WHOLE HEALTH
natural family medicine

PATIENT INFORMATION

Last Name_____

First Name_____ Middle _____

Birthdate _____ Age_____ Gender ☐ M ☐ F

Street Address_____

City_____ State_____ Zip_____

Email_____

Employer_____

Occupation_____

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Spouse/Partner's Name_____

Who can we thank for referring you?

_____

PATIENT PHONE NUMBERS

Home (_____) _____

Work (_____) _____

Cell (_____) _____

Best time and place to reach you _____

Is it OK to leave a message? ☐ Yes ☐ No

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Insurance Company _____

Plan Name _____

ID # _____

Group # _____

Primary Physician_____

Does your visit require a referral? ☐ Yes ☐ No ☐ Unsure

Is the patient the primary subscriber? ☐ Yes ☐ No

If no, please complete subscriber information below:

Name _____

Birthdate _____ SS# _____

Relationship to patient _____

ND coverage ☐ Yes ☐ No Acup. Coverage ☐ Yes ☐ No

EMERGENCY CONTACT

Name _____

Relationship _____

Home (_____)_____

Work (_____) _____

Cell (_____) _____

I authorize Whole Health Natural Family Medicine LLC to disclose necessary health care information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I request that payment of authorized benefits be made on my behalf to Whole Health Natural Family Medicine LLC for any covered services furnished to me by Whole Health Natural Family Medicine LLC. I understand and agree that regardless of my insurance status I am responsible for the balance on this account for any services, medications, or laboratory work. I understand that missed appointments or cancellations within 24 hours of the scheduled appointment time will be subject to a missed appointment fee. I understand that certain services (ie. acupuncture, physical medicine) and/or products may not be covered by my insurance and that non-covered services and/or products will be my responsibility.

_____ _____

Signature of patient, parent, guardian, or representative Date

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INFORMED CONSENT FOR TREATMENT

Name: _____ Date: _____

I hereby authorize the Naturopathic physicians and other practitioners of the Whole Health Natural Family Medicine, LLC (Whole Health) to perform the following specific procedure(s) as necessary to facilitate my diagnosis and treatment:

- **Common diagnostic procedures:** e.g., venipuncture, Pap smears, radiography, laboratory, and x-ray.
- **Minor office procedures:** e.g., dressing a wound, ear cleansing.
- **Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation of vitamins, minerals, amino acids and other nutritional or therapeutic substances.
- **Botanical medicine:** botanical substances (herbal medicines) may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
- **Lifestyle counseling and hygiene:** diet therapy, fasting, elimination diets, promotion of wellness including recommendations for exercise, sleep, stress reductions and balancing of work and social activities.
- **Psychological counseling.**
- **Physical medicine, acupuncture and bodywork.**

Practitioners of Whole Health have discussed and explained to my satisfaction the basic procedures of the above therapies and the risks and benefits of the care I will receive and I have been given the opportunity to ask questions about the treatment plan and procedures. I recognize certain potential risks and benefits of the procedures I am receiving, as they were described to me and as described more generally below:

POTENTIAL RISKS: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, venipuncture for diagnostic testing, and possible prescription drug interaction with prescribed natural supplements or products. Acupuncture may produce temporary numbness, tingling, bruising or redness. Moxibustion, the burning of an herbal preparation on or near the skin, may occasionally cause mild burning or blistering of the skin.

POTENTIAL BENEFITS: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

ALTERNATIVES – I understand that the practitioners at the Whole Health are not primary care physicians, and the procedures that I will receive at the Whole Health are supplementary care to my primary care physician and/or specialist. It has been recommended to me that I consult with a primary care physician and/or a specialist to obtain information about all of the conventional medicine treatment alternatives available to me.

NOTICE TO PREGNANT WOMEN - All female patients must inform the treating doctor if they know or suspect that they are pregnant as some of the procedures and therapies described above may present a risk to the pregnancy.

CONSENT - With this knowledge, I voluntarily consent to the above procedure(s), realizing that no guarantees or warrantees have been given to me by the Whole Health or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

TEACHING CLINIC - I understand that the Whole Health may participate as a teaching clinic, and that students may observe or participate in the care provided with my verbal consent.

CONFIDENTIALITY - I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my lawful representative, or me or unless law permits or requires it. I understand that I may request to view my medical record and can request a copy of it by paying the appropriate copying fee.

I understand that my medical record will be kept for a minimum of seven years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that my practitioner will answer any questions I have, to the best of his/her ability.

I certify that I have read and fully understand this consent and the matters, which have been explained to me. I further certify that I have full authority and accept full responsibility to execute this consent for an on behalf of the above-named patient and that I am signing freely and voluntarily.

_____ _____

Date Signature of Patient

_____

Signature of Patient Representative or Guardian

WHOLE HEALTH
natural family medicine

Amanda M. Levitt, ND • Joshua P. Levitt, ND • Robin Ritterman, ND, LAc • Matthew Fisel, ND

Summary of Privacy Practices

We at Whole Health Natural Family Medicine, LLC understand that your medical/health information is personal and private. In order to provide you with quality care and to ensure compliance with certain legal requirements, we create a record of the care and services you receive in our office(s). We respect the privacy and confidentiality of medical/health information about you and that can be identified with you. This is called "protected health information". Your protected health information is contained in the medical and billing records maintained by our practice. It includes demographic information and information that relates to your present, past or future physical or mental health and related health care services.

Our *Notice of Privacy Practices* ("Notice") is a twelve page document that describes the ways in which we may use and disclose your protected health information. It also describes your rights and our legal obligations with respect to your protected health information.

The Notice applies to uses and disclosures we may make of all your protected health information, whether created by us in our practice or received by us from another health care provider.

The Notice contains seven main sections that are summarized or described below.

A. IT IS OUR LEGAL DUTY TO PROTECT YOUR HEALTH INFORMATION.

B. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO PROVIDE YOU WITH TREATMENT, TO OBTAIN PAYMENT FOR SERVICES RENDERED TO YOU, AND FOR HEALTH CARE OPERATIONS.

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION IN LIMITED SITUATIONS. (Emergencies, legal cases, public health, etc.)

D. YOUR AUTHORIZATION IS REQUIRED FOR ALL OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION.

E. OUTLINES YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.

F. CONTAINS SPECIAL RULES REGARDING THE DISCLOSURE OF MENTAL HEALTH CONDITIONS, SUBSTANCE ABUSE, AND HIV-RELATED INFORMATION.

G. OUTLINES THE PROCEDURES FOR COMPLAINTS.

The Notice in its entirety is posted in our reception area and copies can be made available to you upon request.

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ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices of Whole Health Natural Family Medicine, LLC. I understand that the Notice describes the uses and potential disclosures of my protected health information and informs me of my rights with respect to my protected health information.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Refusals

_____ The above individual refused to accept a copy of the Notice of Privacy Practices.

_____ The above individual received a copy of the Notice of Privacy Practices but refuses to sign an Acknowledgment of Receipt.

_____ _____

Signature of Whole Health Representative Name of Whole Health Representative

2838 Old Dixwell Avenue, Hamden, CT 06518 • Phone (203) 288-8283 • Fax (203) 288-8405

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ADULT SYMPTOM SURVEY

NAME_____**DATE**_____

What is your major complaint? _____

_____

_____

Are you coming for any specific therapy? (i.e. homeopathy, acupuncture, nutritional counseling, physical medicine, "anything that works")_____

_____

This survey will help us to evaluate you more completely. Please place a check mark next to those symptoms which you NOW experience or have experienced in the PAST. Include all the complaints which are familiar to you. If there are one or more words in a line which describe your specific problem you may want to circle those words.

NOW	PAST	GENERAL SYMPTOMS
_____	_____	tired, weak, lack of energy
_____	_____	depression, melancholy, moodiness
_____	_____	worry, anxiety, nervousness, irritability
_____	_____	sleeplessness or sleep too much
_____	_____	frequent colds or other illness
_____	_____	headaches
_____	_____	don't sweat enough
_____	_____	sweat too much
_____	_____	night sweats
_____	_____	dizziness, fainting, convulsions
_____	_____	loss or gain of weight
_____	_____	other_____

NOW	PAST	SKIN AND HAIR
_____	_____	acne or pimples
_____	_____	skin rashes
_____	_____	hives
_____	_____	stretch marks
_____	_____	skin ulcers or sores
_____	_____	dryness, roughness or scaling skin, scalp, elbows, knees, feet, around nose, ears, eyebrows, etc.
_____	_____	hair loss or thinning
_____	_____	dry, coarse hair or split ends
_____	_____	bruise easily
_____	_____	nails weak, ridged or split easily
_____	_____	brown spots or bronzing on skin
_____	_____	moles, warts or skin tags
_____	_____	sunburn easily
_____	_____	cuts heal slowly or scar badly
_____	_____	flush easily
_____	_____	hands or feet numb or tingling
_____	_____	feet burn
_____	_____	athletes foot
_____	_____	other_____

NOW	PAST	RESPIRATORY
_____	_____	cough frequently
_____	_____	spitting up mucus or blood
_____	_____	difficulty breathing
_____	_____	shortness of breath on exertion
_____	_____	chest pain
_____	_____	other_____

NOW	PAST	EYES
_____	_____	nearsightedness or farsightedness
_____	_____	blurred or failing vision
_____	_____	dry, burning or itching eyes
_____	_____	eyes water excessively
_____	_____	eyes sensitive to light
_____	_____	night blindness
_____	_____	bloodshot or puffy eyes
_____	_____	other_____

NOW	PAST	EARS
_____	_____	earaches
_____	_____	noises or ringing in ears
_____	_____	ear discharges
_____	_____	loss of hearing
_____	_____	lots of wax
_____	_____	other_____

NOW	PAST	NOSE AND THROAT
_____	_____	hay fever, sinusitis, runny nose
_____	_____	dry mouth or nose
_____	_____	nosebleeds
_____	_____	cracks in corners of mouth
_____	_____	dry or chapped lips
_____	_____	sore throats or tonsillitis
_____	_____	clear throat often
_____	_____	sore, red or cracked tongue
_____	_____	cold sores or herpes
_____	_____	inability to smell or taste
_____	_____	lots of cavities
_____	_____	bleeding gums
_____	_____	hoarseness
_____	_____	other_____

NOW	PAST	MUSCULO-SKELETAL
_____	_____	muscle pain or stiffness where?_____
_____	_____	swollen, painful or stiff joints
_____	_____	bone pains
_____	_____	painful feet, ankles or calves
_____	_____	tremors or twitches
_____	_____	loss of strength
_____	_____	hernia
_____	_____	muscle wasting
_____	_____	other_____

NOW	PAST	GASTROINTESTINAL
_____	_____	loss of appetite
_____	_____	gagging, difficulty swallowing
_____	_____	nausea or vomiting
_____	_____	bad breath
_____	_____	metallic or bitter taste in mouth
_____	_____	food cravings or strong desires
_____	_____	can't eat fats
_____	_____	heartburn
_____	_____	indigestion or distress
_____	_____	heaviness after eating
_____	_____	belching or gas
_____	_____	bloating
_____	_____	stomach or abdomen tender or painful
_____	_____	symptoms relieved by eating
_____	_____	symptoms worse after eating
_____	_____	avoid certain foods
_____	_____	headache, dizziness or irritability if skip meal
_____	_____	diarrhea or loose stools
_____	_____	constipation
_____	_____	change in bowel movements
_____	_____	light colored or greasy stools
_____	_____	dark stools or blood in stool
_____	_____	feeling of incomplete evacuation
_____	_____	undigested food in stool
_____	_____	foul odor of stool or gas
_____	_____	hemorrhoids
_____	_____	other_____

NOW	PAST	CARDIOVASCULAR
_____	_____	heart beats fast or irregularly
_____	_____	tightness in chest
_____	_____	discomfort at high altitude
_____	_____	dizzy or weak upon standing up
_____	_____	swollen feet, ankles or legs
_____	_____	cold hands or feet
_____	_____	hands or feet turn blue
_____	_____	blue fingernails
_____	_____	leg pains when walking
_____	_____	varicose veins
_____	_____	tendency to anemia
_____	_____	high blood pressure
_____	_____	low blood pressure
_____	_____	other_____

NOW	PAST	URINARY
_____	_____	difficulty urinating
_____	_____	urinate frequently at night
_____	_____	bedwetting
_____	_____	incomplete urination or dribbling
_____	_____	pain when urinating
_____	_____	bladder infections
_____	_____	kidney infections
_____	_____	kidney stones
_____	_____	lower back pain
_____	_____	other_____

NOW	PAST	MALE
_____	_____	prostate problems
_____	_____	difficult or unusual urination
_____	_____	discomfort or pain in genital area
_____	_____	other_____

NOW	PAST	MALE
_____	_____	diminished sexual desire
_____	_____	excessive sexual desire
_____	_____	difficulty maintaining an erection

NOW	PAST	FEMALE
_____	_____	irregular menstruation
_____	_____	pain prior to or with periods
_____	_____	depressed, tense or irritable around periods
_____	_____	painful or swollen breasts
_____	_____	lumps in breasts
_____	_____	discharge from breasts
_____	_____	symptoms occur in monthly pattern
_____	_____	pain, discomfort or itching in genital area
_____	_____	vaginal discharge

NOW	PAST	FEMALE
_____	_____	hot flashes
_____	_____	diminished sexual desire
_____	_____	excessive sexual desire
_____	_____	difficulty having orgasm
_____	_____	inability to conceive
_____	_____	number of pregnancies
_____	_____	number of children
_____	_____	miscarriages or abortions
_____	_____	other_____

Date of last period_____ # of days_____ length of cycle_____
Date of last PAP smear_____ Have you ever had an abnormal PAP? _____
Present type of birth control_____Have you ever used birth control pills or an IUD? _____
What type and for how long?_____

Is your diet?

____typical American
____vegetarian
____vegan
____macrobiotic
____Kosher
____fast food
____low fat
____other

Do you get regular exercise?

what? how often?

_____
_____
_____

Do you use any of the following?

____cigarettes or tobacco ____packs per day
____coffee or black tea ____cups per day
____marijuana or other drugs ____times per week
____alcohol ____times day/week

Are you allergic to anything? Include food, plants medications, pollens, insects, MSG, chemicals, etc.

_____
_____

Please list any vitamins or medication which you are taking. Use the back of the page if necessary

VITAMINS OR MINERALS

_____
_____
_____
_____

PRESCRIPTION MEDICINES

_____
_____
_____
_____

HERBS OR FOOD SUPPLEMENTS

_____
_____
_____

OVER-THE-COUNTER MEDICATIONS

_____
_____
_____

Have you ever been hospitalized or had surgery, a serious illness or accident?

what when where

_____
_____

Have you or any of your family members had any of the problems in this chart? Please indicate who has had which problems by checking the appropriate space.

	Thyroid problems	Diabetes	Tuberculosis	Hypoglycemia	Stroke	Heart Attack	Epilepsy	Cancer	Asthma	Allergies	Anemia	Migraines	Hepatitis	Heart disease	Birth Defects	High Blood Pressure	Gall Bladder Disease	Arthritis	Alcoholism/addictions
Self																			
Children																			
Mother																			
Father																			
Sister(s)																			
Brother(s)																			
Grandparents																			
Others																			

Thank you for taking the time to fill out this questionnaire. For additional comments use the other side.