# Be Well Natural Health Clinics

25283 Cabot Road, Suite 114
Laguna Hills, California 92653
Phone (949)206-9090
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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 $200.00 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 10:00am to 5:00pm and Fridays 10:00am to 1:00pm

Sincerely,

Be Well Natural Health Clinics

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## Pediatric Form

Name _____ Date_____
Parent(s)name(s)_____
Address_____ City_____
State_____Zip Code_____
Telephone Number (home)_____
(Work)_____
(Cell)_____
Email Address_____
Date of Birth_____ Age_____
Gender: Male_____Female_____
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.

Is your child currently receiving healthcare?_____
If yes, where and from whom? _____
If no, when and where did your child last receive medical or health treatment? _____
_____
_____
What was the reason? _____
What are your child's most important health problems? List in order of importance:

1)_____
_____
2)_____
3)_____
4)_____
5)_____

Does your child 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 your child has now **P**= a condition your child has had **N**= never had

## Illness

Scarlet fever?_____ Diphtheria?_____ Rheumatic fever?_____

Mumps?_____ Measles?_____ German measles?_____

## Hospitalizations and Surgery

What hospitalizations or surgeries has your child had?

_____Date:_____

_____Date:_____

_____Date:_____

_____Date:_____

## X-Rays and Special Studies

X-rays, CAT scans, or other studies your child has had:

_____Date:_____

_____Date:_____

_____Date:_____

_____Date:_____

Electrocardiogram?_____Date:_____

Electroencephalogram?_____Date:_____

## Immunizations

Polio?_____ Pertussis?_____

Tetanus Shot?_____ Diphtheria?_____

Measles?_____ Other?_____

## Allergies

Is your child hypersensitive or allergic to:

Any drugs?_____

Any foods?_____

Any environmental?_____

Breast fed?_____ How long?_____

Formula?_____ Type?_____

## Current Medications

Does your child 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 your child is taking.

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

## Typical Food Intake

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Drinks:_____

Foods your child crave:_____

Foods your child dislike:_____

Foods your child is allergic/sensitive to:_____

## General

Height:_____ Weight:_____ Weight 1 yr ago:_____

Max Weight:_____ When:_____

When during the day is your child's 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?_____ Nose bleeds?_____

Stuffiness?_____ Hay fever?_____

Sinus Problems?_____ Loss of smell? _____

## Mouth and Throat

Frequent sore throat?_____ Copious saliva?_____

Teeth grinding?_____ Sore tongue/Lips?_____

Gum problems?_____ Hoarseness?_____

Dental cavities?_____ Jaw clicks?_____

## Neck

Lumps?_____ Swollen glands?_____

Goiter?_____ Pain/Stiffness?_____

## Respiratory

Cough?_____ Sputum?_____

Spitting up blood?_____ Wheezing?_____

Asthma?_____ Bronchitis?_____

Pneumonia?_____ Pleurisy?_____

Emphysema?_____ Difficulty breathing?_____

Pain on breathing?_____ Shortness of breath?_____

Shortness of breathing at night?_____ " " lying down?_____

## Cardiovascular

Heart disease?_____ Angina?_____

High blood pressure?_____ Low blood pressure?_____

Murmurs?_____ Blood clots?_____

Fainting?_____ Phlebitis?_____

Rheumatic fever?_____ Palpitations/Fluttering?_____

Swelling in ankles?_____ 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?_____

## Reproduction

Hernias?_____ Testicular masses?_____

Discharge/sores?_____ Testicular pain?_____

## Habits

Main interest and hobbies?_____

Does your child exercise?_____ How often?_____

What kind of exercise?_____

Hours of sleep?_____

Sleep well?_____

Awaken rested?_____

Spend time outside?_____

Watch television?_____

Read?_____

Have a history of abuse?_____

_____ Any major traumas?_____

_____

Been treated for drug dependence?_____

Does your child eat three meals a day?_____

Does your child drink cola/soda?_____

Does your child eat refined sugar/artificial sweeteners?_____

Does your child crave salt?_____

How does your child's condition affect him/her?_____

_____

_____

_____

_____

What do you think is happening?_____

_____
_____
_____
_____

Why?_____
_____
_____
_____
_____

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

What does your child enjoy most about him/her life?_____
_____
_____
_____
_____

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

[ ] Minimal [ ] Some [ ] Complete

Please write any additional information below:

_____
_____
_____
_____
_____
_____
_____
_____

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 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 Clinic and will comply with them henceforth.

# Consent Treatment of a Minor

I (We) being the parents or guardian of_____
a minor the age of_____ do hereby consent, authorize and request_____
_____ to administer such treatment deemed advisable, necessary or requested on the above minor.

I (We) agree to hold free and harmless from any claims or suits for damages or complications which may result from such treatment.

Signed _____
Parent or Guardian

Witness_____ Date_____