ANIMAS
NATURAL HEALTH

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PATIENT INTAKE FORM

Welcome to Animas Natural Health. We are very excited to get to know you and help you on your way towards your best health! Please take some time to answer this form as completely and thoughtfully as possible and bring this with you to your first visit.

Patient Name:_____

DOB:_____ Age: _____ SS#_____

Address: _____

City: _____State:_____ Zip Code:_____

Email:_____

Phone: (mobile)_____(home)_____

Preferred method of communication?_____

Is it ok to leave a voicemail identifying as Animas Natural Health?_____

Birth Gender: F M GN Identified Gender: F M GN Other:_____

Married:_____ Separated:_____ Divorced:_____ Widowed:_____ Single:_____ Partnership:____

Ethnic heritage/culture: _____

Occupation:_____Hrs/week:_____

Employer:_____Address:_____

Emergency Contact:_____Legal Guardian?_____

Relationship:_____Number:_____

Primary Care Doctor:_____Date Last Seen?_____

Have you ever seen a Naturopathic Doctor before?_____

How did you hear about Animas Natural Health?_____

Please tell me your preference of being addressed in public. Durango is a small town and we may run into each other. Yes, it is ok to say hello:_____ No, I prefer anonymity:_____

PERSONAL HEALTH HISTORY

What is your main reason, or goal, for your visit today?_____

_____

What are your top health concerns?_____

_____

Allergies:(Drugs/Foods/Environmental)_____

_____

Medications: Please list all prescribed, over-the-counter medications, vitamins and other supplements you are taking. (Use the end of this form if you need additional space).

Name:	**Date started:**	**Dosage/Frequency**:

Medical Conditions: Do you currently have or have you had a history of any of the following? (Please circle all that apply):

Adrenal Disorder	Depression	Irritable Bowel Syndrome
Anemia	Diabetes Mellitus	Kidney Disease
Anxiety	Digestive Problem	Liver Disease
Arthritis/Joint disorder	Heart Disease	Stroke
Asthma	Hyperlipidemia	Thyroid Disease
Cancer	Hypertension	Other:
COPD	Inflammatory Bowel Disease	

Surgeries/Hospitalizations: Please specify reason and dates:_____

_____

_____

Family History: Do you have a family history of any of the following?

Alcohol/Drug Abuse	Depression	Mental Illness
Arthritis	Diabetes	Stroke
Asthma	High Cholesterol	Vision Problems
Cancer	Heart Disease	Other:_____
Eczema	Hypertension	Adopted
Heart Problems	Kidney Disease	Family history unknown

Social History:

Tobacco Use (circle one): Never Smoker Former Smoker Second Hand Exposure Current Smoker

Start date:_____ End Date:_____

Smokeless Tobacco? Yes No Past

If current tobacco user, are you wanting to quit?_____

Alcohol Use: Yes No

If yes, how many of the following do you have per week?

Drinks/week: Glasses of Wine:_____Cans of Beer:_____Shots of Liquor:_____

Recreational Drugs? Yes No Type/frequency?_____

Birth Control Method: (Please select all that apply)

Sexually active: Yes No

Abstinence	IUD	Surgical
Cervical Cap	IUS	Vaginal Ring
Condom	Pill	Withdrawal
Hormonal Patch	Rhythm	Vasectomy
Implant	Spermicide	Menopause
Injection	Sponge	None
Inserts	Stroke	Other:_____

Partners? Male Female Both Other

Do you have any children? Yes No Ages?_____

Do you exercise? Yes No Type/Frequency?_____

Dietary restrictions or intolerances?_____

Do you have any religious or spiritual practices? Yes No Type?_____

What brings you the most joy?_____

Review of Systems: Please circle Y(es) below if you've experienced in the last 6 months, or P for significant problem in the past.

Constitutional				**Respiratory**				**Musculoskeletal**			
Fever	Y	N	P	Cough	Y	N	P	Muscle pain	Y	N	P
Malaise/Fatigue	Y	N	P	Coughing blood	Y	N	P	Joint pain	Y	N	P
Chills	Y	N	P	Sputum production	Y	N	P	Neck pain	Y	N	P
Sweating	Y	N	P	Shortness of breath	Y	N	P	Back pain	Y	N	P
Weight loss	Y	N	P	Wheezing	Y	N	P	Falls	Y	N	P
Weakness	Y	N	P	Asthma	Y	N	P	Muscle spasms	Y	N	P
Skin				**Gastrointestinal**				**Endocrine/Heme/Allergies**			
Rash	Y	N	P	Heartburn	Y	N	P	Excessive thirst	Y	N	P
Itching	Y	N	P	Nausea/Vomiting	Y	N	P	Excessive hunger	Y	N	P
Color changes	Y	N	P	Abdominal Pain	Y	N	P	Environmental allergies	Y	N	P
Mole concerns	Y	N	P	Bloating	Y	N	P	Easy bruising/bleeding	Y	N	P
Eczema	Y	N	P	Diarrhea	Y	N	P	Cold intolerance	Y	N	P
Dry skin	Y	N	P	Constipation	Y	N	P	Heat intolerance	Y	N	P
				Blood in stool	Y	N	P	Hair loss	Y	N	P
Head, Ears, Eyes,				Black stool	Y	N	P	Hyperthyroid	Y	N	P
Nose, Throat				Number of bowel				Hypothyroid	Y	N	P
Headaches	Y	N	P	movements/day:	#			Anemia	Y	N	P
Hearing Loss	Y	N	P					Swelling/edema	Y	N	P
Ringing in ears	Y	N	P	**Genitourinary**							
Ear Pain	Y	N	P	Painful urination	Y	N	P				
Ear discharge	Y	N	P	Blood in urine	Y	N	P	**Neurological**			
Nosebleeds	Y	N	P	Urgency	Y	N	P	Dizziness/fainting	Y	N	P
Congestion	Y	N	P	Frequency	Y	N	P	Loss of memory	Y	N	P
Migraines	Y	N	P	Flank pain	Y	N	P	Tremor/seizures	Y	N	P
Sore throat	Y	N	P	Incontinence	Y	N	P	Sensory change	Y	N	P
								Speech change	Y	N	P
Eyes				**Male Reproductive**				Numbness/tingling	Y	N	P
Blurred vision	Y	N	P	Hernias	Y	N	P	Paralysis	Y	N	P
Double vision	Y	N	P	Testicular masses	Y	N	P				
Eye pain	Y	N	P	Sexual difficulty	Y	N	P	**Emotional/Psychiatric**			
Discharge	Y	N	P					Depression	Y	N	P
Redness	Y	N	P	**Female**				Insomnia	Y	N	P
Light sensitivity	Y	N	P	**Reproductive**				Substance abuse	Y	N	P
				Age of first menses	#			Hallucinations	Y	N	P
Cardiovascular				Age of last menses	#			Nervous/anxious	Y	N	P
Chest Pain	Y	N	P	# of pregnancies	#			Poor concentration	Y	N	P
Claudication	Y	N	P	# of live births	#			Mood swings	Y	N	P
High BP	Y	N	P	# of miscarriages	#						
Palpitations	Y	N	P	# of abortions	#			**Immune**			
Leg swelling	Y	N	P	Regular cycles	Y	N	P	Night sweats	Y	N	P
Blood clots	Y	N	P	Painful menses	Y	N	P	Swollen glands	Y	N	P
Shortness of breath	Y	N	P	PMS	Y	N	P	Chronic infections	Y	N	P
when lying down	Y	N	P	Vaginal concerns	Y	N	P	Frequent illness	Y	N	P
Heart murmur	Y	N	P	Breast changes	Y	N	P	Autoimmune disease	Y	N	P
Heart disease	Y	N	P	Sexual difficulty	Y	N	P	Slow wound healing	Y	N	P

Global Health: Please respond to each statement by selecting one box per row

		Excellent	Very Good	Good	Fair	Poor
1	In general, would you say your health is...					
2	In general, would you say your quality of life is...					
3	In general, how would you rate your physical health?					
4	In general, how would you rate your mental health, including your mood and your ability to think?					
5	In general, how would you rate your satisfaction with your social activities and relationships?					
6	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)					
7	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries or moving a chair?					

In the past 7 days... (circle one)

How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable? Never Rarely Sometimes Often Always

How would you rate your fatigue on average? None Mild Moderate Severe Very Severe

How would you rate your pain on average? (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Is there any additional information that you would like to add?_____

_____

Thank you for taking the time to provide me with so much information regarding your health. This will help me to understand how I can help you best. I look forward to walking this journey towards better health with you!

DISCLOSURES AND INFORMED CONSENT

WELCOME. I am honored to be a part of your journey to better health.

SERVICES*:* Naturopathic doctors are health care practitioners who specialize in Naturopathic Medicine, which focuses on whole- person wellness. The medicine is tailored to the client and emphasizes prevention and self-care. Naturopathic Medicine is a branch of the healing arts distinct from other branches. Our services include the prevention, evaluation, diagnosis, and treatment of injuries, diseases, and conditions through education, nutrition, naturopathic preparations, natural medicines, physical medicine, hydrotherapy, sauna therapy, physical agents, and other therapies and modalities designed to support the body's natural healing processes. As a Naturopathic Doctor (ND) I am registered to practice Naturopathic Medicine under the Colorado Naturopathic Doctor Act. I am not a Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), or Doctor of Nursing (DNP) who all are licensed under separate practice acts. As a Naturopathic Doctor in Colorado, I do not prescribe, dispense, administer, or inject any prescriptive medications including controlled substances, general or spinal anesthetics. I do not perform surgery, obstetrics, or administer ionizing radiation therapy. I cannot recommend against a course of care prescribed by a licensed health care provider in another branch of the healing arts. My office does not provide naturopathic treatment to children less than two years old. We recommend that our pediatric patients follow the immunization schedule recommended by the CDC (copy included in your new patient pediatric folder) and have a relationship with a licensed pediatric health care provider.

ALTERNATIVES AND COLLABORATION: Alternatives to Naturopathic Medicine include declining such care and consulting with other providers such as an MD, DO, DC, or DNP. Naturopathic Medicine is not a substitute for other types of health care. I recommend that you have a relationship with an MD or DO, as I am not a primary care provider. Please identify the licensed provider with whom I should attempt to collaborate about the care received in our office:

Primary Care Provider: _____ Phone: _____.

RISKS: Naturopathic Medicine is generally considered safe but may involve some risks including, without limit: all of the risks disclosed with any preparations or medicines; allergic reaction; infection; pain or discomfort; weakness, fainting, or nausea; skin irritation, discoloration, or scarring; aggravation of symptoms; mood changes; inconvenience of lifestyle changes; emotional release or emotional distress; healing crisis; and rarely, neurological injury and pneumothorax. Naturopathic Medicine may adversely interact with specific drugs and may be inappropriate during pregnancy. All female clients 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. Naturopathic manual therapies involve risks including, without limit, fractures, disc injuries, dislocations, and sprains. Additionally, hidden conditions may exist that are not detectable through examination. This may include spinal tumors, weak or occluded arteries, and aneurysms. Accordingly, some people are at risk for stroke or vascular injuries as a result of manual therapies.

EMERGENCIES: If you are having a medical emergency, do not wait to seek care. Call 911.

NO GUARANTEE: Every individual responds to care differently and no guarantee or assurance is made as to the results of care in any specific case, as care may not improve your condition.

PAYMENT, INSURANCE, AND REFUNDS: See our fee schedule for current rates. Payment for services is not conditional on response to care. There is no guarantee of insurance coverage. Any insurance you have is an agreement between you and your insurance carrier and you are responsible for payment of services, whether or not they are covered by insurance. You may terminate care at any time. No refunds are available for any product purchases or services provided.

CONFIDENTIALITY: A record will be kept of health services provided to you. This record is confidential and will not be released to anyone without your written consent or legal documentation.

NEXT PAGE MUST BE SIGNED FOR TREATMENT

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND

I have read and fully understand this consent form, and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words. With this knowledge, I voluntarily consent to the above naturopathic care from Animas Natural Health, LLC. I understand that I am free to discontinue participation in this care at any time.

Print Name of Patient or Person with Authority to Consent **Date**

_____ _____

Signature of Patient or Person with Authority to Consent

_____

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 your 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 health care.

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

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- 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.
- To bill you or to obtain payment from third party payers.
- We may share your health information with a person(s) that *you have named* to be involved with your healthcare.

You have the following rights relating to your protected health information:

- To inspect your health record and receive a copy of your health record upon request.
- To request limits on the use or disclosure of your protected health information.
- To request that your physician amend information in your health record you believe is inaccurate or incomplete.
- To receive an accounting of certain disclosures we have made, if any, of your protected health information.
- To receive a paper copy of this notice upon request

You have the right to receive confidential communications from us by alternative means or at an alternative location if you choose. Please tell us how to best contact you when needed:

___Please do not phone me at home. Use this alternate phone number: _____

___Please do not phone me at work. Use this alternate phone number: _____

___Please do not leave messages on my answering machine.

___Please do not contact me by email.

___Please send mail, including my bills, to this alternate address: _____

_____

___Other request (please describe): _____

By signing below, I acknowledge that I have received and read this notice of privacy practices:

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ ___/_____/_____

Patient Signature (Parent/guardian signature if minor) Date

E-MAIL AGREEMENT

The doctors may use e-mail to correspond with patients as a convenience, but should only be used for brief clarifications and questions. If the matter is too complex then one of the doctors will request an appointment to be made.

I have been advised that:

E-mail is never, ever appropriate for urgent or emergency problems.

E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose. System operators for most e-mail systems have access to all e-mail that passes through their systems.

E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.

There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.

All e-mail correspondence will become a part of my medical record at Animas Natural Health. It is extremely important to include my name on every e-mail sent to the clinic.

Since e-mail may not be monitored while the doctors are away on business or on vacation, I (the patient) will follow-up by telephone or in person if I do not receive a response within one week.

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.

I have been provided with information about the use of Internet e-mail communications between myself and Dr. Hailee Dover and/or Dr. Maly Strietzel, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at any time by contacting the doctors.

I designate that all e-mail correspondence coming from me or to me should be sent to the following Internet e-mail address:

Please print e-mail address clearly: _____

Printed Name: _____

Signature: _____ Date: _____

PAYMENT AGREEMENT

Below is an explanation of the doctors' payment agreement. Feel free to ask if you have any questions about these policies. Please ***initial*** next to the following statements to demonstrate your agreement.

_____ Payment for all services and products is due at the time of the visit. Payment may be made by cash, check, or credit card (Visa, MasterCard, American Express, Discover, JCB and Union Pay). Returned checks will be subject to a $35.00 non-sufficient funds fee.

_____ I am responsible for all charges of all services provided. I understand that Dr. Hailee Dover and Dr. Maly Strietzel do not accept or bill insurance companies. In the event the patient would like to submit a bill to their insurance company for reimbursement, a **super bill** will be provided upon request. If my insurance company requires release of my medical records for payment purposes, I hereby give my permission by signing this form.

_____ I will be charged $50.00 for any missed appointments or late cancellations (less than 24 hours notice), emergencies excluded.

_____ In addition to the fees quoted above, you will be responsible for expenses incurred in connection to your health care provided by Dr. Hailee Dover and /or Dr. Maly Strietzel. Such expenses may include postage, phone calls to the office wherein medical advice is provided to you (other than brief clarifying questions regarding your current treatment plan) or laboratory fees. If we make a payment for you, or on your behalf, you will need to reimburse the clinic promptly.

I have read and understand the above-stated policies of Dr. Hailee Dover and Dr. Maly Strietzel of Animas Natural Health, LLC and will comply with them in all respects.

_____

Patient Name (Please **Print**. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____

Patient Signature (Parent/guardian signature if minor) Date

**Dr. Dover and Dr. Strietzel will do their best to uphold their end, as your Naturopathic Doctor, and provide you with the best value in exchange for your investment in your health. They are so happy that you are prioritizing your well-being and they are excited to work with you.*