Head to Toe Holistic Healthcare

Patient Legal Name: _____ Date of Birth: _____ Gender: **M F Other**

Patient Preferred Name: _____ Marital Status: **Married Single Other**

Is the patient a minor? **Yes No** If yes, parent / guardian name(s): _____

Mailing Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Preferred phone? (circle one) **Home Cell**

Preferred reminder method? (circle one or more) **Call (Home) Call (Cell) Text Cell Email**

Email address(es): _____ Is it okay to contact you via email? **Yes No**

Employer: _____ Work Phone: _____

Spouse: _____ Phone: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number (s): _____

Is this a workers comp or personal injury claim? Yes No

PRIMARY INSURANCE INFORMATION:

Company Name: _____

Primary Policy Holder Name: _____ DOB: _____

Primary Policy Holder Relationship to Patient: **Self Spouse Child Other:** _____

ID #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION:

Company Name: _____

Primary Policy Holder Name: _____ DOB: _____

Primary Policy Holder Relationship to Patient: **Self Spouse Child Other:** _____

ID #: _____ Group #: _____

Please provide the Front Desk with your insurance card(s) including any Medicare / Medicaid cards, as well as an ID Card.

121 W Fireweed Lane, Suite 100, Anchorage, AK 99503
P (907) 222-6887 F (907) 222-6877

PAYMENT FOR SERVICES:

Please read, initial where indicate, and sign below.

PATIENT RESPONSIBILITY: (please initial on each line)

_____ Insurance is not a guarantee of payment.

_____ We cannot accept Tri Care, Denali Kid Care, Medicare, Medicaid, or AARP Supplemental Plans.

_____ It is your responsibility to call your insurance company prior to your appointment to determine if your visit will be covered.

_____ We will try to let you know if you have an insurance company that will not cover naturopathic visits (these include UMR, Aetna Conoco Phillips and Aetna Tesoro). If your company does not generally reimburse for naturopathic visits, you may be asked to pay up front while the claim is being filed.

_____ We will bill your insurance if you present your insurance cards at the time of your appointment. It is important for you to know that we are not always contracted with your insurance carrier. This means that you are responsible for monitoring the processes of your insurance company to make certain your claim is processed in a timely manner, for contacting them if you have questions as to how your claim was processed, and that you are ultimately responsible for payment of services rendered.

_____ If you have a personal injury or workers comp claim, you will be responsible for the charges at the time of the visit. We will give you the paperwork so you can file for reimbursement with your insurance company.

_____ Any co-payments or "patient responsibility" percentages must be paid at the time of service.

_____ If we do not receive a response from your insurance company within 45 days from the date we bill them, the balance will become your responsibility.

_____ You will receive a statement for any remaining balance after all applicable insurances have been applied. That balance is due in full at that time.

_____ If we do not receive your payment in full within 90 days from the date of the first statement or have not heard from you about setting up a payment plan by that time, your account may be turned over to a third-party collection agency.

_____ Injections and dispensary items are not covered by insurance and must be paid in full at the time of the visit.

We accept cash, checks, and all major credit cards. If a payment in check form is returned to us because of insufficient funds, you will be charged a $25 fee. Payment in full at the time of service is required in the following circumstances:

- You do not have insurance coverage, or are covered by a plan we are unable to accept
- You are covered by a personal injury or workers comp claim
- You have not brought your insurance cards with you
- You have not met your deductible
- A contract is required by your insurance policy and we are not contracted with your insurance carrier
- For dispensary items, injections, or other procedures or treatments not covered by insurance

LAB WORK:

If you are a Blue Cross / Blue Shield Patient, we CANNOT bill labs for you. You will be responsible for dealing with the lab and insurance company directly for these, and will need to contact them with any questions. If you have other insurance, we will bill labs for you, but any amount not covered by your insurance company will be your responsibility and we will bill you directly for that.

By signing below, you acknowledge that you have read and understood the above statements and are willing to accept responsibility for services rendered if not covered by insurance. You also understand that you are responsible for laboratory charges not covered by insurance. This authorization is not limited in time.

_____ _____

Patient Signature (or responsible party) *Date*

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PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

This consent form, when signed, gives us permission to release necessary medical information to your medical insurance provider to process your claim, as well as to the pathologist, lab, or other doctor(s) who may be consulted in your diagnosis and treatment. Each of the above will also treat your information with the strictest confidence. This signed consent form gives us authorization to provide your information to a specific person other than yourself. Your information is otherwise confidential.

By signing below, you understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Head to toe Holistic Healthcare (HTTHH) has a Notice of Privacy Practices and you have the opportunity to review this Notice.
- HTTHH reserves the right to change the Notice of Privacy Practices. If we change our Notice, you may obtain a revised copy by contacting our office.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- HTTHH may alter provision of services upon the execution of this Consent.
- In addition, you acknowledge receipt of the HTTHH Notice of Privacy Practices provided to you today.

Do we have your permission to:	(please circle)	
Leave a message on your cell phone?	Yes	No
Leave a message on your answering machine at home?	Yes	No
Leave a message at your place of employment?	Yes	No
Discuss your medical condition with any member of your household?	Yes	No
If yes, whom: _____		
Relationship: _____		
Consult within Head to Toe Holistic Healthcare?	Yes	No

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient or Personal Representative | Relationship / Description of Personal Representative's Authority

_____ _____

Signature of Witness | Date

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Head to Toe Holistic Healthcare

Health History

Today's Date: _____ Name: _____ Date of Birth: _____

Gender: **M** **F** **Other** Occupation: _____

Marital Status: **Single** **Married** **Domestic Partner** **Divorced** **Widowed**

How did you hear about us? _____

Other Healthcare Providers you see: _____

_____

Main Health Concern: _____

Secondary Health Concern(s): _____

_____

Goals for your visit: _____

Things that make you better: _____

Things that make you worse: _____

Please check the symptoms you experience from the following list:

General Symptoms:

_____ Tired

_____ Weak

_____ Frequently Ill

_____ Excessive Bleeding

_____ Swollen glands

➔ where: _____

Tend to be _____ chilly or _____ hot

Symptoms of _____ numbness _____tingling

➔ where:_____

History of _____anemia _____bleeding disorder

Other _____

Head:

_____ Headaches

_____ Migraines

_____ Clouded Thinking

History of _____ head injuries / concussions

➔ How many and when: _____

_____

_____

_____

_____

_____

Other _____

Eyes:

Vision is _____ near sighted or _____ far sighted

Vision is _____ blurred _____ has lots of floaters

_____ double _____ changing recently

Eyes are _____ dry _____ burning _____ itchy

_____ watering _____ light sensitive

_____ bloodshot _____ puffy

Other _____

Ears:

History of _____ ear infections _____ ear aches

➔ when _____ as an adult

_____ as a child

Ears have _____ noises _____ ringing

_____ discharge _____ lots of wax

Hearing is _____ poor _____ very sensitive

_____ changing recently

Other _____

Nose and Throat:

History of or currently have _____ hay fever

_____ sinusitis _____ nose bleeds

_____ canker sores _____ dry or chapped lips

_____ cracks in the corners of the mouth

_____ sore, red, or cracked tongue

_____ cold sores/herpes _____ hoarseness

Sense of smell is _____ reduced _____ absent

Teeth have _____ lots of cavities _____ pain

_____ root canals

Gums _____ bleed _____ get infected

_____ are receding / have pockets

Throat _____ is frequently sore

_____ has post nasal drip

Other _____

Cardiovascular:

_____ Heart beats fast or irregularly

_____ Chest tightness or pain

_____ Dizzy or weak on standing up

_____ Swollen feet, ankles, or legs

_____ Unusually cold hands or feet

_____ Hands or feet turn blue or white with cold

_____ Leg pains when walking

_____ Varicose veins or inflammation of the veins

_____ Heart murmur

_____ History of heart attack

_____ History of heart surgery

_____ Unusual blood pressure

➔ _____ high _____ low

Other: _____

Lungs:

Frequent _____ cough _____ wheezing

_____ Shortness of breath or difficulty breathing

➔ when _____ on exertion

_____ at rest

_____ laying down

_____ Chest pain

History of _____ pneumonia

_____ pleurisy

_____ bronchitis

_____ exposure to toxic fumes/dust/chemicals

History of _____ sleep apnea

_____ snoring

_____ use of a CPAP

Other _____

Stomach and Intestines:

Appetite is _____ increased _____decreased

Difficulty swallowing _____ everything

_____ solids _____ liquids

Stomach upset _____ nausea _____ vomiting

_____ heartburn/reflux

Foods bother me _____ heaviness after eating

_____ tired after meals

Fats make me feel unwell _____ nausea

_____ loose stool _____ bloating

Gas _____ belching _____ flatulence

_____ foul odor

Abdomen is _____ painful _____ bloated

_____ noisy

Stool is _____ very loose _____ slightly loose

_____ slightly hard/dry _____ very hard/dry

_____ alternates between constipation and diarrhea

_____ is light colored

_____ is very dark / black

_____ has blood in it

_____ is greasy/oily

_____ has mucous in it

_____ has unusual undigested food in it

History of or currently have _____ hemorrhoids

_____ anal fissures _____ anal itching

_____ parasites (giardia, pin worms, etc)

_____ jaundice _____ bad breath

_____ laxative use

_____ antacid or reflux medication use

_____ anorexia _____ bulimia

Food allergies/sensitivities to _____

_____

Other: _____

Urinary:

_____ Difficulty urinating

_____ Pain on urination

_____ Frequent urination at night

➔ If so, how many times per night? _____

_____ Bed wetting

_____ Incomplete urination or dribbling

_____ Change in color, odor, or frequency of urination

_____ Uncontrolled urination

_____ Bladder infections / Urinary tract infections

_____ Kidney stones

_____ Kidney disease

Other _____

Female:

Age of first period _____

Are your periods normal? _____

Cycle length and flow length? _____

Clotting or cramping? _____

Day 1 of last period _____

Age of menopause _____

Mother's age of menopause _____

Type of current birth control _____

Type of past birth control _____

Number of Pregnancies _____

Number of Children _____

Are you a DES* daughter? **YES** **NO**

** mother prescribed DES during pregnancy (1938-1971)*

History of sexually transmitted diseases? **YES** **NO**

Male:

_____ Diminished or _____ increased sexual desire

_____ Sexually transmitted diseases including herpes

_____ Erectile dysfunction

_____ Prostate Problems

_____ Pain or lump in scrotum

_____ Discharge from the penis

_____ Sores or rashes in the genital area

_____ Infertility

Are you a DES* son? **YES** **NO**

** mother prescribed DES during pregnancy (1938-1971)*

Other: _____

Muscles and Bones:

Muscles are _____ painful _____ stiff

_____ frequently cramp _____ weak

➔ where _____

Joints are _____ painful _____ stiff

_____ frequently dislocated

➔ where _____

History of _____ abnormal bone scans (DEXA)

_____ fractures

➔ where _____

Other _____

Skin and Hair:

Skin has _____ acne or pimples _____ rashes

_____ eczema _____ itchy spots/hives

_____ulcers / sores _____ brown spots

➔ where _____

_____ Easily Bruise

_____ Easily Sunburn

_____ Loss of Hair on Legs

_____ Dry skin ➔ where _____

Skin and Hair: *cont:*

Unusual Growths _____ moles _____ warts

_____ skin tags

_____ History of skin cancer or suspicious lesions being removed

Fungal Infections _____ Athlete Foot

_____ Ring Worm _____ Jock Itch

Hair is _____ Thinning

Changing _____ Color _____ Texture

Nails _____ Break Easily _____ Are Ridged

____ Split Easily ____ Have Fungal Growth

Other _____

Neurological / Psychological:

_____ Tingling or numbness

➔ where _____

History of or currently having _____ fainting

_____ seizures or convulsions

_____ speech problems

_____ nervous breakdown

_____ lack of coordination

_____ trouble walking

I experience unusual or bothersome levels of

_____ anxiety _____ preoccupation

_____ indecision _____ depression

_____ moodiness _____ irritability

_____ easy crying _____ anger

_____ History of or currently are taking psychoactive medications (for anxiety, depression, etc)

➔ which one(s) _____

_____

Other: _____

Nutrition:

Please list typical foods in your diet *(think of yesterday)*:

Breakfast _____

_____

Lunch _____

_____

Dinner _____

_____

Beverages (how much) Water: _____ Soda: _____

Alcohol: _____ Coffee: _____ Black tea: _____

Juice: _____ Other: _____

Any special diets/foods you avoid _____

_____

Food allergies / sensitivities _____

_____

Food cravings _____

_____

Number of Meals per Day _____

Number of Snacks per Day _____

Social History:

Do you smoke _____ now? _____ in the past?

➔ how much? _____

Medication allergies _____

_____

Other allergies _____

_____

Medications _____

_____

_____

_____

_____

_____

_____

Social History: *cont*:

Supplements/Vitamins/Herbs _____

_____

_____

_____

_____

_____

Do you use antibiotics _____ more than twice a year

_____ less than twice a year

➔ date of last use_____/_____/_____

Over the counter(OTC) _____ laxatives _____ asprin

_____ advil /tylenol _____ antacids

Other medications/drugs/OTC _____

_____

Past Prescriptions _____

_____

Lifestyle:

Do you Exercise? **YES** **NO**

➔ what kinds? _____

➔ how often? _____

Average Stress level (out of 10) _____ / 10

➔ stressors _____

➔ coping strategies_____

Average Energy level (out of 10) _____ / 10

Sleep: do you sleep well? **YES** **NO**

➔ how many hours? _____

➔ wake rested? **YES** **NO**

Do you enjoy your work? **YES** **NO**

Do you spend time outside? **YES** **NO**

How many hours a week do you spend on the computer (outside of work)? _____

Main interests and hobbies _____

Do you have firearms in your house? **YES** **NO**

➔ are they locked up? **YES** **NO**

Screening History: *Please note dates and significant findings of your last screening, if applicable.*

Annual Physical _____

Screening Labs _____

PAP _____

➔ History of abnormal PAP? When? _____

_____

Mammogram _____

Colonoscopy _____

Dental _____

Eye _____

Bone Density (DEXA) _____

Prostate Exam _____

Other _____

Past Medical History: Please list any surgeries / major illnesses / hospitalizations:

(including breast implants, prosthesis, heart valve, or other implants)

_____

Date: _____

_____

Date: _____

_____

Date: _____

_____

Date: _____

_____

Date: _____

_____

Date: _____

Optional: *if you are dealing with a chronic health concern, please create a timeline of your life and health history; including stressors, trauma, travel, treatments, toxic exposures, etc.*

Birth

Family History: *please indicate if you or your family members have experienced any of the following:*

Condition	Self	Mother	Father	Siblings
Alcoholism				
Allergies – food				
Allergies - environmental				
Anemia				
Anorexia				
Arthritis				
Asthma				
Birth Defects				
Bleeding Disorder				
Bulimia				
Cancer / Leukemia (kind and age?)				
Cataracts				
Depression				
Diabetes				
Drug Abuse				
Emphysema				
Epilepsy / Seizures				
Gallbladder Disease				
Glaucoma				
Gout				
Heart Attack - and age of 1st heart attack?				
Heart Disease - Circulatory Problems				
Hepatitis or Liver Disease				
High Blood Pressure				
Hypoglycemia				
Kidney or Bladder Disease				
Kidney Stones				
Lyme Disease				
Malaria				
Mental Illness				
Migraine Headaches				
Mononucleosis				
Multiple Sclerosis				
Muscular Dystrophy				
Obesity				
Osteoporosis				
Physical Abuse				
Rheumatic Fever				
Sexual Abuse				
Scoliosis (curvature of the spine)				
Stroke				
Suicide				
Thyroid Problems, Goiter				
Tuberculosis (TB)				
Ulcers				
Sexually Transmitted Diseases				
History Unknown				
Other:				