Be Well Natural Health Clinics

25283 Cabot Road, Suite 114
Laguna Hills, California 92653
Phone (949)206-9090
Fax (949)206-9092

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Introduction Letter

Thank you for choosing our clinic to help you with your medical needs. We are here to help in any way possible. If you have any questions, please feel free to ask. We are enclosing a new patient information packet which contains 1) History and Intake forms, 2) Patient Payment Responsibility, 3) Acknowledgment of Receipt of Notice of Privacy Practices and 4) Consent for Complementary and Alternative Services. All of these forms need to be filled out completely.

If the forms are not filled out completely we will ask you to finish them before you see your doctor. This may take up some of the appointment time reserved for you.

Our clinic requires a minimum 24 hour notice to cancel your appointment. There is a $250.00 missed appointment fee for new patients and a $105.00 missed appointment fee for follow ups. We require a credit card to secure your appointment date and time, your credit card will be automatically charged for a missed appointment.

If you have any questions please feel free to contact the office during our office hours. Monday through Thursday 10am to 5pm and Fridays 10am to 1pm.

We also ask that you please not wear any perfume or strong smelling lotions. Thank you.

Sincerely,

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Name _____ Date_____
Address_____ City_____
State_____Zip Code_____
Telephone Number (home)_____
(Work)_____
(Cell)_____
Email Address_____
Date of Birth_____ Age_____
Identification/ Social Security #_____
Gender: Male_____Female_____
Single_____ Married____Partnership_____Separated_____Divorced_____
Occupation_____Hours Per week_____
Retired_____Employer_____
Work address_____
Work Phone Number_____
How did you hear about our office?_____
Has any other family member already been a patient at the clinic?____
_____

Emergency contact_____
Relationship_____Phone #_____
Address_____

Health History Questionnaire

SUCCESSFUL HEALTH AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE DOCTOR HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Are you currently receiving healthcare? _____
If yes, where and from whom? _____
If no, when and where did you last receive medical or health treatment?
_____
_____
_____
What was the reason? _____
What are your most important health problems? List in order of importance:
1)_____
2)_____
3)_____
4)_____
5)_____

Do you have any known contagious diseases at this time?_____
If yes, what?_____

Family History

	Father	Mother	Brother	Sister	Spouse	Child
Age (if living)						
Health (G=good/P=poor)						
Age at death						
Check those applicable						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hay fever/Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Cause of death						

For all the following sections please write Y, P or N on the line:
Y= a condition you have now **P**= a condition you have had **N**= never had

Childhood Illness

Scarlet fever?_____ Diphtheria?_____ Rheumatic fever?_____
Mumps?_____ Measles?_____ German measles?_____

Hospitalizations and Surgery

What hospitalizations or surgeries have you had?

_____Date:_____

_____Date:_____

_____Date:_____

_____Date:_____

X-Rays and Special Studies

X-rays, CAT scans, or other studies you have had:

_____Date:_____

_____Date:_____

_____Date:_____

_____Date:_____

Electrocardiogram?_____Date:_____

Electroencephalogram?_____Date:_____

Immunizations

Polio?_____ Pertussis?_____

Tetanus Shot?_____ Diphtheria?_____

Measles?_____ Other?_____

Allergies

Are you hypersensitive or allergic to:

Any drugs?_____

Any foods?_____

Any environmental?_____

Current Medications

Do you take or use?

Laxatives?_____ Pain Relievers?_____Antacids?_____

Cortisone?_____ Appetite Suppressant?_____ Antibiotics?_____

Tranquilizers?_____ Thyroid Medication?_____ Sleeping Pills?_____

Prednisone?_____ Hormone Replacement Therapy? _____ Birth Control? _____

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking.

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

Typical Food Intake

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Drinks:_____
Foods you crave:_____
Foods you dislike:_____
Foods you are allergic/sensitive to:_____

General

Height:_____ Weight:_____ Weight 1 yr ago:_____
Max Weight:_____ When:_____
When during the day is your energy the best?_____
The worst?_____

Mental /Emotional

Treated for emotional problems?_____ Depression?_____
Mood Swings?_____ Anxiety?_____
Considered/Attempted Suicide?_____ Tension?_____
Poor concentration?_____ Memory Problems?_____

Endocrine

Hypothyroid?_____ Heat or cold intolerance?_____
Hypoglycemia?_____ Diabetes?_____
Excessive thirst?_____ Excessive Hunger?_____
Fatigue?_____ Seasonal Depression?_____

Immune

Vaccinations?_____ Reactions to vaccinations?_____
Chronic fatigue Syndrome? _____ Chronic Infections?_____
Chronically swollen glands? _____ Slow wound healing?_____

Neurological

Seizures?_____ Paralysis?_____

Muscle weakness?_____ Numbness or tingling?_____

Loss of memory?_____ Easily stressed?_____

Vertigo or dizziness? _____ Loss of balance?_____

Muscoskeletal

Joint pain or stiffness?_____ Arthritis?_____

Broken bones?_____ Weakness?_____

Muscle spasms or cramps?_____ Sciatica?_____

Blood/Peripheral vascular

Easy bleeding or bruising?_____ Anemia?_____

Deep leg pain?_____ Cold hands/feet?_____

Varicose Veins?_____ Thrombophlebitis?_____

Skin

Rashes?_____ Eczema/Hives?_____ Acne/Boils?_____

Color change?_____Perpetual hair loss?_____ Lumps?_____

Night sweats?_____

Head

Headaches?_____ Head injury?_____

Migraines?_____ Jaw/TMJ problems?_____

Eyes

Spots in eyes?_____ Cataracts?_____

Impaired vision?_____ Glasses or contacts?_____

Blurriness?_____ Eye pain/strain?_____

Color blindness?_____ Tearing/dryness?_____

Double vision?_____ Glaucoma?_____

Nose and Sinus

Frequent colds?_____
Stuffiness?_____
Sinus Problems?_____
Nose bleeds?_____
Hay fever?_____
Loss of smell? _____

Mouth and Throat

Frequent sore throat?_____
Teeth grinding?_____
Gum problems?_____
Dental cavities?_____
Copious saliva?_____
Sore tongue/Lips?_____
Hoarseness?_____
Jaw clicks?_____

Neck

Lumps?_____
Goiter?_____
Swollen glands?_____
Pain/Stiffness?_____

Respiratory

Cough?_____
Spitting up blood?_____
Asthma?_____
Pneumonia?_____
Emphysema?_____
Pain on breathing?_____
Shortness of breathing at night?_____
Sputum?_____
Wheezing?_____
Bronchitis?_____
Pleurisy?_____
Difficulty breathing?_____
Shortness of breath?_____
Shortness of breath lying down?____

Cardiovascular

Heart disease?_____
High blood pressure?_____
Murmurs?_____
Fainting?_____
Rheumatic fever?_____
Swelling in ankles?_____
Angina?_____
Low blood pressure?_____
Blood clots?_____
Phlebitis?_____
Palpations/Fluttering?_____
Chest pains?_____

Gastrointestinal

Trouble swallowing?_____ Heartburn?_____

Change in thirst?_____ Change in appetite?_____

Nausea?_____ Vomiting?_____

Vomiting blood?_____ Blood in stool?_____

# of Bowel Movements per week?_____

Is this a change?_____ Pain/Cramps?_____

Constipation?_____ Belching/Gas?_____

Diarrhea?_____ Black stools?_____

Gall bladder disease?_____ Jaundice?_____

Ulcer?_____ Liver disease?_____

Hemorrhoids?_____

Urinary

Pain on urination?_____ Increased frequency?_____

Frequency at night?_____ Inability to hold urine? _____

Frequent infections?_____ Kidney stones?_____

Male Reproduction

Hernias?_____ Testicular masses?_____

Testicular pain?_____ Prostate disease?_____

Venereal disease?_____ Discharge/sores?_____

Are you sexually active?_____ Chlamydia?_____

Sexual orientation?_____ Gonorrhea?_____

Impotence?_____ Condyloma?_____

Premature ejaculation?_____ Herpes?_____

Syphilis?_____ Birth control?_____

What type?_____

Female Reproduction

Age of 1st menses?_____ Date of last menses?_____

Are cycles regular?_____ Length of cycle?_____

Bleeding between cycles?_____ Duration of menses?_____

Painful menses?_____ Clotting?_____

Heavy/Excessive flow?_____ Discharge?_____

PMS?_____ Sexually active?_____

PMS Symptoms?_____

Birth Control?_____ What type?_____

Number of pregnancies?_____ Number of live births?_____

Number of miscarriages?_____ Number of abortions? _____

Endometriosis?_____ Ovarian cysts?_____

Difficulty conceiving?_____ Cervical Dysplasia?_____

Menopausal Symptoms?_____ Abnormal PAP?_____

Pain during intercourse?_____ Sexual difficulties?_____

Chlamydia?_____ Gonorrhea?_____

Herpes?_____ CondylomA?_____

Syphilis?_____ Do you do breast exams?_____

Sexual orientation?_____ Breast tenderness/lumps?_____

Nipple discharge?_____

Habits

Main interest and hobbies?_____
_____
_____
_____

Do you have a religious or spiritual practice?_____What?_____

Do you exercise?_____ How often?_____

What kind of exercise?_____
_____
_____

Hours of sleep?_____ Enjoy your work?_____

Sleep well?_____ Take vacations? _____

Awaken rested?_____ Spend time outside?_____

Have a supportive relationship? _____ Watch television?_____

Have a history of abuse?_____ How many hours?_____

Any major traumas?_____ Read?_____

Used recreational drugs?_____ How many hours?_____

Been treated for drug dependence? _____ Use alcoholic beverages?_____

Do you eat three meals a day? _____ Treated for alcoholism?_____

Do you go on diets often?_____ Do you use tobacco?_____

Do you drink coffee?_____ Smoked previously?_____

Do you drink black/green tea?_____ How many years?_____

_____ Do you drink cola/soda?_____ How many packs per day?_____

Do you eat refined sugar/artificial sweeteners?_____

Do you add salt?_____

How does your condition affect you? _____
_____
_____
_____
_____
_____

What do you think is happening?_____
_____
_____
_____
_____

Why?_____
_____
_____
_____
_____

What do you feel needs to happen for you to get better?_____
_____
_____
_____
_____

What do you enjoy most about your life?_____
_____
_____
_____
_____

How much effort are you willing to make at this time to improve your health?

[ ] Minimal [ ] Some [ ] Complete

Please write any additional information below:

Welcome !

Please bring in any and all medications, vitamins or supplements you are currently taking. If you have any questions, please ask!

Patient Payment Responsibility Agreement

Dear Patient,

This letter is to keep you informed of the policies regarding your payment responsibilities.

AS a patient of Be Well Natural Health Clinics you are responsible for the total charges incurred from each visit to your practitioner. Charges are to be paid at the time of each visit.

We recognize and appreciate that health care can involve major financial commitment. We aim to provide you with effective and affordable health care.

Visa, MasterCard, Discover, American Express, Checks and Cash are all acceptable forms of payment.

For insurance companies that cover alternative and complementary services we will assist you in billing your insurance company. Please remember that you have the primary relationship with your insurance company and you are responsible for the total amount owed at the time of your visit. We will provide you with the appropriate super-bill with the appropriate codes needed for you to be reimbursed by your insurance company. You will need to mail the super-bill provided to your insurance company and your insurance company will reimburse you for all the amounts covered. Before your first visit contact your insurance company or refer to your insurance contract agreement regarding coverage for Alternative and Complementary medical services. Items to note are: 1)the service is covered, 2)for which diagnosis is covered, 3) how many visits are allowed per calendar year, 4) the amount of your deductible, 5) are there any limitations. Answers to these questions will help clarify treatment and financial responsibility.

Patients will be billed a missed appointment fee for any missed appointment or cancellation with less than a 24 hour notice. This charge will not be submitted to your insurance.

Payment for all pharmacy items is due at the time of the visit. Most insurance companies do not cover Naturopathic pharmacy items.

Please sign this form acknowledging you have read and agreed to the above notice. Please feel free to contact us regarding any questions.

Signature:_____Date:_____
I have read the above stated policies of Be Well Natural Health Clinics and will comply with them henceforth.