GENERAL HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION:

Name		Date	
Height	Weight	DOB	Age

What is your MAJOR symptom/problem?	YEAR SYMPTOM BEGAN
1.	

ACCIDENT INFORMATION:

Is your condition due to an accident? ▫No ▫Yes Date:_____ Type of accident? ▫ Automobile ▫ Work ▫ Home ▫ Other_____(explain)

MEDICATIONS: (All PAIN medication)	DOSAGE & FREQUENCY	RESPONSE (none, short term, helps)

PATIENT CONDITION

1. Have you had this problem before? ▫ Yes ▫ No
2. Is your condition getting progressively worse? ▫ Yes ▫ No
3. Is the problem: ▫ Constant ▫Comes and goes ▫ **worse in am** ▫ **worse in pm** ▫stiffness in: **am or pm**
4. How does it feel? ▫ Burning ▫ Sharp ▫ Shooting ▫ Dull ▫Aching ▫ Stiff ▫ Tingling ▫ Throbbing ▫Swelling ▫Cutting ▫Knifelike ▫ Excruciating ▫Numbness ▫ Pins and needles ▫ Bone pain ▫Pressure ▫ Stabbing ▫ Tight band ▫Sore ▫Bruised ▫Other
5. **Joint noises?** ▫clicking ▫grinding ▫popping ▫locking ▫swelling?
6. **Headaches?** Yes or No. **Frequency?** ▫1-2 per week, ▫3-4 per week, ▫more? **Duration?** ▫4-6 hours ▫Days

Circle below the severity of your current pain on a scale of 0-10

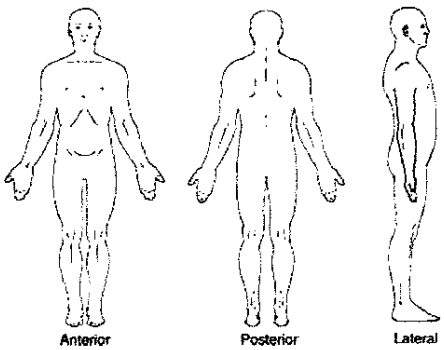
(No pain) **0 1 2 3 4 5 6 7 8 9 10 (severe pain)**

Circle below the *maximum severity* of pain experienced on a scale of 0-10

(No pain) **0 1 2 3 4 5 6 7 8 9 10 (severe pain)**

1. What makes your condition better? _____
2. What makes your condition worse? _____
3. **Does it interfere with your** ▫ Work ▫ Sleep ▫Daily Routine ▫Recreation ▫ Sports ▫Hobbies ▫ Other
4. **What activities/movements are painful to perform:** ▫Sitting ▫Standing ▫Walking ▫Bending ▫ Lying down ▫Getting up ▫Turning neck/trunk ▫When still or moving ▫Kneeling/squatting ▫Driving ▫Lifting
5. **What treatment or therapies have you tried?** ▫ Physical therapy ▫ Chiropractor ▫Acupuncture ▫Pain injections ▫Massage▫ Other_____ **Did it help?** Y/N ▫**Short term**

PLACE A MARK WHERE IT HURTS



IRIE Natural Center for Health

Patient Name_____ **DOB**_____

PAST HEALTH HISTORY

Have you been diagnosed with ▫ Cancer ▫ High Blood Pressure ▫ Diabetes ▫Kidney disorder▫ Liver disorder
Any Surgeries related to current issue? ▫Yes ▫ No Type:_____ What year: _____
Any major accidents?▫ Y ▫N What year: _____
Any fractures? ?▫ Y ▫N What location_____ What year: _____
Have you had any imaging ▫ X-rays ▫ MRI ▫ CT ▫ Ultra Sound ▫ LABs Results: ▫ **Normal** or▫ **Abnormal**
Last blood work? _____ ▫ **Normal** or▫ **Abnormal**
Any Allergies to medication? ▫ Y ▫N What medication? _____
Any seizure history? ▫ Y ▫N
Are you currently taking anticoagulants such as Aspirin, Warfarin or Coumadin? ▫ Y ▫N

SOCIAL HEALTH HISTORY

Do you smoke cigarettes? ▫ Y ▫N #per day _____ **Former Smoker?** ▫
Do you drink alcohol? ▫ Y ▫N ▫ **occasionally**
Are you currently working? ▫ Y ▫N Occupation? _____
Do your job duties include ▫ desk job ▫ standing ▫ lifting ▫stooping▫ kneeling ▫ twisting of body▫ turning of neck ▫ bending neck.
Do job duties involve, lifting up to_____lbs x ____per week
How many hours a night do you sleep? _____ **Does your pain interfere with your sleep?**▫Yes ▫No
Energy level:(Please circle) 0 1 2 3 4 5 6 7 8 9 10 **(10/10 is feeling best)**
Cannabis Experience: ▫New ▫Moderate ▫Experienced
If this a renewal has MMJ: ▫Improved quality of life ▫Decreased pain ▫Improved sleep ▫Improved mood
Since last visit is your pain? ▫About the same ▫A little: **better or worse** ▫A lot: **better or worse**

ORGAN SYSTEM REVIEW- DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

General: ▫Chills ▫Fever ▫Weight loss ▫Night sweats ▫ Night pain ▫AM stiffness ▫Rashes ▫Puffy ▫Poor appetite

Head: ▫ Ear ringing ▫Headaches ▫ Blurry vision ▫ Glaucoma ▫Nasal fractures ▫Tooth pain ▫Jaw pain ▫Vertigo ▫Tongue pain ▫Macular degeneration ▫Facial paralysis ▫Vision loss

Musculoskeletal: ▫Neck pain ▫Back pain ▫Weakness ▫Muscle/joint pain or stiffness ▫Paralysis ▫Limitation of movement ▫ Arthritis ▫Fibromyalgia ▫ Muscle atrophy ▫ Muscle spasms ▫ Pain bending ▫Pain lifting

Cardio: ▫ Chest pain ▫Murmurs ▫ Cardiac disorder ▫High Blood Pressure ▫Angina ▫Abnormal EKG ▫Congestive Heart Failure ▫Heart Attack ▫Kidney Disorder ▫Arrhythmia ▫Pacemaker/defibrillator

Lungs: ▫Shortness of breath ▫Asthma ▫COPD ▫Emphysema ▫ Lung Cancer ▫ Respiratory disorder

Abdomen: ▫ Crohn's disease ▫ Hepatitis C ▫ Nausea ▫ Vomiting ▫ Decreased appetite ▫Constipation ▫Diarrhea ▫Rectal Bleeding ▫Bowel dysfunction ▫ Bladder dysfunction BM's per/day____
Any pain with urination? ▫ Y ▫N ▫Heartburn ▫Ulcers ▫Hemorrhoids Bleeding? ▫ **Y** ▫**N**

Male: ▫ Prostate cancer ▫ Testicular cancer ▫Low sex drive ▫ Weight gain ▫Sexual dysfunction ▫ Fatigue ▫Problems reaching climax ▫Urinary urgency/frequency ▫Enlarged prostate

Female: ▫PMS ▫Heavy Bleeding ▫Pelvic pain ▫Vaginal discharge ▫Low sex drive ▫Fatigue ▫Insomnia ▫Urinary incontinence ▫ Fibroids ▫Uterine/cervical cancer ▫Severe menstrual cramps ▫Heavy periods ▫Abnormal breast exam ▫Endometriosis ▫Pain with intercoure ▫Abnormal pap ▫Gynecolgoical surgery
Date of last menstrual cycle: _____ **Are you pregnant?** ▫ **Y** ▫**N**

Breast: ▫ Cancer ▫ Prior surgery/biopsy Last mammogram_____
▫Chemo ▫Radiation ▫Nausea ▫Weight loss ▫ Breast pain ▫Breast implants

Neuro: ▫MS ▫Epilepsy ▫ ALS ▫ Alzheimer's ▫ Fainting ▫Dizziness ▫ Numbness ▫ Tingling/burning ▫Tremors ▫Stroke ▫ Seizures ▫ Headaches ▫Motor/verbal tics

Heme-Lymph: ▫Lymph node enlargement or tenderness ▫Ankle swelling, ▫Bleeding disorder ▫Cancer

Psych: ▫PTSD ▫Anxiety ▫Depression ▫Panic Attacks ▫Bipolar ▫Schizophrenia ▫ASD ▫ADD/ADHD ▫Insomnia ▫Personality DO

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

MARIJUANA PROGRAM PATIENT ATTESTATION

I, _____ , attest that:

I will not divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant A.R.S. Title 36, Chapter 28.1 and that the information provided in the application is true and correct.

_____ _____

Signature Date Signed

IRIE Natural Center for Health

IRIE NATURAL HEALTH CENTER

Feeling good the natural way
6625 S Rural Rd., #103, Tempe, Az 85283
480-341-9400 fax 1-623-321-0218

2019

Patient Information

Today's Date:_____

Patient Name:_____
(First) **(Last)**

Date of Birth: _____ Gender: Male Female

Please circle one Arizona Driver's License / Arizona I.D. / Passport **ID/DL #**_____

Arizona Driver's License Arizona I.D. or Passport **Issue date:**_____

Residence Address: _____

City:_____ Zip:_____ County_____

Mailing Address **(only if different):**_____

City:_____ Zip:_____ County_____

***Phone: ( )_____

***Email Address:** _____

What is your medical condition? Please circle all that apply: Chronic Pain/ Nausea/ Seizures/ Muscle Spasm/ HIV/Crohn's/ Alzheimer's/Cancer/ Glaucoma/ Hep C/ PTSD/ Migraine

Name of Primary Care Doctor of Facility? _____

Are you currently taking any prescription pain medication? Y or N

Have you had any surgeries related to this condition? Y or N

Any side effect from the pain medication? Y or N

Do you receive Food Stamps/ SNAP? Y or N Do you receive Disability (SSDI)? Y or N

Are you a Veteran? Y or N Are you over 65 years old? Y or N

Would you like to be notified of any medical marijuana clinical studies? Y or N

IRIE Natural Center for Health
Dr. Sonya M. Johnson, ND
Informed Consent Form

I understand that the evaluation, diagnosis and treatment by Dr. Johnson at IRIE Natural Health Center, may include, but is not limited to:

- Intake
- Physical examination
- Botanical medicine including cannabinoid medicine
- Bioidentical hormone replacement therapy
- Homeopathic remedies
- Nutritional Medicine (nutritional supplements, intravenous (IV) micronutrient therapy and intramuscular (IM) injection therapy)
- Dietary Counseling
- Acupuncture and Cupping
- Prescription medication to be filled at pharmacy
- Over- the counter medications

As with all forms of medicine, I understand I am informed that there are risks and benefits with evaluation, diagnosis, and treatment, including but not limited to:

Potential Risks: discomfort or minor bruising from Acupuncture or cupping; allergic reaction to prescribed herbs, supplements, or prescription medicine; a temporary aggravation of preexisting symptoms.

Potential Benefits: restoration of the body's optimal functioning capacity, relief of pain and/or disease symptoms, assistance in disease or injury recovery, and prevention of disease progression or recurrence.

Notice to Pregnant Women: all female patients must alert Dr. Johnson if they know or suspect that they are pregnant, as certain therapies could pose a risk to pregnancy. Including medical marijuana and the potential dangers to fetuses caused by smoking or ingesting marijuana while pregnant or to infants while breastfeeding.

By signing below, I **(print name)** _____ acknowledge that I have been provided ample opportunity to read this form, or that it has been read to me. I understand that it is my responsibility to request that Dr. Johnson explain all therapies and procedure to my satisfaction during our consultations and I acknowledge that no guarantees have been offered to me concerning the results intended from the treatment

Furthermore. I acknowledge and agree that in the event of a medical emergency or when urgent medical care is necessary, I will seek urgent care or go to the nearest emergency room. I intend for this consent form to cover the entire course of the treatment for my present condition, as well as any future conditions for which I may seek treatment at IRIE Natural Health Center.

FEES ARE DUE AT TIME OF SERVICE

Every effort is made to keep fees low and affordable. Maximum clinic visit fees are as follows:

- General medicine: Initial intake $245, Follow-up visits $125
- Bio-identical Hormone replacement therapy consultation $245
- IV therapy Myers Cocktail Vitamin mineral infusion $75-$150 may be higher for specialized protocols
- B12 injection #5 for $29, Fat burning injection #3 $39, Magnesium injection $25 , Testosterone injection $25
- Hormone Saliva or Blood Spot Home lab test $150-$329
- Acupuncture and cupping Initial/Follow-up $99/$65
- Botanical tinctures 1oz/2oz $20/$35
- New Patient MMJ Certification ($300/ $225), Physician Certification ($65), Physical Exam ($65), Processing ($20)
- Renewal Patient MMJ Certification ($255/ $180), , Physician Certification ($65), Physical Exam ($20)Processing ($20)
- New Minor Patient MMJ Certification ($585/ $510), Physician's Certification ($150, Physical Exam ($65)Processing ($20)
- Renewal Minor Patient MMJ Certification ($520/ $445), Physician's Certification ($130), Physical Exam ($20)Processing ($20)
- MMJ Evaluation ($65)
- AZDHS Processing only, Replacement lost/stolen card, Change of address ($35)

_____ _____

Signature of patient or guardian Date