New Patient Intake

Full Name: _____

Gender: M F DOB: / / Age: _____

Address: _____

Home/Cell Phone: _____ Email Address: _____

May we correspond with you by email: Y N

Relationship Status: Single Married/Partnered Divorce/Separated Widowed

Emergency Contact: _____ Phone: _____

Employer: _____ Occupation: _____

Insurance Company: _____

How did you hear about us? _____

Patient Medical History

Weight: _____ Height: _____

List your main reason(s) for coming in today: _____

_____

List any past hospitalizations, surgeries or major illnesses and approximate dates: _____

_____

_____

Are you currently under the care of another physician? Y N

If yes, Physician's name: _____ Phone: _____

Reason for care: _____

Allergies ï Please list any medications, foods or environmental allergies and your reaction(s):

_____

_____

Medications ï List all prescription & over-the-counter medications & dosages you are currently taking:

_____

_____

Supplements ï List all herbal, homeopathic, hormonal, nutritional supplements you currently take and their dosage: _____

_____

bring your bottles to appointment

Imaging/Diagnostic Studies ï List any recent (i.e. X-ray, MRI, Ultrasound, Thermography, Mammogram, DEXA Scan): _____

_____

Female Gynecological History:

Date of Last Menstrual Period: _____

Last Annual/Pam Exam: _____

Have you ever had an Abnormal Pap: _____

# of Full Term Pregnancies: _____ # of Miscarriages: _____ # of Abortions: _____

Family History: _____

Father still living? Y N If not, age & cause of death: _____

Mother still living? Y N If not, age & cause of death: _____

Check if any of your family members have had any of the following:

___ Alzheimerôs/Dementia	___ Heart Disease	___ Severe Depression
___ Breast Cancer	___ High Blood Pressure	___ Mental Illness
___ Cancer, other	___ Bleeding Disorder	___ Thyroid Condition
___ Diabetes	___ Genetic Disorder	___ Autoimmune Condition

List any other significant family medical history that is not listed above: _____

_____

_____

Review of Systems ï 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	

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 above: _____

_____

Constitutional:

Your temperature: _____ Normal _____ Chilly _____ Warm
Do you prefer: _____ Cold _____ Heat
Perspiration: _____ Easily Perspire _____ Do not perspire easily
Favorite Foods: _____ Foods that disgust you: _____

Energy best at: __ Morning (6-11am) __ Afternoon (11-4pm) __ Evening (5-9pm) __ Night (after 10pm)
Fears: _____
Company: ___ Usually want people around me ___ Prefer to be alone ___ A bit of both
You would describe yourself asé _____

Habits/Lifestyle:

Typical Breakfast, Lunch and Dinner on a weekday?
B: _____
L: _____
D: _____
Any special diet (Vegetarian, Vegan, Gluten-free, etc.) _____

Water: Number of 10-12 ounce glasses daily: _____ Caffeine (coffee, tea, soda): _____ cups per day
Alcoholic beverages per week: _____ History of alcoholism: Y N

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, _____ (patientôs 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 ñrecordsò 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 as any conditions that may arise in the future that I may seek treatment for at this clinic. By signing this form, I agree to the above statements

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 (ñhackedò); 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

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

Print Patientôs Name:_____

Signature (Patient or Legal Guardian): _____

Date: _____

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_____
Patientôs Representative or Parent _____

TRUE
HEALTH AND WHOLENESS

Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing