Natural Bio Health™

Natural Bio Health - Health History Intake Form

Name:		Email:	Date:
Address:			
City:	State:	Zip:	
Phone:	Cell:	DOB:	Age/Sex:
Occupation:		Number of Children:	
Marital Status: Married ☐ Divorced ☐ Widow ☐ Partner ☐ Single ☐			

Do we have permission to speak to your spouse or significant other about your treatment?

YES ☐ **NO** ☐

Spouse's Name:	Phone:

Drug Allergies:	Other Allergies:

Current Medications and Vitamins:

Surgeries *(include dates if possible)*:

Injuries:

Height:	Weight:

Last Blood Pressure Reading:

Date of BP Reading?	Pacemaker, or another medical device?

Current Physician(s):

Have you ever taken Natural Hormones or Synthetic Hormones?

YES ☐ **NO** ☐

If yes to the above, please name the hormones and describe your experience:

Primary health concerns and/or goals:

Family Medical History: *(check all that apply)*

Adult ADD, Adult ADHD	☐	Hypothyroidism	☐
Allergies (Hives, Rashes, Sinus Congestion)	☐	Increased Blood Clotting	☐
Anxiety Disorders, Depression, Bi-Polar	☐	Infertility, Hormone Regulation Issues	☐
Asthma	☐	Kidney Disease	☐
Autism	☐	Mental Disorder - Alzheimer's or Dementia	☐
Auto-Immune Disorders (Lupus, Rheumatoid Arthritis, Hashimoto's, etc.)	☐	Migraines, Headache	☐
Cancer	☐	Neurological Cancer	☐
Chronic Fatigue, Fibromyalgia	☐	Obesity	☐
Chronic Immune Dysfunction (Yeast, Viral, Lyme Disease, etc.)	☐	Osteoporosis	☐
Chronic Pain, Neuralgias, Neuropathies	☐	PCOS	☐
Diabetes	☐	Post-Concussion Syndrome	☐
Epilepsy	☐	Psoriasis	☐
Food Sensitivities	☐	Seizure Disorders	☐
Frequent Miscarriages	☐	Stress	☐
Glaucoma	☐	Stroke	☐
Heart Disease	☐	Thyroid Disease	☐
Heavy Menstrual Period	☐	Vertigo, Dizziness	☐

Personal Medical History: *(check all that apply)*

ADD or ADHD, Youth or Adult	☐	Heart Disease, Palpitations, or Murmur	☐
Allergies (Hives, Rashes, Sinus Congestion)	☐	Heavy Menstrual Period	☐
Alzheimer's Disease or Dementia	☐	Hepatitis	☐
Anemia	☐	High Blood Pressure	☐
Anxiety Disorders	☐	Hypertension	☐
Arthritis, Joint Pain, or Muscle Pain	☐	Hypothyroidism	☐
Asthma	☐	Incontinence	☐
Autism	☐	Increased Blood Clotting	☐
Auto-Immune Disorders (Lupus, Rheumatoid Arthritis, Hashimoto's, etc.)	☐	Infertility, Hormone Regulation Issues	☐
Bronchitis	☐	Insomnia or Poor Sleep Quality	☐
Chest Pain	☐	Interstitial Cystitis	☐
Crohn's Disease or Ulcerative Colitis	☐	Irritable Bowel Syndrome	☐
Chronic Fatigue	☐	Kidney Disease	☐
Chronic Fever	☐	Migraines, Headache	☐
Dizziness	☐	Neurological Cancer	☐
Chronic Pain Neuralgias	☐	Neuropathies	☐
Chronic Sinusitis	☐	Obesity	☐
Circulation Issues	☐	Osteoporosis	☐
Depression, Bi-Polar	☐	Other Cancer:	☐
Diabetes	☐	PCOS	☐
Fainting	☐	Post-Concussion Syndrome	☐
Erectile Dysfunction	☐	Psoriasis	☐
Eczema	☐	Seizure Disorders	☐
Epilepsy	☐	Stress	☐
Fibromyalgia	☐	Stroke	☐
Food Sensitivities	☐	Thyroid Disease	☐
Frequent Infections (Yeast,Viral,Lyme Disease)	☐	Ulcers	☐
Gallbladder Disease	☐	Uterine Cancer	☐
Glaucoma	☐	Venereal Disease	☐
Gluten Sensitivities	☐	Vertigo	☐
Gout	☐		☐

Symptoms: *(check all that apply)*

Addiction	☐	Muscle Cramps	☐
Afternoon Crash	☐	Nervousness	☐
Brain Fog	☐	Oral Temp Below 98.5	☐
Breast Soreness	☐	Overall decreased sexual desire	☐
Can't gain muscle with exercise	☐	Poor muscle tone/loss of strength	☐
Cold Extremities (Hands, Feet)	☐	Poor stamina	☐
Constipation	☐	Pouches under the eyes	☐
Cravings for Sweets	☐	Puffy Eyes & Face	☐
Difficulty Turning Off Stress	☐	Reliance on coffee/stimulants	☐
Dizziness on first standing	☐	Sense of Unhappiness	☐
Drooping triceps	☐	Sensitivity to Smells	☐

Feel like you are aging	☐	Short term memory loss	☐
Glass Half Empty Feeling	☐	Shortness of Breath	☐
Headaches and migraines	☐	Slow Heartbeat	☐
Increased Aggression	☐	Sugar or Carb Cravings	☐
Increasing stomach size	☐	Swelling of hands and feet	☐
Lack of Energy	☐	Thinning of Hair	☐
Lack of Motivation	☐	Throat Clearing	☐
Loose or wrinkled skin	☐	Tingling in fingers/feet	☐
Loss of outer 1/3 of eyebrow	☐	Weight Gain/Trouble Losing Weight	☐
Low Blood Pressure	☐	Workaholic	☐
Moodiness	☐	Wrinkled hands	☐

Sleep: *(check yes or no)*

Difficulty falling asleep	**YES** ☐	**NO** ☐
Snoring	**YES** ☐	**NO** ☐
Wake up refreshed	**YES** ☐	**NO** ☐
Daytime drowsiness	**YES** ☐	**NO** ☐
Early morning awakening	**YES** ☐	**NO** ☐
Sleep Apnea	**YES** ☐	**NO** ☐

Habits: *(check yes or no)*

Smoking	**YES** ☐	**NO** ☐
If yes, how many packs daily, and for how long? Interested in stopping?		
Coffee	**YES** ☐	**NO** ☐
If yes, how many cups daily? Any other caffeinated beverages?		
Alcohol	**YES** ☐	**NO** ☐
If yes, what types? How many drinks daily/weekly?		
Drug History	**YES** ☐	**NO** ☐

If yes, please briefly describe:		
Have you ever been treated for a mental or eating disorder?	**YES** ☐	**NO** ☐
If yes, please describe:		
Have you ever been involved in a weight loss program?	**YES** ☐	**NO** ☐
If yes, please describe:		
Have you ever taken weight loss medication?	**YES** ☐	**NO** ☐
Name of medications:		

Eating Patterns:

Graze All Day	**YES** ☐	**NO** ☐
Skip Meals	**YES** ☐	**NO** ☐
Eat Breakfast	**YES** ☐	**NO** ☐
Snack at Night	**YES** ☐	**NO** ☐
Eat at Regular Times	**YES** ☐	**NO** ☐
Eat Late	**YES** ☐	**NO** ☐
Problem Foods?	**YES** ☐	**NO** ☐
Which foods, e.g. carbs, sugars, fats, and/or salt?		
Have you ever had success at weight loss?	**YES** ☐	**NO** ☐

If yes, what worked for you?

Weight Gain History:

Problem with weight?	**YES** ☐	**NO** ☐
If yes, please describe when the weight concern started, e.g. child, teen, adult, peri/post-menopausal? Do you have an issue with rapid or slow weight gain?		

Inciting Factors: *(check all that apply)*

Stress	☐	Birth Control	☐
Marriage	☐	Hysterectomy	☐
Divorce	☐	Tubal Ablation	☐
Illness	☐	Depot Provera Injection	☐
Accident	☐	Emotional	☐
Medication	☐	Birth of Children	☐

Female Only Section:

Birth Control	**YES** ☐	**NO** ☐
If yes, please describe both present and past types, as well as reason for taking.		
Breast Exam(s)	**YES** ☐	**NO** ☐
Date of last exam?		
Menstrual Period	**YES** ☐	**NO** ☐
Age of onset? Date of last period? Regular/Irregular? Duration of bleeding in days? Light/medium/heavy?		
Pap Smear/Mammogram/Chest X-Ray?	**YES** ☐	**NO** ☐

Date of last exam(s)?		
Have you had a Hysterectomy?	**YES** ☐	**NO** ☐
Partial/Total? Date?		
Miscarriages?	**YES** ☐	**NO** ☐
If yes, how many?		
Have you had an ablation?	**YES** ☐	**NO** ☐
Tubal Ligation?	**YES** ☐	**NO** ☐
Cramps?	**YES** ☐	**NO** ☐
Moodiness/Depression with Menses?	**YES** ☐	**NO** ☐
Trouble with Arousal or Desire?	**YES** ☐	**NO** ☐
Vaginal Dryness?	**YES** ☐	**NO** ☐
Frequent Vaginal Infections?	**YES** ☐	**NO** ☐
Premenstrual Syndrome (PMS)?	**YES** ☐	**NO** ☐
If yes, how severe, e.g. mild, moderate, severe?		
Losing urine coughing or sneezing?	**YES** ☐	**NO** ☐
Hot Flashes/Night Sweats?	**YES** ☐	**NO** ☐
If yes, how severe, e.g. mild, moderate, severe?		
Breast, Endometrial, or Uterine Cancer?	**YES** ☐	**NO** ☐
Fibrocystic Breasts?	**YES** ☐	**NO** ☐

Infertility?	**YES** ☐	**NO** ☐
Polycystic Ovaries (PCOS)	**YES** ☐	**NO** ☐

Male Only Section:

Prostate Problems?	**YES** ☐	**NO** ☐
Date of last Prostate exam?		
History of Prostate Cancer?	**YES** ☐	**NO** ☐
Decreased sex drive?	**YES** ☐	**NO** ☐
Currently on Viagra/Cialis?	**YES** ☐	**NO** ☐
Trouble urinating?	**YES** ☐	**NO** ☐
Decrease in size of urination stream?	**YES** ☐	**NO** ☐
Increased number of times urinating at night?	**YES** ☐	**NO** ☐
Trouble with erectile dysfunction?	**YES** ☐	**NO** ☐
Trouble with premature ejaculation?	**YES** ☐	**NO** ☐

I state that all of the information provided above is true and accurate and I understand that this information will be relied upon by the medical staff of Natural Bio health.

Printed Name:

Signature:

Date:

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make

disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request are striction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Printed Name:

Signature:

Date: