Health Through Nature, PLC
New Patient Document

CONFIDENTIAL PATIENT INFORMATION

Today's Date _____
Patient Name_____**Birthdate** _____ **Age**____**Sex** M F
Cell phone _____ **Alt: phone**_____
Email Address _____
Address_____
City _____ **State** _____ **Zip** _____ **Occupation** _____
Marital Status Married Single Separated Divorced
Name of Spouse/Partner/Guardian _____
Occupation _____ **Work Phone** _____

Your preferred method of contact: appointment reminders and communication
Please check one:
1. Mobile Text ____ **2. Voice Notification**_____ **3. Email** _____

Emergency contact person_____
Emergency contact number_____
Relationship to patient_____

Would you like to receive our newsletter? Email address:_____

List in order of importance your health concerns:

	Concern	**Started when**
1.		
2.		
3.		
4.		

What other health professionals have you seen for your concerns? _____
_____
Primary Care Practitioner _____

List all Prescription Medicines, Over the Counter Medicines, Nutrient Supplements, Homeopathic Medicines, or Herbs you are taking and include dosages _____
_____
_____
_____

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New Patient Document

List all Allergies and how you react to them.
Drugs _____
Foods _____
Environmental _____

PAST MEDICAL HISTORY ***Please circle any prior concerns***

Tobacco use	Alcohol abuse	Substance Abuse	Head Injury
Periodontal	Neck Injury	Asthma	Tuberculosis
Heart Attack	Hypertension	Stroke	Chest Pain
Palpitations	Hepatitis	Anemia	Constipation
Ulcers	STD	Diabetes	Thyroid Disease
Mononucleosis	Root Canal	Eczema	Allergies
Major Trauma	Depression	Cancer, type_____	

Other_____
_____

List all surgeries and hospitalizations, including date/year occurred
1. _____
2. _____
3. _____

FAMILY HISTORY

	Father	Mother	Siblings	Grandparent	Spouse	Children
High Blood Pressure						
Heart Attack/Stroke						
Asthma/Allergies						
Mental Illness						
Auto Immune DZ.						
Diabetes Mellitus						
Osteoporosis						
Cancer						

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Diet

Do you follow a special diet? Yes No
What type? _____
Exercise How often do you exercise? _____
What type of exercise? _____
How long do you exercise? _____
Hobbies
_____

Social Life

Enjoy job Yes No **Hours worked per week: _____**
Active spiritual practice Yes No
Quality of significant relationship _____
How committed are you towards making valuable changes?
Little Moderately Very

Please indicate other things you believe are important for your provider to know.
_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

Present Weight _____ Weight one year ago _____ Height _____

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New Patient Document

Regarding the next section: Please circle (Y) if you the problem now, (P) if you had the problem in the past.

SKIN

Rash	**Y P**	**Hives**	**Y P**	**Itchy**	**Y P**
Dry Skin	**Y P**	**Psoriasis/Eczema**	**Y P**	**Excess Perspiration**	**Y P**
Cancer	**Y P**	**Lump**	**Y P**		

HEAD

Headache	**Y P**	**Oily/ Dry Hair**	**Y P**	**Migraine**	**Y P**
Dandruff	**Y P**	**Hair Loss**	**Y P**	**Head Injury**	**Y P**

NOSE

Frequent Cold	**Y P**	**Polyps**	**Y P**	**Nose bleeds**	**Y P**
Congestion	**Y P**	**Seasonal Allergies**	**Y P**	**Post nasal drip**	**Y P**

Eyes

Dry / Watery	**Y P**	**Strain**	**Y P**	**Cataracts**	**Y P**
Double vision	**Y P**	**Itchy**	**Y P**	**Styes**	**Y P**
Glaucoma	**Y P**	**Blurry vision**	**Y P**		

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MOUTH/THROAT

Canker sores	**Y P**	**Cold Sores**	**Y P**	**Loss of taste**	**Y P**
Sore throat	**Y P**	**Gum disease**	**Y P**	**Hoarseness**	**Y P**
Dentures	**Y P**	**Cavities**	**Y P**		

Respiratory

Cough	**Y P**	**Wheezing**	**Y P**	**Bronchitis**	**Y P**
Shortness of Breath	**Y P**	**Asthma**	**Y P**	**Pneumonia**	**Y P**

CARDIOVASCULAR

High blood pressure	**Y P**	**Edema**	**Y P**	**Murmurs**	**Y P**
Arrhythmia	**Y P**	**Chest Pain**	**Y P**	**Palpitations**	**Y P**

URINARY TRACT

Incontinence	**Y P**	**Urgency**	**Y P**	**Discharge/ Blood**	**Y P**
Frequent Infections	**Y P**	**Pain with urination**	**Y P**		

GASTROINTESTINAL

Heartburn	**Y P**	**Nausea**	**Y P**	**Recent BM Changes**	**Y P**
Indigestion/Bloating	**Y P**	**Vomiting**	**Y P**	**Diarrhea/Constipation**	**Y P**
Ulcer	**Y P**	**Change in appetite**	**Y P**	**Hemorrhoids**	**Y P**

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MALE HEALTH

Testicular pain/swelling	**Y P**	**Impotency**	**Y P**	**S.T.D.**	**Y P**
Discharge	**Y P**	**Hernia**	**Y P**		

FEMALE HEALTH

Age of Menses		**PMS**	**Y P**	**How often Period occurs**	
How long period lasts		**Times Pregnant**		**Heavy Menstrual bleeding**	**Y P**
Menstrual cramping	**Y P**	**Miscarriages / Abortions**	**Y P**	**Menstrual pain**	**Y P**

MUSCULOSKELETAL

Weakness	**Y P**	**Arthritis**	**Y P**	**Stiffness**	**Y P**
Leg Cramps	**Y P**	**Tremors**	**Y P**	**Pain**	**Y P**

MENTAL/EMOTIONAL

Depression	**Y P**	**Anger/Irritability**	**Y P**	**Suicidal**	**Y P**
Tense	**Y P**	**Anxiety**	**Y P**	**Fear/Panic**	**Y P**
Eating disorder	**Y P**				

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Insurance

At time of payment you will receive a copy of your bill in the form of an invoice/receipt. This will show the diagnosis, fees for service and any medicines/supplements purchased. You can submit this form directly to your insurance company for reimbursement. The following insurance information will assist our office in dealing with any follow-up inquiries from your insurance company regarding your claims.

Primary Insurance
Company_____
Secondary Insurance
Company_____
Do you have a health savings account?
_____

How did you hear about Health Through Nature?_____

Cancellation Policy

Please let us know if you will be running late for your appointment or have to reschedule. We are graceful with understanding that emergencies arise but appreciate a 24-hour notice for cancellations. Missed appointments without notice will result in a $50 missed appointment fee.

Prescriptions

You may receive prescriptions or recommendations for therapeutic agents in connection with your treatment. These may be filled with your Naturopathic Medical Doctor or by a Pharmacy of your choice.

If you request refills on your Pharmaceutical Prescriptions it is best to have your Pharmacy fax our office a refill request. Please give 24 hours notice on prescription refills.

If you request refills on your Naturopathic Prescriptions please give our office a 72 hour notice.

I have read the policies of Health Through Nature, PLC and I hereby authorize examination and treatment_____

Signature (patient, parent/guardian)

www.healthTnature.com questions@healthTnature.com
1757 E Baseline Rd Ste 139 Gilbert, AZ 85233 P: 480-926-9696 F: 480-926-9229

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State and Federal regulations require certain notices to patients and compliance with applicable provisions of law. These notices are enumerated below:

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

Health Through Nature, PLC, and other healthcare providers are required by law to take all reasonable measures to protect your privacy and are required to abide by the provisions of the privacy notice. Your medical information may be disclosed to others who work with Health Through Nature,PLC in connection with therapies and treatment in the office, to third party payers (e.g., insurance companies) if required for payment of service, or to other healthcare workers in the event of an emergency medical situation. In circumstances, your approval will be required before making your health care information available to others and you may revoke this approval if at some future date you so decide.

Communications: All modes of communication provided by you on the intake form (e.g.,mailing address, email, phone) will be available to the office and staff of Health Through Nature, PLC unless you request restriction of this information.

Copies and amendments: You have the right to see your medical information and to request copies of your health information.

Complaints: You have the right to complain to Health Through Nature, PLC concerning any breach of privacy rights.

De-identified information: Your healthcare information may be de-identified (e.g., all information as to name, address, phone, etc.) and subsequently used for educational purposes, e.g. to train other physicians or to educate patients.

Please contact Health Through Nature, PLC if you would like any further restrictions placed on your health care information or if you would like an accounting matter disclosed to third parties

Health Through Nature, PLC reserves the right to revise this notice as may be required and will provide revised notice of material changes to active patients.

I HAVE READ AND AGREE WITH THE PROVISIONS OF THESE NOTICES.

Signature_____**Date**_____

revised 5/14

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