

New Patient Intake

Full Name:			
Gender: M F	DOB: / /		Age:
Address:			
May we correspond wit	h you by email: Y N		
Relationship Status:	Single Married/Partnered	Divorce/Separated	Widowed
Emergency Contact:		Phone:	
Employer:		Occupation:	
Insurance Company:			
How did you hear abou	t us?		
	Patient Med	·	
List your main reason(s) for coming in today:		
	itions, surgeries or major illne		
	r the care of another physiciar		
If yes, Physician's name	:	Phone:	
Reason for care:			



			& dosages you are currently taking:
Supplements ó List all herbal, hor their dosage:	_		upplements you currently take and
	any recent	· ·	asound, Thermography, Mammogram
Female Gynecological History:			
Date of Last Menstrual Period:			
Last Annual/Pam Exam:			
Have you ever had an Abnormal I	Pap:		
# of Full Term Pregnancies:	# o	f Miscarriages:	# of Abortions:
Family History:			
•			e of death:
Mother still living?	Y N	If not, age & cause	e of death:
Check if any of your family meml	oers have h	ad any of the following	y:
Alzheimerøs/Dementia	1	Heart Disease	Severe Depression
Breast Cancer	1	High Blood Pressure	Mental Illness
Cancer, other	1	Bleeding Disorder	Thyroid Condition



Review of Systems ó Check any of the symptoms that you are currently experiencing or experienced in the past 6 months

General:	Yes	Throat/Neck:	Yes	Eyes:	Yes
Weight Loss/Gain		Frequent sore throat		History of Eye Injury	
More tired than usual		Voice Hoarseness		Blurred Vision	
Night Sweats		Change in Voice		Recent Change in Vision/vision loss	
Fevers		Swollen Lymph nodes		Excessive Tears/watery	
		Difficulty Swallowing		Dry Eyes	
Head:				Frequent Eye Infection/"pink-eye"	
Frequent Headaches/ Migraines		Ears:		Eye Twitching	
Dizziness/Vertigo		Frequent Ear Infections		Glaucoma	
History of Head Injury		Ringing in Ear/Tinnitus		Cataracts	
TMJ/ Jaw pain or clicking		Loss of hearing			
Nose/Sinuses:		Gastrointestinal/Abdomen		Breasts:	
Loss of smell/Change in smell		Number of bowel		Do you do Self breast	
Frequent Sinus Infection/ Pain		Change in Bowel Habit		Breast pain/tenderness	
Hay fever/allergies		Constipation		Nipple Discharge	
Nasal Polyp		Diarrhea		Lump in Breast	
Frequent Nose Bleeds		Bloody Stool		Discoloration on breast	
		Black Stool		Currently Breastfeeding?	
Mouth/ Dental:		Hemorrhoids		History of Breast	
Frequent Tooth pain/infection		Excessive Bloating & Gas		Breast Implants	
Bleeding Gums/ gingivitis		Intestinal Polyps		Breast Cancer	
Sores in mouth/tongue		Abdominal Pain/cramps			
Teeth Grinding		Nausea/Vomiting		Female	
		Liver Disease		Pain/cramps with Periods	
Respiratory/Chest:		Yellowing of skin or eyes		irregular periods	
Asthma				Insomnia/ trouble sleeping	
Shortness of Breath		Urinary:		Change in libido or sexual	



	MEMELLI	
Frequent Cough	Increased urinary frequency	Night sweats
Coughing up blood	Incontinence/urine leakage	Vaginal Discharge or odor
Chest pain/ painful breathing	Waking at night to urinate	Vaginal Dryness
	Bloody Urine	Frequent Infections: BV or
Cardiovascular/Heart:	Foul-smelling or cloudy	Pain with intercourse/sex
Rapid heart beat	Frequent bladder infections	PMS
Chest Pain/tightness in chest	History of Kidney	History of Ovarian Cyst
History of Heart Attack	History of Kidney Stones	History of Endometriosis
High Blood Pressure		Are you currently sexually
High Cholesterol/Triglycerides	Male	Are you taking Birth
Sensation of missed	History of Hernia	Do you have an IUD?
History of Heart Murmur	Erectile Dysfunction/sexual	Other form of
History of Fainting	Change in libido or sexual	Difficulty Conceiving
History of Rheumatic Fever	Testicular Pain or Mass	Have you had a
Ankle Swelling	Discharge from penis	PCOS
History of Blood Clots	Sores/lesions on	
	History of sexually	
	History of Prostate Disease	
	Currently Sexually Active?	
	History of sexually	
	Transmitted infection	
Endocrine:	Musculoskeletal:	Skin:
Hair Loss	Chronic Aches/Pains	Rashes
Brittle hair	History of Broken Bones	Acne, boils
Increased thirst	Arthritis	Eczema
Intolerance to cold/heat	Osteoporosis	Psoriasis
Excessive Hunger/Thirst	Leg Cramps	Hives
Excessive Urination	Restless Legs	Change in moles
History of Diabetes Type I	Muscle Twitches?	Dry or Itchy skin
History of Diabetes Type II	Low Back Pain/Sciatica	Oily Skin
Hypothyroid	Stiffness upon waking	History of Skin Cancer



Hyperthyroid/ Graves disease	General Stiffness	Excessive Sweating	
Goiter on Thyroid	Nerve Pain/ Neuropathy	Color Changes	
History of Thyroid Cancer	Weakness	Sores that won't heal	
Hashimoto's Disease	Numbness	Easy Bruising	
Cushing's Disease	History-Back/neck surgery		
Addison's Disease	History-orthopedic surgery	Nails:	
Other Endocrine Condition?	Knee Pain/stiffness	Fungus	
	Shoulder pain/stiffness	Pitting	
Other:	Injury to back/neck	Discoloration	
History of any Cancer	Injury-legs/arms/shoulders	Break Easily	
History of Auto-Immune Condition	Carpal tunnel syndrome		
History of Eating Disorder	Tingling in hands/feet		
History of Abuse	Tendonitis		
	Plantar Fasciitis/heel pain		

Please list any conditions that	were not addressed ab	ove:	
Constitutional:			
Your temperature:	Normal	Chilly	Warm
Do you prefer:	Cold		Heat
Perspiration:	Easily Perspire		Heat Do not perspire easily
Favorite Foods:		_ Foods th	nat disgust you:
Fears:	·		Evening (5-9pm) Night (after 10pm)
1 0	•		be alone A bit of both
You would describe yourself a	asi		
Habits/Lifestyle:			
• •	nch and Dinner on a w	•	
B:			
L:			
D:			
Any special diet (Vegetarian	Vegan Gluten-tree etc	c)	



Water: Number of 10-12 ounce glasses daily: Caffeine (coffee, tea, soda): cups per data Alcoholic beverages per week: History of alcoholism: Y N	ay
Tobacco product use: No, never Yes, currently Yes, but I have quit	
Recreational drugs: Y N Which ones:History of drug addiction: Y N	
Exercise:	
Your current routine:	
Sleep:	
Number of hours on typical night: Feel well rested upon waking in the morning? Y	N
Hobbies:	-
Current stress level: Mild Moderate Severe	
Cause of your stress:	_



Informed Consent

Consent to receive health advice: I, _____ (patient on name), hereby voluntarily request and willingly consent to receive health advice from Dr.Familoni.

Acknowledgment of Risks:

I understand that Naturopathic Medicine practiced at True Health and Wholeness, LLC is generally considered safe, but may pose certain risks to me. These potential risks may include allergic reaction to supplements recommended to me, muscle soreness following an acupuncture and/or Tuina massage session, redness and swelling at site of needling. I agree to contact a staff member of True Health and Wholeness, LLC immediately if I believe any adverse reaction may be occurring due to a treatment that was recommended or performed at this clinic. I will inform my practitioner of any previous allergic reaction I have had to any pharmaceutical, nutritional supplement, herbal supplement, homeopathic supplement or topical medicine. I understand that certain nutritional and herbal supplements may be harmful to pregnant women and/or their unborn child. I will inform my healthcare practitioner at True Health and Wholeness, LLC if/when I become pregnant, if there is a chance that I may be pregnant, or if I am lactating.

I understand that Naturopathic Medicine and Acupuncture are generally very safe and effective, but I realize that there is no guarantee of cure for my medical condition.

HIPAA/Privacy Policy and Legal Notice

True Health and Wholeness complies with all aspects of the federal HIPPA law, which stipulates your rights as a medical patient. At TH-W you have the right to the following:

- All of your medical records in our possession are controlled so that only your medical provider and essential office staff are allowed to see the contents of your records.
- Your records will not be shared with anyone outside of this office except for the very rare occasions as
 mandated by law, including a court order, or in cases where the law mandates that we act to preserve life
 by breaking confidentiality, as in the case where we firmly believe that you might endanger the life of
 another or yourself.
- Clinics that contract with insurance companies are required by contract to divulge records to the insurance company. Because of this we do NOT accept insurance and we will NOT share your records with outside private companies.
- At TH-W we believe that your medical records are YOUR medical records. You may request a copy of your records and we will make you a copy within 7 working days of your request. We may charge you reasonable copying fees for this service. Your õrecordsö include anything actually in your chart, but does not include incidental notes that doctors may make for their own use but which are never entered into the official chart notes. The HIPPA law allows doctors to refuse a request for records in extremely rare and unusual cases.



- We will not confirm or deny that you are a patient at our clinic, even to your family members, unless you have given us explicit permission to do so. Your right to seek medical care with complete confidentiality is a right we take seriously.
- At TH-W we occasionally use cases from our clinic in teaching settings. When we use a clinic case
 history we edit the history so that your name and other identifiers are never used, no details are divulged
 that would allow anyone to identify you personally. We encourage you to consider allowing your case
 history, to be used for teaching, research and writing purposes, but the decision to do so is yours and
 yours alone.

If you have any questions or concerns about our privacy policy, or your rights as a patient in our clinic, please bring them to us at your earliest convenience.

Note:

Dr. Familoni is a Licensed Naturopathic Medical Doctor in Washington, District of Columbia and a Licensed Acupuncturist in Washington DC, and the States of Maryland and Virginia. The State of Virginia does not currently offer licensure for Naturopathic Physicians so it must be clear that the Doctors at True Health and Wholeness are not legally allowed to diagnose or treat a specific condition. We will work with you as health consultants to assist you in optimizing your overall state of health through a safe and natural approach. We will suggest to you a course of care to help you achieve your health goals. A licensed physician should manage serious or emergent health concerns.

I understand the above notice: _	Date:
I intend this form to cover my current condition(s), as well that I may seek treatment for at this clinic. By signing this	· ·
Printed name of Patient	Date:
Signature (Patient or legal guardian)	Date:



Office Policies

Thank you for choosing True Health and Wholeness for your healthcare needs. Please take a moment to read about our office policies. Understanding these policies will help us to best serve you!

Appointments: We have reserved your scheduled appointment time for you and ask that if you need to **cancel** that you need to give us **24 hours advance notice**. If you miss your appointment or cancel with less than 24 hours, we will **charge your account \$50**. This fee will be waived for emergency situations.

Payment & Insurance: Payment in full is due at time of service. We will gladly provide you with a service summary for you to self-submit to your insurance company for potential reimbursement.

Telephone: We are more than happy to have a brief phone conversation to answer your questions. If this phone conversation goes **beyond 10 minutes** or substitutes for an office visit (such as changes made to your treatment plan) you will be billed the rates of a phone consult.

Email: If you choose to email your doctor, please know that email is only intended for brief questions and to clarify treatment plans. Your doctor will typically respond within 2 business days. We do not have a secured server for email, therefore it does have the risk of mal-use from an outside party (õhackedö); it is your choice to use email or phone for communication with your doctor.

Supplements: We appreciate your supporting local business by purchasing your high quality nutritional, herbal and homeopathic supplements at TH-W. We strive to keep our prices affordable. Please note that we are **unable to refund** any purchased product once it has left our premise or has been shipped to you. Please call ahead to pick-up a refill for your supplements, so that we can confirm this item is in-stock.

Refills: We require patients to **have a follow-up office visit** before we will **refill** prescription drugs. This allows us to make changes to the dosage or treatment as necessary. No new supplements will be given over a phone consult; the patient must be seen in-office first

Print Patient

Name:

Signature (Patient or Legal Guardian):

Date:

By signing this form, you are agreeing to the Office Policies at True Health and Wholeness



INFORMED CONSENT FOR ACUPUNCTURE TREATMENTS

I voluntarily consent to be treated by the True Health and Wholeness Center. The Clinic offers several treatment modalities. The course of the treatment will be determined between the health practitioner and myself.

The treatments consist of, but are not limited to:

- 1. The use of acupuncture needles to stimulate acupuncture points and meridians
- 2. Use of electrical, laser, ultrasound, water, mechanical, or devices to stimulate acupuncture points and meridians
- 3. Indirect Moxibustion
- 4. Acupressure
- 5. Cupping
- 6. TuiNa
- 7. Infra-red Heat Lamp
- 8. Traditional Chinese Herbal Supplements
- 9. Dietary advice based on traditional Chinese medical theory
- 10. Facial Rejuvenation

I acknowledge that there are some risks to the treatment. These side effects may include, but are not limited to the following:

- 1. Some pain following treatment in the insertion area
- 2. Minor bruising
- 3. Infection
- 4. Needle sickness such as dizziness, fainting and nervousness
- 5. Patients with severe bleeding disorders or pace makers should inform the practitioner prior to any treatment.

If you are pregnant or have a history of seizures, you should also inform the practitioner.

I understand that there is neither an implied nor stated guarantee of success of effectiveness of a specific treatment of series of treatments. I understand that all my questions regarding the procedure will be answered, and that I am free to withdraw my consent and to discontinue treatment at any time.

I hereby authorize TRUE Health and Wholeness to release any information regarding my condition to the referring physician (if any) and/or to my insurance for the processing of any claim. With notification, I also authorize TRUE Health and Wholeness to obtain my medical records from other physicians or medical centers.

Payment in full is expected at the time of each appointment. I agree to give 24 hours notice to the clinic if I must cancel or re-schedule an appointment. I understand that I will be charged at current clinical rates after 2 missed appointments when no notice is given or for failing to show up to the appointment. Exceptions may be made in a case of an emergency. I understand that in case of unavoidable lateness by me or by the clinic, the schedule may be adjusted to provide for my treatment in its entirety.

Thank you for you cooperation and consideration.	
Signature	Date
Patient Representative or Parent	



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