



Natural Bio Health - Health History Intake Form

Referred by: _____

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:
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Drug Allergies:	Other Allergies:
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Current Medications and Vitamins:

Surgeries <i>(include dates if possible)</i> :
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Injuries:

Height:	Weight:
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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
<i>If yes, how many packs daily, and for how long? Interested in stopping?</i>		
Coffee	YES	NO
<i>If yes, how many cups daily? Any other caffeinated beverages?</i>		
Alcohol	YES	NO
<i>If yes, what types? How many drinks daily/weekly?</i>		
Drug History	YES	NO

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

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
<i>Which foods, e.g. carbs, sugars, fats, and/or salt?</i>		
Have you ever had success at weight loss?	YES	NO

If yes, what worked for you?

Weight Gain History:

Problem with weight?	YES	NO
<i>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?</i>		

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

<i>Date of last exam(s)?</i>		
Have you had a Hysterectomy?	YES	NO
<i>Partial/Total? Date?</i>		
Miscarriages?	YES	NO
<i>If yes, how many?</i>		
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
<i>If yes, how severe, e.g. mild, moderate, severe?</i>		
Losing urine coughing or sneezing?	YES	NO
Hot Flashes/Night Sweats?	YES	NO
<i>If yes, how severe, e.g. mild, moderate, severe?</i>		
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
<i>Date of last Prostate exam?</i>		
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 restriction 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: