitate reducing treatment time so that the next patient may begin their treatment on schedule. We thank you for your consideration.

Patient's initials _____ Date _____

SUPPLEMENT RETURN POLICY

To insure the optimum quality of our physician grade supplements, we apologize that we cannot accept returns on these items once they have been purchased and have left the office:

- any opened supplements
- any oil supplements
- any softgels

All other unopened supplements may be returned within one week of purchase.

*Please note: Some of the supplements Dr. Smith prescribes can be purchased at health food stores or other locations. **Dr. Smith can only vouch for the quality and potency of the supplements that he offers through his office.**

Patient's initials _____ Date _____

Notice of Privacy Rights

Our commitment to your privacy:

We are dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Agreements:

- I understand that record will be kept of the health services provided to me.
- I understand that this record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law.
- I understand that my provider may discuss my case with clinic members and any students under their tutelage.
- I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.
- I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit.
- I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.
- I understand that any questions I have will be answered by my provider to the best of their ability.

NMSA/LT Requirements

- Is required by federal law to maintain the privacy of your Private Health Information (PHI) and to provide you with a Privacy Notice detailing NMSA/LT's legal duties and privacy practices with respect to your PHI.
- Under the Privacy Rule it may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you must contact Naturopathic Medicine of Southern Arizona (NMSA)/Laser Therapeutics (LT) Privacy Officer as follows:

Name: Naturopathic Medicine of Southern Arizona/ Laser Therapeutics

Address: 1636 N. Swan Road, Suite 102

Tucson, AZ 85712

Telephone: (520) 577-6888

Effective Date: February 2, 2007

Patient Acknowledgement

With this signature, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Please print your name: _____

Please sign your name: _____ Date: _____