A Natural Choice

Dr. Heather Boyd-Roberts, N.D.
360-573-CARE (2273)
www.anaturalchoice.org
help@anaturalchoice.org

Name: _____ Today's Date: _____
Last First Middle

Age: _____ Birth Date _____ Single ___ Married____ Div. ___ Sep.___ Sig. Other ____ Gender: Female ◯ Male ◯

Home Address: _____ Home Phone:_____
Street or PO Box City State Zip Code Cell Phone:_____

Can we leave personal information on your voicemail or message system? Home phone: yes or no Cell phone: yes or no
(circle one) (circle one)

Employer & Address: _____ Work Phone_____

When & Where are the best times to reach you? _____
Email Address**:** _____
Spouse/Parent Name: _____
Spouse Address:_____ Work Phone:_____
Street or PO Box City State Zip Code

If someone other than the PATIENT is responsible for payment, complete the following:

Name of responsible party _____ Address: _____
Relationship to patient: _____ Cell Phone: _____
Employer: _____ Work Phone:_____
Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number: _____

Please sign and return to the receptionist

I authorize Dr. Heather Boyd-Roberts to furnish my insurance company with all information which the insurance company may request concerning my present illness or injury with the exception of those results which require specific authorization as determined by law. I assign to the doctor all money to which I am entitled for medical expenses relative to the services performed from time to time, but not to exceed my indebtedness to the physician. I understand this office cannot accept responsibility for collecting insurance claims or negotiating a settlement on a disputed claim. Some services provided are not covered by insurance. Whatever the outcome of my insurance claim, I am responsible for payment of my account.

I acknowledge that I am financially responsible for all charges and these will be paid at the time of service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of benefits.

Signed: _____ **Print Name:** _____ **Date:** _____

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HEALTH HISTORY

1. Main health concern and other comments:

_____
_____
_____
_____
_____
_____
_____
_____

Answer the following questions.

Recreational Drugs used recently or excessively in the past - Specify _____

Did you smoke before? If yes, how long and when did you stop? _____

Did you drink alcohol excessively before? If yes, when did you stop? _____

In the past 18 months have your experienced:

Divorce or separation from a loved one	Y	N
Death of a loved one	Y	N
Bankruptcy or major financial hardship	Y	N
Serious illness or injury	Y	N
Loss of job	Y	N
Significant legal challenges	Y	N
Relocation of home	Y	N

Rate your stress level on a scale of 1-10 where 10 is high _____

What is the main reason for your stress? _____

_____
_____
_____

If over level 5, what steps are you taking to reduce your stress level? _____

List Drug Names, Dosage and Reason for Taking Including Over the Counter medication:

_____
_____
_____
_____
_____
_____
_____

2. List any supplements you are currently taking and why:

_____
_____
_____
_____

3. Any surgeries, hospitalizations, trauma or accidents including elective surgeries such as breast implants or mole removal:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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5. Please list any history of significant family illness (e.g. cancer, diabetes, arthritis, osteoporosis, heart disease, stroke, neurological disease, lupus and autoimmune diseases, alcoholism etc.). Next to the condition write the relative who has the condition (ie self, mother…):

Mother Illnesses / Age: _____

Father Illnesses/ Age: _____

Brothers Illnesses/Age: _____

Sisters Illnesses/ Age: _____

Grandparents maternal Illnesses/Age: _____

Grandparents paternal Illnesses/Age: _____

Other: _____

6. **List your Food, Environment or drug allergies**

_____

_____

_____

_____

7. Please write 2 days of your typical diet below:

Breakfast _____

_____

_____

Lunch _____

_____

_____

Dinner _____

_____

_____

Breakfast _____

_____

_____

Lunch _____

_____

_____

_____

Dinner _____

_____

_____

8. Circle the following if you:

- Diet often ☐ Skip meals
- Do not exercise regularly ☐ Vegetarian
- Are under excessive stress ☐ Are exposed to chemicals
- Irregular eating times ☐ Eat after 7pm regularly

- Smoke cigarettes - How many per week? _____
- Drink alcohol - How many per week? _____
- Drink coffee - How many per week? _____
- Drink soda pop - How many per week? _____
- Use sugar - How much each day? _____
- Drink less than 8 glasses of purified water daily? N Y
- Eat less than 5 servings of veggies & fruit daily N Y

9. How many meals per week do you prepare at home?

_____

10. How many meals do you eat per week in a sit down restaurant? _____

11. How many meals do you eat per week in a fast food restaurant? _____

12. Do you have a pacemaker? **Y N**

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Please complete these questions with thought. I realize they are challenging, but they are crucial for me to understand your needs. If you are bringing your child to our clinic, please complete this as your desires for your child and your understanding of our approach etc.

Context of Care

NAME _____ **DATE** _____

1. Why have you chosen our clinic to support your health needs? _____
2. What three expectations, concerns, or goals do you have from your visit today? _____
3. For your care to be a true win for you, what do you want to take place over the course of your care? _____
4. What do you feel you understand about our approach? _____
5. What expectations do you have of me personally as your doctor? _____
6. Reflect on your highest priorities in life and list the top 3 that come to your mind and speak to your heart. Then list your top 3 favorite things to do? _____
7. What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list). _____
8. What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits? (Please list). _____
9. What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health? _____
10. What is your potential level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed). 1 2 3 4 5 6 7 8 9 10
11. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making? _____
12. How long do you feel it will take to reach your desired state of health? _____

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Health History Questionnaire

Name: _____ Date: _____

Successful health and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything you don't understand with a question mark.

Thoughtfully circle the number which best describes the frequency and severity of your symptoms. If you are unsure or do not have these symptoms, please leave it blank. Where response options are yes 'Y', or no 'N', simply circle the appropriate response.

0=Never/rarely 1=Occasionally / slightly 2=Moderate intensity or frequency 3=Intense/severe/frequent

SLEEP

1. Average time you go to bed _____
2. Average time you wake up _____
3. # of hours of sleep you get each night _____
4. Number of times you wake at night _____
5. Difficulty falling asleep at bedtime 0 1 2 3
6. Awake through the night and have difficulty getting back to sleep 0 1 2 3
7. Restless body or mind as trying to fall asleep 0 1 2 3
8. Experience restless legs 0 1 2 3
9. Awake feeling tired and sluggish 0 1 2 3
10. Currently use any natural, OTC or prescription medication to help me go to sleep N Y

ENERGY

1. Fatigue 0 1 2 3
2. Energy on a scale of 1-10 (ten = high energy) _____
3. Awake tired or find it difficult to get up in the morning 0 1 2 3
4. Have coffee, tea, tobacco, sugar or other stimulants as "pick me up" or "stress modifier" N Y

ANXIETY / DEPRESSION

1. Anxiety or significant worries 0 1 2 3
2. Difficulty sitting quietly without fidgeting 0 1 2 3
3. Tension or Stressed 0 1 2 3
4. Hyperactivity / Restlessness 0 1 2 3
5. Panic attacks 0 1 2 3
6. Feel depressed or sad 0 1 2 3
7. Find yourself withdrawing from people or public places 0 1 2 3
8. Seasonal depression 0 1 2 3
9. Experience feelings of indifference, apathy (don't care attitude) 0 1 2 3
10. Feel like crying for no apparent reason 0 1 2 3
11. Take over the counter or prescription medicines to elevate your mood or counter depression N Y
12. Considered or attempted suicide N Y
13. Treated for emotional problems N Y
14. Mood swings N Y
15. Irritable / anger too rapidly 0 1 2 3

MEMORY / CONCENTRATION

1. Have a short attention span 0 1 2 3
2. Experience mental fog, sluggishness, confusion and/or memory lapses? 0 1 2 3
3. Memory problems 0 1 2 3
4. Poor concentration 0 1 2 3

WEIGHT

Where 0 is totally satisfied and 10 is totally dissatisfied

1. WEIGHT CHALLENGES Y N
2. What is your estimated weight _____
3. What is your height _____
4. What was your highest weight _____
5. What is your ideal weight _____
6. What age did you start to gain weight _____
7. Was there a reason for your weight gain Y N
8. Do you strongly want to lose weight Y N
9. Are you motivated to lose weight Y N

Carefully and completely circle the number (where applicable) which best describes the frequency and severity of your symptoms. If you are unsure or do not have these symptoms, leave it blank.

0= Never/ Rarely 1=Occasionally/slightly 2= Moderate in intensity and 3= Intense, severe, frequent

IMMUNE FUNCTION

1. Catch colds, flu's or infections easily/repeatedly 0 1 2 3
2. Current or recurrent cold sores, fever blisters 0 1 2 3
3. Current or recurrent sore throat or post nasal drip 0 1 2 3
4. Current or recurrent cough with mucus 0 1 2 3
5. Current or recurrent discharge from eyes 0 1 2 3
6. Current or recurrent nasal congestion or discharge –thick, yellow, green 0 1 2 3
7. Current or recurrent swollen glands in neck, armpits, and/or groin 0 1 2 3
8. Get recurrent yeast and/or bladder infections? 0 1 2 3
9. Current or recurrent inflamed or bleeding gums 0 1 2 3
10. Loss of taste or smell 0 1 2 3
11. Troubles seeing at night 0 1 2 3

ALLERGIES

1. Muscles fatigue quickly 0 1 2 3
2. Moody, irritable, tired 0 1 2 3
3. Joint pains, redness and swelling 0 1 2 3
4. Chronic pain, stiffness throughout body 0 1 2 3
5. Dark circles under eyes 0 1 2 3
6. Migraine or recurrent headaches 0 1 2 3
7. Recurrent localized or general itching-eyes, ears, throat, nose skin, anus 0 1 2 3
8. Clear watery discharge from nose, eyes, ears 0 1 2 3
9. Recurrent sneezing, wheezing or cough 0 1 2 3
10. Moldy, damp environment triggers symptoms 0 1 2 3
11. Chronic or recurrent post nasal drip 0 1 2 3
12. Heart palpitations after eating certain foods 0 1 2 3
13. Bruise easily N Y
14. Recurrent hives or welts N Y
15. Known food or inhalant allergies / Hay fever N Y

RESPIRATORY

1. Cough 0 1 2 3
2. Sputum 0 1 2 3
3. Wheezing 0 1 2 3
4. Asthma N Y
5. Difficulty breathing 0 1 2 3
6. Shortness of breath 0 1 2 3
7. Shortness of breath when lying down 0 1 2 3
8. Chest congestion / heaviness / pressure 0 1 2 3
9. Pain on breathing 0 1 2 3
10. Spitting up blood N Y
11. Pneumonia present or in the past N Y
12. Bronchitis present or repeated in the past N Y
13. Pleurisy present or in the past N Y
14. Emphysema N Y

NOSE AND SINUS

1. Frequent colds 0 1 2 3
2. Stuffy nose 0 1 2 3
3. Sinus problems / congestion / pressure / pain 0 1 2 3
4. Nose bleeds 0 1 2 3
5. Hay fever / allergies 0 1 2 3
6. Sneezing fits 0 1 2 3
7. Loss of smell N Y

HEAD NECK

1. Headaches 0 1 2 3
2. Migraines 0 1 2 3
3. Head injury N Y
4. Jaw / TMJ problems 0 1 2 3
5. Lumps in neck 0 1 2 3
6. Goiter N Y
7. Swollen glands in neck 0 1 2 3
8. Pain / stiffness in neck 0 1 2 3

MOUTH AND THROAT

1. Excessive mucous / Gagging or frequent need to clear throat 0 1 2 3
2. Chronic coughing 0 1 2 3
3. Frequent sore throats 0 1 2 3
4. Hoarseness, loss of voice 0 1 2 3
5. Swollen or discolored tongue 0 1 2 3
6. Canker sores / Sore tongue / Lips / Cold sores 0 1 2 3
7. Teeth grinding 0 1 2 3
8. Gum problems / bleeding 0 1 2 3
9. Dental cavities 0 1 2 3
10. Metal fillings or crowns 0 1 2 3

BLOOD SUGAR REGULATION

1. Hypoglycemia N Y
2. Experience fatigue or sleepiness if it's been too long since your last meal? 0 1 2 3
3. Experience anxiety associated with hunger? 0 1 2 3
4. Feel shaky, jittery, internal trembling? 0 1 2 3
5. Awake with mild headaches or develop them if it has been too long since you last meal? 0 1 2 3
6. Crave sweets frequently? 0 1 2 3
7. Diabetes or elevated insulin N Y
8. Get recurrent and/or persistent sores on your legs? 0 1 2 3
9. Get numbness or prickling/tingling sensations in your limbs? 0 1 2 3
10. Get recurrent and/or persistent gum or skin infections? 0 1 2 3
11. Have excessive thirst and/or appetite? 0 1 2 3

Carefully and completely circle the number (where applicable) which best describes the frequency and severity of your symptoms. If you are unsure or do not have these symptoms, leave it blank.

0= Never/ Rarely 1=Occasionally/slightly 2= Moderate in intensity and 3= Intense, severe, frequent

EYES / EARS

1. Spots in eyes N Y
2. Impaired vision N Y
3. Blurriness N Y
4. Double vision N Y
5. Cataracts N Y
6. Glasses or contacts N Y
7. Eye pain / strain N Y
8. Tearing / dryness N Y
9. Glaucoma N Y
10. Drainage discharge from ears 0 1 2 3
11. Ringing in ears or hearing loss 0 1 2 3

DIGESTION

STOMACH

1. Heartburn/gastritis 0 1 2 3
2. Stomach ache or pain when emotionally upset 0 1 2 3
3. Stomach pain, burning, aching when you go too long without eating 0 1 2 3
4. Stomach problems improve with rest and relaxation 0 1 2 3
5. Present or past history of ulcer and/or h. pylori 0 1 2 3
6. Belching / burping / bloating / gas 0 1 2 3
7. Poor appetite, disinterest in foods 0 1 2 3
8. Difficulty swallowing 0 1 2 3
9. Ulcer N Y
10. Black stools 0 1 2 3
11. History of anemia, unresponsive iron therapy N Y
12. Spoon shaped nails N Y
13. Sores in corners of mouth or smooth tongue N Y

INTESTINES

1. # Bowel movements per week _____
2. Difficulty gaining weight 0 1 2 3
3. Diarrhea / loose stools 0 1 2 3
4. Constipation 0 1 2 3
5. Bowels feel like they don't completely empty 0 1 2 3
6. Narrow, thin stools 0 1 2 3
7. Hard, dry stools 0 1 2 3
8. Mucus seen in stools 0 1 2 3
9. Blood in stool 0 1 2 3
10. Pain / cramps 0 1 2 3
11. Hemorrhoids / rectal itching / pains 0 1 2 3
12. History of colitis, Irritable Bowel Syndrome (IBS), diverticulitis, crohn's disease or ulcerative colitis N Y
13. Rash in groin and/or recurrent vaginitis or cystitis 0 1 2 3

LIVER / GALLBLADDER

1. Liver disease or abnormal enzymes N Y
2. Gallbladder disease N Y
3. Jaundice N Y
4. Pain under right side of rib cage 0 1 2 3
5. Nausea and or vomiting 0 1 2 3
6. Pains in right mid-back and under shoulder blade 0 1 2 3
7. Fatty/oily foods cause indigestion 0 1 2 3
8. Itching of skin, worse at night 0 1 2 3
9. Fluid retention (elevated extra cellular water and weight often varies widely with hand, feet and ankle swelling) 0 1 2 3
10. Reddened blotchy skin, especially palms of hands 0 1 2 3
11. Dry flaky skin and/or dry brittle hair 0 1 2 3
12. Elevated total cholesterol to HDL ratio (>4) N Y
13. Are you sensitive to caffeine N Y
14. Are you sensitive to fragrances, exhaust fumes, strong odors 0 1 2 3
15. Do you feel ill after ingesting small amounts of alcohol 0 1 2 3
16. Do you take OTC or prescription medication daily N Y
17. Do you regularly consume more than 2 alcoholic beverages daily? (more than: 2 oz. of 40 proof alcohol, 6 oz. of wine, or 2 bottles of beer) N Y

HORMONAL SYSTEM

THYROID FUNCTION

Section A HYPOFUNCTION SCREEN

1. Hypothyroid N Y
2. Chilly or cold hands and feet 0 1 2 3
3. Puffy face, eyelids, hands and or feet 0 1 2 3
4. Edema or fluid over shins 0 1 2 3
5. Skin excessively dry, discoloration 0 1 2 3
6. Thick brittle nails 0 1 2 3
7. Slow heart rate N Y
8. Swelling of the thyroid gland (front of neck) N Y
9. Outer third of eyebrows thinning N Y

Section B HYPERFUNCTION SCREEN

1. Rapid heart rate 0 1 2 3
2. Excessive perspiration 0 1 2 3
3. Insomnia 0 1 2 3
4. Hyper, jittery, anxious, on edge feeling 0 1 2 3
5. Unexplained weight loss 0 1 2 3

Carefully and completely circle the number (where applicable) which best describes the frequency and severity of your symptoms. If you are unsure or do not have these symptoms, leave it blank.

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ADRENAL FUNCTION

1. Progressive fatigue after exertion or stress 0 1 2 3
2. Episodic blurred vision, dizzy on standing 0 1 2 3
3. Rapid mood swings, irritable 0 1 2 3
4. Chronic, recurrent joint pains 0 1 2 3
5. Sensitive to minor changes in weather and surroundings 0 1 2 3

MENS HEALTH

PROSTATE

1. Prostate disease or enlargement N Y
2. Frequent or urgent need to urinate 0 1 2 3
3. Delayed, weak, or interrupted urine stream 0 1 2 3
4. Pain or burning upon urination at times 0 1 2 3
5. Up to urinate several times a night 0 1 2 3
6. Difficulty urinating and/or dripping after 0 1 2 3
7. Frequent sense of bladder fullness 0 1 2 3
8. Ejaculation causes pain at times 0 1 2 3
9. Lack of sex drive, impotency 0 1 2 3
10. Unexplained "burning" sensation in heels 0 1 2 3
11. Current or history of prostatitis N Y
12. Benign prostatic hypertrophy (swelling of prostate) N Y
13. Elevated PSA (>4) or diagnoses of prostatic cancer N Y

REPRODUCTIVE FUNCTION

1. Testicular pain or mass 0 1 2 3
2. Venereal disease past or present (chlamydia, gonorrhea, condyloma, herpes) N Y
3. Difficulty attaining an erection / Impotence 0 1 2 3
4. Low sexual drive 0 1 2 3
5. Genital and/or rectal rash or irritation at times 0 1 2 3
6. Decreased body, legs, arm pit or facial hair N Y
7. Are you sexually active N Y

WOMENS HEALTH

PREMENSTRAL SYNDROME / PMS

Answer YES if you experience these symptoms two weeks prior to menstruation. If you have the symptom all month long also circle the number to the question.

1. PMS (If no skip to Female Hormonal Balance Section below) N Y
2. Insomnia 0 1 2 3
3. Abdominal bloating 0 1 2 3
4. Breast tenderness, swelling 0 1 2 3
5. Breast lumps appear 0 1 2 3
6. Heart palpitations 0 1 2 3
7. Sweating and flushing 0 1 2 3
8. Depressed, irritable, nervous 0 1 2 3
9. Easily angered, resentful 0 1 2 3
10. Easily overwhelmed 0 1 2 3
11. Nausea and/or vomiting 0 1 2 3
12. Diarrhea or constipation 0 1 2 3
13. Headache 0 1 2 3
14. Food cravings, binge eating 0 1 2 3
15. Back pain 0 1 2 3
16. Numbness, tingling in hands and feet 0 1 2 3
17. Lower abdominal cramping 0 1 2 3
18. Feeling hopeless, sad 0 1 2 3
19. Weight gain – water retention 0 1 2 3
20. Suicidal feelings 0 1 2 3
21. Other Symptoms N Y

FEMALE HORMONAL BALANCE

1. Sexually active N Y
2. Birth control Type _____
3. Number of Pregnancies _____
4. Number of miscarriages _____
5. Number of live births _____
6. Number of abortions _____
7. Menopause or Peri-menopause N Y
8. Surgical menopause (partial / complete) N Y
9. Hot flushes and or spontaneous sweating 0 1 2 3
10. Insomnia that started with peri-menopause 0 1 2 3
11. Mood / memory changes since peri-menopause 0 1 2 3
12. Age of 1st Menses _____
13. 1st Day of Last Menstrual cycle _____
14. Duration of Menses _____
15. Length of average cycle _____
16. Irregular menstrual cycle N Y
17. Bleeding between cycles 0 1 2 3
18. Painful menses 0 1 2 3
19. Excessive / heavy menstrual flow 0 1 2 3
20. Clotting 0 1 2 3
21. Discharge between periods 0 1 2 3
22. Genital itch or discharge 0 1 2 3
23. Breast cysts N Y
24. Ovarian cysts N Y
25. Endometriosis N Y
26. Fibroids N Y

Carefully and completely circle the number (where applicable) which best describes the frequency and severity of your symptoms. If you are unsure or do not have these symptoms, leave it blank.

0= Never/ Rarely 1=Occasionally/slightly 2= Moderate in intensity and 3= Intense, severe, frequent

27. Disinterest in sex 0 1 2 3
28. Painful intercourse 0 1 2 3
29. Repeated vaginitis now or in the past 0 1 2 3
30. Vaginal pain and/or itching 0 1 2 3
31. Abnormal growth of hair above lip 0 1 2 3
32. Difficulty conceiving N Y
33. Venereal disease (chlamydia, herpes, syphilis, gonorrhea, condyloma) N Y
34. Sexual difficulties 0 1 2 3
35. Abnormal PAP N Y
36. Cervical dysplasia N Y
37. Do you do self breast exams N Y
38. Breast tenderness / lumps N Y
39. Nipple discharge N Y

OTHER

URINARY FUNCTION

1. Kidney disease N Y
2. Pain on urination 0 1 2 3
3. Increased frequency or urgency 0 1 2 3
4. Wake at night to urinate 0 1 2 3
5. Frequent infections now or in the past 0 1 2 3
6. Inability to hold urine 0 1 2 3
7. Kidney stones now or in the past N Y
8. Retain fluid throughout body 0 1 2 3
9. Lower back pain just below rib cage 0 1 2 3
10. Rarely need to urinate or difficulty passing urine 0 1 2 3

NEUROLOGICAL SYSTEM

1. Seizures N Y
2. Muscle weakness 0 1 2 3
3. Loss of memory 0 1 2 3
4. Vertigo or dizziness 0 1 2 3
5. Paralysis 0 1 2 3
6. Numbness or tingling 0 1 2 3
7. Easily stressed 0 1 2 3
8. Loss of balance 0 1 2 3

CARDIOVASCULAR SYSTEM

1. Heart disease N Y
2. High Blood Pressure N Y
3. Low Blood Pressure N Y
4. Murmurs N Y
5. Chest pains 0 1 2 3
6. Angina 0 1 2 3
7. Palpitations / Fluttering / Irregular beat 0 1 2 3
8. Fainting 0 1 2 3
9. Rheumatic fever in past N Y
10. Swelling in ankles 0 1 2 3
11. Phlebitis 0 1 2 3
12. Blood clots 0 1 2 3
13. Cholesterol low or high N Y

BLOOD / PERIPHERAL VASCULAR

1. Easy bleeding or bruising 0 1 2 3
2. Deep leg pain 0 1 2 3
3. Varicose veins 0 1 2 3
4. Anemia N Y
5. Cold hands / feet 0 1 2 3
6. Thrombophlebitis 0 1 2 3

SKIN

1. Rashes 0 1 2 3
2. Eczema / Dry skin 0 1 2 3
3. Hives now or in past 0 1 2 3
4. Acne / boils 0 1 2 3
5. Color changes 0 1 2 3
6. Perpetual hair loss 0 1 2 3
7. Lumps in skin 0 1 2 3
8. Night sweats 0 1 2 3
9. White spots on nails N Y
10. Nails brittle, crack or split 0 1 2 3

MUSCULOSKELETAL SYSTEM

1. Joint pain or stiffness 0 1 2 3
2. Broken bones 0 1 2 3
3. Muscle spasms or cramps 0 1 2 3
4. Arthritis 0 1 2 3
5. Weakness 0 1 2 3
6. Sciatica 0 1 2 3
7. Osteoporosis 0 1 2 3

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Cancellation / No Show Policy

- A Natural Choice scheduled appointments represent time set aside specifically for you as a patient. We have a significant waiting list of patients who would love to take any cancelled appointments. People need time to adjust their schedule to take advantage of this. Because of this we have a new policy, all cancellations must be made by noon 48 hours prior to your appointment. If your appointment is on Monday, your cancellation must be made by noon, the Friday before your appointment.

- Patients who cancel or no show on three separate occasions will be allowed to schedule additional appointments only at the discretion of the staff at A Natural Choice.

- If you do not cancel by noon 48 hours prior to your appointment, you will be charged 50% of the cost of your scheduled visit.

My signature indicates that I have read and understand the A Natural Choice cancellation and no show policies.

Patient or Legal Guardian Signature: _____Date:_____

IMPORTANT OFFICE POLICIES

In an ongoing effort to serve our patients more effectively and efficiently, we have established the following policies and procedures.

To assist us in our ability to provide you with excellent care, please read the following information carefully. If you require clarification or have any questions, please consult with our staff.

1. Clinic Hours: Our clinic is open from 8:00 AM to 5:30 PM, Monday – Friday.

2. Ordering Supplements:
The success of your Nutrition Plan is dependent on your following through with the prescribed supplement plan. Please refill through us. Products that have the same label and are seemingly from the same company online are not necessarily the same quality.

We do not have an online store at the request of our vendors so to order. To place an order you can stop by, call us or email us at help@anaturalchoice.org. Orders over $75 ship for free.

Keep an eye out for out upcoming Loyal Program and make sure when you order you ask about our specials.

3. Payment policies:
   a. For patients without health insurance, payment in full for all clinic services and products is expected on the day of service.
   b. For patients with health insurance, if your coverage has not been verified prior to your first visit, payment in full for all clinic services and products is expected on the day of service. If your coverage can be verified prior to your next visit, you will then be responsible for only your co-pay, non-covered services, and products at that time.
   c. For services covered by insurance we will bill your insurer. Co-payments and percentage due will be expected on the day of service. Note that insurance companies do not cover supplements and some services and payment for these is expected on the day of service.
   d. Payment may be made by check, cash, debit card, Visa, MasterCard, or Discover card.

I have read and understand the policies and procedures of Natural Choice Health Care.

Signature:_____ Date:_____

Print Name:_____ Date:_____

CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I authorize A Natural Choice and its personnel to provide ongoing medical care, treatment and procedures as order by the physicians and/or other health care providers. I acknowledge that no guarantee can or will be made as to the results of the care, treatment and medication prescribed.

Printed Name: _____ Signature:_____ Date:_____

Notice: Patient Privacy

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

How Medical information about you may be used and disclosed and how you can access this information.

- We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you and the related administrative activities.
- We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent.
- As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information and complaining if you think your rights have been violated.
- We have available, a detailed **Notice of Privacy Practices** which fully explains your rights and our obligations under the law. We may revise our Notice from time to time.
- You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask at the front desk and we will provide you with a copy.
- If you have any questions concerns or complaints about the Notice or your medical information, please contact our office at (360) 573-2273.

Acknowledgement of Receipt of Notice of Privacy Practices
(To be filed in patient's health records)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

( ) I choose to restrict all persons other than myself access to my medical records and/or billing information.

( ) I choose to authorize the following individuals(s) to have access to my medical records and/or call on behalf of my billing information, please list them below:

Spouse _____

Other _____ Relationship _____

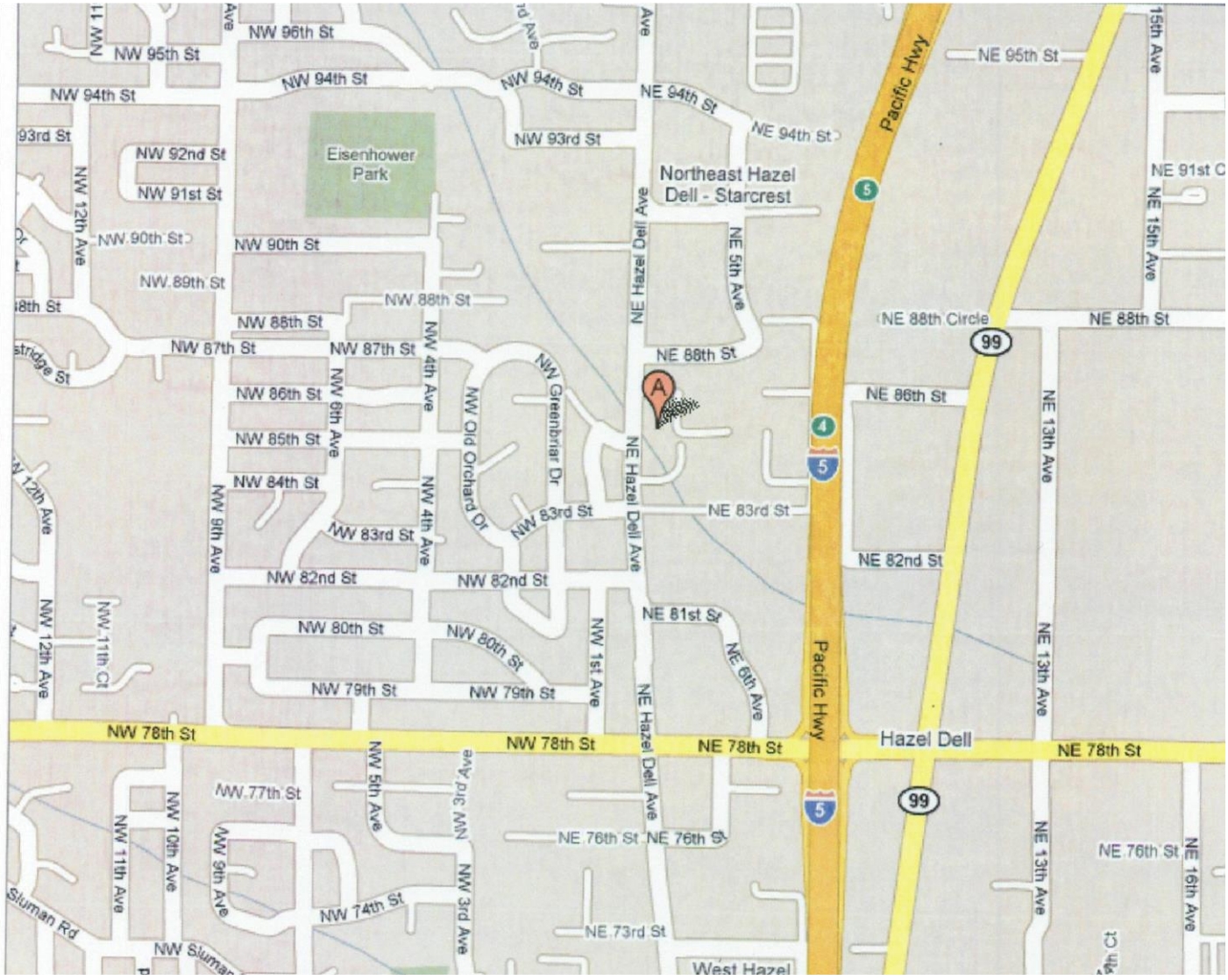
Your signature _____ Date _____

Relationship (if not signed by patient) _____

Address: 8513 NE Hazel Dell Ave, Suite #203

If you are travelling south on I-5 take the 99th Street exit. Turn right onto 99th Street. Turn left at the next major intersection, Hazel Dell Ave. Drive past the Target store on the left. Shortly after the Target store you will see a tan building with a black roof on the left side of the road. Pull into the drive way of Oak Place Professional Offices. We are located in the back building on the second floor, Suite 203.

If you are travelling north on I-5 take the 78th street exit. Turn left onto 78th Street. Turn right at the next major intersection, Hazel Dell Ave. Drive past the Safeway in the JM Plaza on the right. Our driveway is shortly past the white insurance house that you will see on the right side. Turn right into the Oak Place Professional Offices. We are the back building, upstairs in Suite 203.



A Natural Choice
8513 NE Hazel Dell Ave, Suite #203, Vancouver, WA 98665
360-573-2273
www.anaturalchoice.org