Welcome! Please fill this form out entirely and bring it with you to your first office visit.

Name ______________________________________ DOB ___________ SSN _______________

Address ______________________________ City ____________ State _____ Zip ______

Home/Cell Telephone _________________ E-mail address _________________________

- ❑ Ok to leave message with detailed information
- ❑ Ok to e-mail with detailed information (NOT a secure email)
- ❑ Leave message with call back number only

Work Phone ______________________

- ❑ Okay to leave messages with detailed information on work or cell phone
- ❑ Leave messages with call back information only

Today's Date _____________ Age ______ Male / Female (circle one) Occupation ________________

Employer ___________________________________ Hrs per Week _______

Who may I thank for referring you? ___________________________________

Emergency Contact ___________________________________ Phone _________________________

What are your primary health concerns? Please list in the order of their importance to you.

1) ___________________________________ Past treatment: __________________________________

2) ___________________________________ Past treatment: __________________________________

3) ___________________________________ Past treatment: __________________________________

What are the primary expectations you have for your visit today?

1) ____

2) ____

Are you currently receiving health care? Y N

If yes, where and from whom? Please provide contact information (phone and address) if available.

____
____

If no, when was the last time you received medical care and why?

____
____
____

General Information:

Height _______ Weight _______ Weight 1 yr ago _______ Maximum weight _______ When ______
Blood pressure: Most recent blood pressure reading: ____/____ When was this taken? ________

Childhood Illness (Please circle any that you have had):

☐ Diphtheria ☐ Measles ☐ Scarlet Fever ☐ German Measles
☐ Mumps ☐ Rheumatic Fever ☐ Chickenpox ☐ Other: ___________

Immunizations: (Please circle any that you have had. If you don't know if you've had one, place a question mark beside it):

☐ Diphtheria ☐Measles/Mumps/Rubella ☐ Meningitis ☐ Polio ☐ Tetanus
☐Chickenpox ☐ Hepatitis A/B/C ☐ Pertussis ☐ Flu ☐Other: ________________

Hospitalizations and Surgeries:
____When?___________
____When?___________
____When? ___________

Diagnostic Studies:

☐ Electrocardiogram (EKG) ☐ X-Ray ☐ Bone Density Scan (DEXA) ☐ CT Scan
☐ Electroencephalogram (EEG) ☐ Mammogram ☐MRI ☐ Other: __________

When? ____

Are you aware of having allergies or sensitivities to any of the following? If so, describe your reaction to each one:
Drugs: ____
Foods: ____
Chemicals/Perfumes: ____
Animals: ____

Which medications, either by prescription or over-the-counter, are you taking or have you taken in the past 6 months?
☐ Laxatives ☐ Pain Relievers ☐ H2 Blockers/Ulcer Medication ☐ Antacids
☐ Cortisone/Prednisone ☐ Appetite Suppressants ☐ Antidepressants ☐ Antibiotics
☐ Tranquilizers ☐ Thyroid medication ☐ Cholesterol-lowering medication
☐ Sleeping medication ☐ Other: ____

Please list, by name, any prescription medications you currently take, over-the-counter medications, and all vitamins/supplements/herbs you take regularly at this time. Include dosage, if known. ***Note: Please bring each of these with you to your first office visit.***

1) ____

2) ____

3) ____

Family History:	**Mother**	**Father**	**Siblings**	**Spouse/Partner**	**Children**
Age (if living)	______	______	______	______	______
Health (good/fair/poor)	______	______	______	______	______
Age at death (if deceased)	______	______	______	______	______
Cause of death	______	______	______	______	______

Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Multiple Sclerosis
- ☐ Parkinson’s
- ☐ Alzheimer’s
- ☐ Stroke
- ☐ Other (list below)

Please list other significant family medical history not listed above:

____

____

Lifestyle:

Check the appropriate box:	**Yes**	**No**
Get 8 hours of sleep nightly (if no, write how much sleep you get)		
Sleep Well		
Awaken Rested		
In an intimate relationship?		
If yes, is it satisfying?		
Satisfied with friends/family?		
History of abuse		
Suffered trauma in past 3 years		
Use recreational drugs		
Treated for drug/alcohol dependence		
Drink alcohol? How many drinks per night _____ / Per week _____		
Use tobacco? If yes, how many cigarettes daily ____? How many years? ____ If you’ve quit, how long has it been? _____		
Enjoy your work?		
Take vacations?		
Exercise? What type? _________________________________ How often? ___________________		
Watch TV? Hours daily ____		
Read? Hours daily ____		
Eat 3 meals daily?		
Go on diets?		
Drink tea? Herbal, caffeinated or both? (please circle)		
Drink coffee?		
Drink soda? Regular or diet? (pls circle)		
Add sugar/splenda/nutrasweet/salt to food?		
Microwave food?		
Eat meals out regularly (more than 3 times weekly)		
Eat prepared/processed/fast foods?		

Review of Systems

In this section, check the box if you have the symptom currently or if you have experienced it in the past 6 months. Some questions are yes/no, in which case check the box to indicate "yes."

Mental/Emotional	
Depression	
Mood swings	
Considered/Attempted suicide	
Poor concentration	
Anxiety or nervousness	
Memory problems	

Endocrine	
Hair loss	
Brittle nails	
Excessive thirst	
General fatigue	
Fatigue after meals	
Excessive hunger	

Head	
Headaches	
Migraines	
Head injury	
Jaw pain/TMJ	
Pain or difficulty moving muscles	
Energy and Immune	
Chronic fatigue syndrome	
Swollen glands	
Ongoing infections	
Slow wound healing	
Colds/flu more than once yearly	
Fatigue	

Neurological	
Seizures/Epilepsy	
Muscle weakness	
Loss of memory	
Vertigo/dizziness	
Numbness or tingling	
Involuntary shaking or unsteadiness in hands	
Ears	
Impaired hearing	
Earaches	
Ringing	
Itching inside or outside	

Nose and Sinuses	
Frequent head colds	
Stuffiness	
Sinus pain	
Nose bleeds	
Hay fever	
Loss of smell	

Eyes	
Spots in vision	
Blurriness	
Double vision	
Eye pain/strain	
Uncomfortable tearing or dryness	
Glaucoma	

Mouth and Throat	
Frequent sore throat	
Teeth grinding	
Gum bleeding/pain/disease	
Sore tongue/lips	
Hoarseness	
Jaw clicks	

Neck	
Lumps	
Pain or stiffness	

Skin	
Rashes	
Acne	
Lumps or boils	
Eczema/rash	
Hives	
Generalized itching	
Urinary	
Pain with urination	
Frequency at night; If so, how often do you wake to urinate each night __	
Frequent infections	
Unable to hold urine	
Kidney stones	
Splitting of stream	

Respiratory	
Cough	
Spitting of blood	
Asthma	
Pain on breathing	
Shortness of breath at night	
Shortness of breath daily	
Shortness of breath lying down	
Lung congestion/sputum	
Wheezing	
Difficulty breathing	

Cardiovascular	
Heart disease	
High blood pressure	
Low blood pressure	
Blood clots	
Ankle swelling	
Chest pain	
Heart murmurs	
Fainting	
Heart palpitations/fluttering	

Intestinal	
Trouble swallowing	
Change in thirst	
Change in appetite	
Nausea/vomiting	
Burning pain in stomach	
Hemorrhoids	
Heartburn	
Abdominal pain or cramps	
Frequent belching or excess gas	
Constipation	
Diarrhea	
Black stools	
Blood in stools	
How often are BMs: ______________	

Musculoskeletal	
Joint pain or stiffness	
Muscle spasms or cramps	
Arthritis	
Weakness	
Sciatica or pain down one leg	

Blood/Peripheral Vascular	
Easy bleeding/bruising	
Deep leg pain	
Varicose veins	
Anemia	
Cold hands/feet	

Male Reproduction	
History of hernias	
Are you sexually active? Yes No	
Sexual Orientation?	
Use birth control? What type __________	
Impotence	
Premature ejaculation	
Testicular masses or pain	
Discharge or sores on penis	
History of STI?	
Genital warts	
Genital herpes	

Female Reproduction/Breasts	
Age at first menses (first period) _____	
Age of last menses (if menopausal) ____	
Usual length of cycle (monthly): ______	
Duration of menstruation (days of bleeding) ____	
Last menstrual period _______________	
Do you think you may be pregnant?	
Irregular cycles	
Painful menses	
Heavy flow	
Light flow	
Bleeding/spotting between periods	
Clotting	
Discharge	
PMS	
Menopausal symptoms/hot flashes	
Date of last annual exam/Pap ______	
Sexually active Yes No	
Sexual Orientation __________________	
Use of birth control; if so, what type _________________________________	
Pain during intercourse	
Difficulty conceiving	
History of abnormal pap	
Sexual difficulties	
Genital herpes	
Genital warts	
History of STI?	
Breast pain/tenderness	
Breast lumps	
Nipple discharge	

Number of pregnancies ______
Number of live births ______
Number of miscarriages _______
Number of abortions _______

Are there any other health concerns that you have which have not been covered in this questionnaire?

____

____

____

Signature: ____________________________

Date: ________________________________

Consent Form: Sanctuary Health, LLC/Dr. Petra Caruso, N.D.

Consent to Treatment
Naturopathic medicine therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. A common complication includes but is not limited to temporary worsening of symptoms before steady, lasting improvement is seen. This is termed a "healing crisis" and is considered by naturopathic physician a normal process of healing. More serious complications are extremely rare. Additional information on side effects and complications for particular treatments is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

____

Print Name Signature of Patient Date

Agreement to Payment Policy of Woodstock Natural Health Clinic
By signing below, I understand that full payment for all services and products I receive from Sanctuary Health, LLC, and Dr. Petra Caruso is required at the time of service, except that portion billed to my insurance company. Further, I understand that Sanctuary Health/Petra Caruso, ND, may submit my bill to my insurance carrier, if I so request, and that I am responsible for any services not covered by my insurance company, as well as any co-pay, coinsurance or deductible required by my insurance. Appointments must be cancelled 24 hours prior. Otherwise, there is a $50 fee for missed appointments.

I will provide records to other providers at no charge. If the patient would like to obtain these records for their own needs, there will be a $35 charge.

____ Signature of Patient

Consent Regarding Use of Information – Please initial if you consent to the statement below, or leave blank if you do not consent.

______ Dr. Petra Caruso sometimes uses email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by an outside party with the technical skills to intercept such correspondences. By initialing this line, you are consenting to allow me to correspond with you via email despite these potential risks.

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appoint reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restriction on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of you protected health information and to provide you with notice of our legal duties and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provision effective for all protected health information that we maintain. We will post and you may request a written copy of revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filing a complaint.

Please Sign Below To Indicate That:

1. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such a Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

2. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

3. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:____

Signature:____

Relationship to Patient:______________________________________

Date:____

How Do I Check My Insurance Benefits?

I will bill your insurance for your visit; however, it is your responsibility to be aware of your coverage and co-pay, as well as any deductible and maximums. **If a claim is denied due to non-coverage, it will be your responsibility.**

Patient Name ____Date of Birth _________________

Insurance Company ______________________________ ID#______________________

1. When did my *coverage begin and through when is it valid*?
   Beginning Date of Coverage_________ Ending Date of Coverage_________

2. Do I need *a referral from my primary care physician* (PCP) before seeing a naturopathic physician (N.D.)?
   ___Yes ___No

3. Is Dr. Petra Caruso, N.D., *In-Network or a Preferred Provider* with my insurance?
   ___Yes ___No

4. What are my *benefits* for the following services?

   Naturopathic: % Covered_______ ; Co-pay/ Co-Insurance______; Year Max_____

5. Is there a copay per **visit**? **___Yes _______Amount ___No**

6. Are there any limits to seeing an ND? For example, are "E & M" codes disallowed?

   ____Yes ____No

7. What is my *deductible for the year* and has any or all of it been met?

   Deductible $_______ Amount of Deductible met so far $________ Date____

   Is naturopathic care **subject to this deductible**? **____Yes ____No**

8. Are labs covered by my insurance? **____Yes ____No** If yes, at what percentage? ______

9. Which labs are *in-network* with my insurance plan? Peace Health _____ Providence ______ Quest Diagnostics ______ Lab Corp _________

10. What was the *name of the representative* I spoke with________________ **Date_____**

*Please be aware that this is not a guarantee of payment. If an insurance company gives you inaccurate information they may not honor the benefits that were quoted but getting it in writing helps!