



**the naturopathic physician, L.L.C.**

**Dr. Hanna Ian, Consulting Physician ~ Patient Medical History**

**\*\* Please be sure to read and sign the last two pages of this form \*\***

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Date of birth \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip. \_\_\_\_\_ Phone (H)(\_\_\_\_) \_\_\_\_\_

e-Mail address \_\_\_\_\_ Phone (W)(\_\_\_\_) \_\_\_\_\_

***As these are not considered "secure" communication devices:***

Is it acceptable for us to contact you via e-mail? **Yes / No**

Is it acceptable for us to leave messages on a voice mail / answering machine for you? **Yes / No**

Occupation \_\_\_\_\_

Employer's name: \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

If under 18, Parent or Guardian name(s): \_\_\_\_\_

Name and phone number of someone we may contact in an emergency \_\_\_\_\_

Gender: Male Female Marital status: \_\_\_\_\_

Current height: \_\_\_\_\_ Weight: \_\_\_\_\_ Last physical examination: \_\_\_\_\_

Are all vaccines current? \_\_\_\_\_ Have elected to decline vaccination \_\_\_\_\_

Last chest X-Ray: \_\_\_\_\_ Last blood tests: \_\_\_\_\_

Last eye examination: \_\_\_\_\_ Last dental visit: \_\_\_\_\_

***If adult***, when was your last: Pneumonia vaccine: \_\_\_\_\_ Tetanus booster: \_\_\_\_\_ Flu vaccine: \_\_\_\_\_

Any other diagnostic tests in the past 3 years, if so what and when: \_\_\_\_\_

***\*\*If child***, last well child visit: \_\_\_\_\_

***\*\*If male***, last prostate exam / PSA evaluation: \_\_\_\_\_

***\*\*If female***, last Pap test: \_\_\_\_\_, physical exam: \_\_\_\_\_, breast exam: \_\_\_\_\_

Last mammogram: \_\_\_\_\_ . Do you do self breast exams? **Yes / No**

Please list all medications, vitamins, herbs, hormones and all prescriptions you are currently taking:


**Please list any past surgeries / hospitalizations: (include approximate date)**


**Do you have a family history of any of the following diseases: (Check those that apply)**

	Brother/Sister	Mother	Maternal GM	Maternal GF	Father	Paternal GM	Paternal GF
Diabetes							
Cancer							
Heart Disease							
Stroke							
Other							

**When was your last medical care:** \_\_\_\_\_

**Who did you see at that time:** \_\_\_\_\_

**Who is your primary care medical provider:** \_\_\_\_\_

<p><b>Please list <i>ALL</i> your known <i>ALLERGIES</i>; <u>Drug, Food, Insect, Animal, etc.:</u></b></p> <p>_____</p> <p>_____</p>
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**The following pages are for health history information: Please fill out all areas that apply to you and your case. If you are in for URGENT or ACUTE CARE, these can be filled in later. Turn to the**

last two pages, read and sign them.

<b><i>I have questions about:</i></b>			
<b>Diet</b>	<b>Exercise</b>	<b>Vaccinations</b>	<b>My current medications</b>
<b>Prevention of _____</b>			

Please list your major health concerns.

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What treatments have you tried for the above concerns?

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<b><i>Occupation:</i></b> _____
<b>Hobbies:</b> _____
<b>What type of exercise do you participate in:</b> _____
<b>How much time do you schedule for exercise weekly?</b> _____

Are there any foods that you know you have reactions to, and what are those reactions:

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Please add comments as needed to clarify the symptoms listed, leave blank any which do not apply.

**Rate the following as : 1 = three or four times yearly, 2 = monthly, 3 = once a week, 4 = Daily**

**HEAD:**

| 1 2 3 4 Headaches

- 1 2 3 4 Dry Scalp
- 1 2 3 4 Acne
- 1 2 3 4 Dizzy

\_\_\_\_\_

\_\_\_\_\_

**EYE / EAR / NOSE / THROAT:**

- 1 2 3 4 Vision blurry
- 1 2 3 4 Dry eyes
- 1 2 3 4 Dark circles under eyes
- 1 2 3 4 Earwax builds up
- 1 2 3 4 Earaches
- 1 2 3 4 Hearing loss
- 1 2 3 4 Ringing in ears
- 1 2 3 4 Sinus pain / infection
- 1 2 3 4 Nose / sinuses dry
- 1 2 3 4 Nose runs
- 1 2 3 4 Seasonal allergies
- 1 2 3 4 Voice hoarse
- 1 2 3 4 Sore throat
- 1 2 3 4 Postnasal drip
- 1 2 3 4 Nose bleeds

**CHEST:**

- 1 2 3 4 Heart pounds
- 1 2 3 4 Heart “flutter”
- 1 2 3 4 Shortness of breath
- 1 2 3 4 Asthma (Triggered by \_\_\_\_\_)
- 1 2 3 4 Chest pains
- 1 2 3 4 Wheezing
- 1 2 3 4 Coughing

Diagnosed heart / cardiovascular disease: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**GASTROINTESTINAL:**

**NEURO-ENDOCRINE:**

- 1 2 3 4 Panic / Anxiety attacks
- 1 2 3 4 Irritability
- 1 2 3 4 Feel bad when not eating regularly

- 1 2 3 4 Heartburn
- 1 2 3 4 Stomach aches
- 1 2 3 4 Gas / Bloating
- 1 2 3 4 Fatty meals bother
- 1 2 3 4 Constipation
- 1 2 3 4 Diarrhea
- 1 2 3 4 Blood or Mucus in stools
- 1 2 3 4 Vomiting
- 1 2 3 4 Hemorrhoids

Bowel movements:

\_\_\_\_ Daily, \_\_\_\_ Other

- 1 2 3 4 Increased appetite
- 1 2 3 4 Decreased appetite

**URINARY TRACT:**

- 1 2 3 4 Bladder infections
- 1 2 3 4 Kidney infections
- 1 2 3 4 Burning with urination
- 1 2 3 4 Frequent urination
- 1 2 3 4 Blood in urine
- 1 2 3 4 Urinary incontinence (Constant Occasional)

\_\_\_\_\_

**MUSCULO-SKELETAL:**

- 1 2 3 4 Joint pains
- 1 2 3 4 Back pain **Upper Lower All**
- 1 2 3 4 Neck pain
- 1 2 3 4 Muscle aches
- 1 2 3 4 Bruising **Easy Only with trauma**
- 1 2 3 4 Sprains Locations: \_\_\_\_\_
- 1 2 3 4 Joint stiffness
- 1 2 3 4 Arthritis

Diagnosed with Fibromyalgia **YES NO When**\_\_\_\_\_

- 1 2 3 4 Weight gain
- 1 2 3 4 Weight loss
- 1 2 3 4 Mood swings
- 1 2 3 4 Snack often

1 2 3 4 Increased thirst  
 1 2 3 4 Insomnia  
 1 2 3 4 Feel restless at bedtime  
 1 2 3 4 Wake up easily at night  
 My stress level weekly averages: **1-2-3-4-5-6-7-8-9-10**  
**(1 is low – 10 is high)**

**ENERGY**

1 2 3 4 Sleep soundly  
 1 2 3 4 Wake rested  
 1 2 3 4 Feel energetic in the morning  
 1 2 3 4 Heart races  
 1 2 3 4 Easy fatigue  
 1 2 3 4 Feel down / depressed  
 1 2 3 4 Poor memory  
 1 2 3 4 Slow starter  
 1 2 3 4 Afternoon tiredness  
 1 2 3 4 Tired all day  
 1 2 3 4 Tired, no matter how much I sleep

**DIET:** [Just an average day]

Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

Do you smoke **Yes No**

How many drinks with alcohol do you have weekly: \_\_\_\_\_

**Circle things you eat MORE than 3 times a week:**

TUNA      OTHER FISH      RAW VEGETABLES  
 CHEESE    WHEAT PRODUCTS    SOY PRODUCTS  
 RAW NUTS/SEEDS      POULTRY      RED MEAT

**MALE ONLY: Circle what applies to you.**

Frequent urination (Specify: **Day Night**)

Incomplete urination  
 Discharge from urethra  
 Trouble initiating urination  
 Hernias (Specify: **Current Past**)  
 Decrease in sex drive  
 Erectile difficulty  
 Rectal burning / itch

**FEMALE ONLY: Circle what applies to you.**

PMS symptoms \_\_\_\_\_

Duration: **1 - 2 - 3 – ALL : Week(s) before period**

Menses painful      Heavy flow      Light flow

Menses change (duration, regularity, flow, pain)

Avg. cycle length **22-25 days, 26-30 days, other** \_\_\_\_\_

Date last period started: \_\_\_\_\_

**Menopause Began:** \_\_\_\_\_

Ages your mother & Grandmother entered menopause? \_\_\_\_

Decrease in sex drive

Vaginal discharge

Yeast infections

Hot flushes

Acne (**At / Before**) menses

Pain in breasts (Specify **With cycle / Constant**)

Hair growth on face

Difficulty in: (Conception, Carrying to term)

Hernias (Specify **Current Past**)

**Number of Pregnancies** \_\_\_\_\_

**Number of Births** \_\_\_\_\_



**FINANCIAL POLICIES STATEMENT**  
**the naturopathic physician, L.L.C.**  
**15436 West Statler Circle, Surprise, Arizona 85374 623-792-8889**

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1. We respect the relationship you have with your health insurance provider. We do not have a relationship with your insurance provider and do not know the coverage and terms your company provides for naturopathic medical care. For this reason it is your responsibility to verify coverage for services or laboratory testing.
2. We do not bill insurance companies nor accept third-party payment for services rendered. We will provide you with a statement of services which contains all information needed to seek reimbursement from your insurance company. Please be advised that many insurance companies do not offer coverage or reimbursement for naturopathic medical care.
3. We do not bill patients for services rendered. Payment for services is required at the time services are provided. For your convenience we accept cash, check, debit card, Master Card, Visa and Discover. We do not accept American Express.
4. Medicare does not provide insurance coverage for services or laboratory tests provided in this office, nor neutraceuticals dispensed from the medicinary.
5. The cost for laboratory testing and other services may not be covered by your insurance provider. It is your responsibility to verify coverage for such services, or alert our office if there are questions regarding a specific service. Once services are rendered or ordered they become your financial responsibility.
6. We request a 24-hour notice to cancel or change appointments. Appointments missed or canceled with less than 24 hours notice will be charged at the intermediate rate. Exceptions are made for extraordinary events and inclement weather.
7. Bank checks returned for insufficient funds will accrue a fee of \$50.00.
8. In order to maintain fresh neutraceuticals dispensed from the medicinary we cannot offer refunds for products 60 days from purchase date. There is a 10% restocking fee for all returns.
9. All special orders require payment in advance or a credit card on file. Charges incurred for shipping and handling on special orders will be passed on to you.

**I have read, understand and agree to abide by the above policies:**

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Signature (Parent or Guardian if patient is under 18 years of age)

Date

**INFORMATION REGARDING LABORATORY PROCEDURES**

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**\*\* PLEASE READ CAREFULLY - THIS MAY AFFECT CHARGES BILLED TO YOU \*\***

Laboratory tests ordered through this office are sent to many outside laboratory providers. In some cases we will have information about your insurance and the particular lab test and laboratory being used. In other cases we do not have such information. The following is a listing of common occurrences regarding laboratory testing and payment of such services. It is intended to give you information prior to the ordering and incurrence of charges for laboratory tests.

1. Our office orders the test(s) we believe to be medically necessary for your case. **The office has no involvement in the charges for those tests, the billing of those tests, or the insurance company's payment or non-payment of those tests.** These issues are between you, your insurance carrier, and the laboratory used. If clarifications of indication for the test or coding of tests are required, we will provide the necessary information to the laboratory or insurance company.
2. If we know that a particular laboratory is favored by your insurance company, we will use that facility. **However, occasionally we are not notified by the insurance companies when they change preferred laboratory providers.** The use of a non-preferred laboratory can increase the cost to you for a given test. If we know a particular lab test is never covered we will inform you in advance, but occasionally we do not have access to that information.
3. Laboratory testing is often very expensive. We do not establish the cost of laboratory tests. Laboratories establish the cost for the test they perform. If your insurance provider offers coverage for the laboratory test, the cost of the test is negotiated between your insurance provider and the laboratory. If your insurance provider provides partial coverage for a specific laboratory test your co-payment is paid directly to this office, will appear on your bill, and is due at the time the test is ordered.
4. There are times this office is not informed by the laboratory when there is an increase in the cost of a laboratory test. In the event of lack of communication between your laboratory and this office regarding the cost of a laboratory test, you are still responsible for the cost of the laboratory test or any difference between the published cost and actual cost for laboratory testing.
5. It is possible that even after your insurance carrier authorizes a lab test that they will refuse to pay for it. You need to be aware of this, and realize that if your insurance does not pay you are still responsible for the charges, either to this office or to the laboratory. We have no control over, nor responsibility for this eventuality.

**I have read, and understand this information regarding laboratory fees:**

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Signature (or signature of parent if patient is a minor child)

Date

**the naturopathic physician, L.L.C.**

**15436 West Statler Circle, Surprise, Arizona 85374 623-792-8889**

**NOTICE OF PRIVACY POLICIES**

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## **THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

### **Introduction**

the naturopathic physician, L.L.C. is committed to treating you and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, how and when we use or disclose the information. It also describes your rights as they relate to your protected health information. This Notice is effective July 1, 2006 and applies to all protected health information as defined by federal regulations.

### **Understanding Your Health Record/Information**

Each time you visit the naturopathic physician, L.L.C., a record of your visit is made. This record contains your symptoms, examination and test results, diagnosis treatment, and a plan for future care or treatment. This information, often referred as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to other.

### **Your Health Information Rights**

Although your health record is the physical property of the naturopathic physician, L.L.C., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided in 45 CFR164.528,
- Amend your health record as provided in 45 CFR164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided in 45 CFR164.528,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

### **Our Responsibilities**

the naturopathic physician, L.L.C. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction,
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to

the procedures included in the authorization.

### **To Report a Problem**

If you believe your privacy rights have been violated, you can file a complaint at the following address:

Office for Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Building HHH, Room 509F  
Washington, D.C. 20201

### **Examples of Disclosure for Treatment and Health Operations**

*Health Information for Treatment:* Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to the treatment.

*Notification:* We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

*Communication with Family:* Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care.

*Research:* We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

*Funeral Directors:* We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

*Marketing:* We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

*Food and Drug Administration (FDA):* We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and produce defects, or post-marketing surveillance information to enable produce recalls, repairs or replacement.

*Workers Compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

*Public Health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

*Law Enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

*Spouse:* We may talk to your spouse in the case of emergency, unless there are specific written instructions not to do so.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potential endangering one or more patients, workers or the public.

## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**I acknowledged that I have received a copy of  
The Naturopathic Physician, L.L.C.'s Notice of Privacy Practices.**

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Patient or legally authorized individual signature

Date

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Print name if signed on behalf of the patient

Relationship to patient

Revisions:

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FOR OFFICE USE ONLY

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for this reason:

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