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: ________________

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

ID #: _______________________________________ Group #: ________________________________

SECONDARY INSURANCE INFORMATION:

Company Name: ____

Primary Policy Holder Name: _______________________________________ DOB: ________________

Patient Relationship to Secondary Policy Holder: **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.

PAYMENT FOR SERVICES:

Please read, initial where indicate, and sign below.

PATIENT RESPONSIBILITY: (please initial on each line)

2102 Cleveland Avenue, Anchorage, AK 99517
P (907) 222-6887 F (907) 222-6877

_____ 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: ______________________________	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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PLEASE TAKE PICTURES OR PHOTOCOPIES OF THE FOLLOWING:

We need a copy of the FRONT of an ID card with your picture and current address on it - usually a driver's license or state ID.

We need a copy of the FRONT of any insurance cards you currently have.

We need a copy of the BACK of any insurance cards you currently have.

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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:					