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** (for insurance purposes) Preferred Pronouns: _____

How do you identify: **_____man _____non-binary _____woman _____prefer to self describe, below**

Self-describe:_____

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

Occupation: _____

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 complete the following pages for your health history:

COVID-19:	**COVID Vaccination History:**
_____ positive COVID test(s)	_____ No history of COVID vaccinations
➔ when: _____	
_____ symptoms of COVID	Date of 1st COVID vaccination: _____
➔ when: _____	➔ type: _____
➔ what where they?	Date of 2nd COVID vaccination: _____
	➔ type: _____
	Date of 1st Booster vaccine: _____
➔ how long did they last?	➔ type: _____
➔ have you fully recovered?	Date of 2nd Booster vaccine: _____
Have you had COVID more than once? **YES NO**	➔ type: _____
If so, when?	

GENERAL SYMPTOMS:	**EARS:**
_____ Fatigue	_____ history of ear infections
_____ Weakness	_____ history of ear aches
_____ Frequent Illness	➔ when _____ as an adult
_____ Excessive Bleeding	_____ as a child
_____ Swollen glands	_____ ringing in ears
➔ where: _____	_____ other noises
Tend to be _____ chilly or _____ hot	_____ discharge
_____ history of anemia	_____ lots of wax
_____ history of bleeding disorder	_____ poor hearing
Other :	_____ very sensitive hearing
	_____ changing recent
EYES:	Other:
_____ near sighted	
_____ far sighted	**HEAD:**
_____ blurred vision	_____ Headaches
_____ have lots of floaters	_____ Migraines
_____ double vision	_____ Clouded Thinking
_____ changing recently	_____ History of head injuries
_____ dry eyes	➔ How many and when:
_____ burning eyes	
_____ itchy eyes	
_____ watery eyes	
_____ light sensitive	➔ Sought treatment at ER?
_____ bloodshot eyes	
_____ puffiness	
Other:	Other:

NOSE AND THROAT:	**Cardiovascular (cont.)**
History of or currently have:	_____ Swollen feet, ankles, or legs
_____ hay fever	_____ Unusually cold hands or feet
_____ sinusitis	_____ Hands or feet turn blue or white with cold
_____ nose bleeds	_____ Leg pains when walking
_____ canker sores	_____ Varicose veins or inflamed veins
_____ dry or chapped lips	_____ Heart murmur
_____ cracks in the corners of the mouth	_____ History of heart attack
_____ sore, red, or cracked tongue	_____ History of heart surgery
_____ cold sores/herpes	_____ High blood pressure
_____ hoarseness	_____ Low blood pressure
_____ reduced sense of smell	Other:
_____ absent sense of smell	
_____ bleeding gums	**URINARY:**
_____ gums get infected	_____ Difficulty urinating
_____ gums are receding / have pockets	_____ Pain on urination
_____ lots of cavities in teeth	_____ Frequent urination at night
_____ teeth are painful	➔ If so, how many times per night? _____
_____ history of root canals	_____ Bed wetting
_____ frequent sore throats	_____ Incomplete urination or dribbling
_____ post nasal drip	_____ Change in color, odor, or frequency
_____ frequent use of nasal sprays	_____ Uncontrolled urination
Other:	_____ Bladder infections
	_____ Urinary tract infections
CARDIOVASCULAR:	_____ Kidney stones
_____ Heart beats fast or irregularly	_____ Kidney disease
_____ Chest tightness or pain	Other:
_____ Dizzy or weak on standing up	

LUNGS:	**SKIN AND HAIR:**
_____ frequent cough	_____ acne or pimples
_____ wheezing	_____ rashes
_____ Shortness of breath or difficulty breathing	_____ eczema
➔ when _____ on exertion	_____ itchy spots/hives
_____ at rest	_____ ulcers / sores
_____ laying down	_____ brown spots
_____ Chest pain	➔ where _____
History of:	_____ Easily Bruise
_____ pneumonia	_____ Easily Sunburn
_____ pleurisy	_____ Loss of Hair on Legs
_____ bronchitis	_____ Dry skin
_____ exposure to toxic fumes/dust/chemicals	➔ where _____
_____ sleep apnea	_____ moles
_____ snoring	_____ warts
_____ use of a CPAP: _____current _____past	_____ skin tags
_____ COVID lung infection	_____ history of skin cancer or suspicious lesions being removed
Other:	_____ athletes Foot
	_____ toenail Fungus
	_____ ring worm
	_____ jock itch
	_____ thinning hair
History of smoking:	_____ hair changing texture or color
_____ never smoked	_____ nails break or split easily
_____ current smoker	_____ nails are ridged
_____ past smoker	_____ have a fungal growth
➔ quit date: _____	Other:

STOMACH AND INTESTINES:	**Stomach and Intestines (cont.):**
_____ increased appetite	Bowel Movements:
_____ decreased appetite	_____ daily
_____ difficulty swallowing everything	_____ every other day
_____ difficulty swallowing solids	_____ other: _____
_____ difficulty swallowing liquids	Stool Appearance:
_____ nausea	_____ very loose
_____ vomiting	_____ slightly loose
_____ heartburn/reflux	_____ slightly hard/dry
_____ heaviness after eating	_____ hard/dry
_____ tired after meals	_____ alternates - constipation and diarrhea
_____ nausea after eating fats	_____ light colored
_____ loose stool after eating fats	_____ very dark/black
_____ bloating after eating fats	_____ has blood in it
_____ belching	_____ is greasy/oily
_____ flatulence	_____ has mucous in it
_____ foul odor	Other:
Current History of:	
_____ hemorrhoids	
_____ anal fissures	
_____ anal itching	**OVER THE COUNTER MEDICINE (OTC) USE:**
_____ parasites (giardia, pin worms, etc)	_____ asprin
_____ jaundice	_____ advil /tylenol
_____ bad breath	Other:
_____ laxative use	
_____ antacid or reflux medication use	
_____ anorexia	
_____ bulimia	

MUSCLE AND BONES:	**NEUROLOGICAL/PSYCHOLOGICAL:**
Muscles are:	_____ Tingling or numbness
_____ painful	➔ where _____
_____ stiff	History of or currently having:
_____ frequently cramp	_____ fainting
_____ weak	_____ seizures or convulsions
➔ where _____	_____ speech problems
Joints are:	_____ nervous breakdown
_____ painful	_____ lack of coordination
_____ stiff	_____ trouble walking
_____ frequently dislocated	I experience unusual or bothersome levels of:
➔ where _____	_____ anxiety
History of:	_____ preoccupation
_____ abnormal bone scans (DEXA)	_____ indecision
_____ fractures	_____ depression
➔ where _____	_____ moodiness
Other:	_____ irritability
	_____ easy crying
PAST MEDICAL HISTORY:	_____ anger
Please list any surgeries / major illnesses / hospitalizations <u>and the dates</u>: *(including breast implants, prosthesis, heart valve, or other implants)*	_____ History of or currently are taking psychoactive medications (for anxiety, depression, etc)
	➔ which one(s):
	Other:
	How often do you use antibiotics?
Optional: *if you are dealing with a chronic health concern, please create separate a timeline of your life and health history; including stressors, trauma, travel, treatments, toxic exposures, etc.*	Date you last took antibiotics:_____

SCREENING HISTORY: *Please note dates and significant findings of your last screening, if applicable.*	**NUTRITION:** Please list typical foods in your diet *(think of yesterday)*:
Annual Physical :	Breakfast:
Screening Labs:	
	Lunch:
PAP:	
➔ History of abnormal PAP? When? _____	Dinner:
Mammogram:	
Colonoscopy:	Beverages (amount/day) Water: _____ Soda: _____
Dental:	Alcohol: _____ Coffee: _____ Black tea: _____ Juice: _____
Eye:	Other: _____
Bone Density (DEXA):	
Prostate Exam:	Any special diets/nutritional philosophy:
Other:	
MEDICATIONS/SUPPLEMENTS:	Foods you avoid:
Medication allergies:	
—What happens?	Food allergies/sensitivities & what happens?
Other allergies:	
Medications and approximate start date:	
Supplements/Vitamins/Herbs:	
	Food cravings:
Marijuana use approximate start date:	Number of Meals per Day:
What forms do you use?	Number of Snacks per Day:

LIFESTYLE:	**MALE AND FEMALE:**
Do you Exercise? **YES** **NO**	_____ diminished sexual desire
➔ what kinds?	_____ increased sexual desire
➔ how often?	_____ history of sexually transmitted diseases (including herpes)
Average Stress level (out of 10): _____/10	Are you a DES* son/daughter? **YES** **NO** ** mother prescribed* diethylstilbestrol *during pregnancy (1938-1971)*
➔ stressors:	
	FEMALE ONLY:
	Age of first period**:**
➔ coping strategies:	Are your periods normal?
	Cycle length and flow length?
	Clotting or cramping?
Average Energy level (out of 10):_____ /10	Day 1 of last period:
Sleep: do you sleep well? **YES** **NO**	Age of menopause:
➔ how many hours?	Mother's age of menopause:
➔ wake rested? **YES** **NO**	Type of current birth control:
Do you enjoy your work? **YES** **NO**	Type of past birth control:
Do you spend time outside? **YES** **NO**	Number of Pregnancies:
How many hours a week do you spend on the computer (outside of work)?	Number of Children:
Main interests and hobbies:	
	MALE ONLY:
	_____ Erectile dysfunction
	_____ Prostate Problems
Do you have firearms in your house? **YES** **NO**	_____ Pain or lump in scrotum
➔ are they locked up? **YES** **NO**	_____ Discharge from the penis
	_____ Sores or rashes in the genital area
	_____ Infertility

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

CONDITION:	**Self**	**Mother**	**Father**	**Brothers**	**Sisters**
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 (indicate what kind)					
Migraine Headaches					

CONDITION:	**Self**	**Mother**	**Father**	**Brothers**	**Sisters**
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:					