Ross Avenue Wellness Center

WOMEN'S HEALTH INTAKE FORM

PATIENT INFORMATION

Name:		Date:
Date of Birth:	Age:	Gender: Female Male
Address:		
City, State, Zip:		
Phone 1: May we leave messages at this number? Yes No	Phone 2: May we leave messages at this number? Yes No	
Email: May we email you information about our office? Yes No		
May we add you to our online supplement dispensary list? ☐ Yes ☐ No		
Emergency Contact (name and phone): Relationship to you:		
Who is your current Primary Care Doctor? What is the name and number of their clinic?		
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When were you last seen by a medical professional and for what condition?		
How did you find our office?		

WHAT ARE YOUR CURRENT HEALTH CONCERNS? PLEASE LIST IN ORDER OF IMPORTANCE.

1.
2.
3.
4.
5.
6X

PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE INTERESTED IN:

Food Allergy Testing	Hormone Testing	Heavy Metal Testing
Nutritional Testing	Fertility Testing	Wellness Screening
Testing for Depression	Complete Cardiovascular Panel	Gynecologic & Breast Exam
Anxiety or Mental Health	Anti-aging/Preventive Medicine Testing	Digestive Analysis

MEDICAL AND FAMILY HISTORY

Please list your current and past diagnoses (if any):
Please list past hospitalizations and surgical procedures (include date and hospital):
Have you been fully vaccinated? ☐ Yes ☐ No ☐ Unsure
List any known allergies to medications, foods or other substances as well as your reaction:
Have you traveled outside the United States in the past two years? ☐ Yes ☐ No. If yes, where?

MEDICATIONS AND SUPPLEMENTS

List all current medications, vitamins, herbs and other supplements you take, including dosages.

Medications:	Vitamins, Herbs, Other Supplements:

FAMILY HISTORY

List any serious health conditions your family members have experienced. Include diabetes, heart disease, autoimmune disease, cancer, additions, eating disorders, mental disorders, allergies, genetic disorder or any other major concerns.

Condition:	Family Member:	Age of onset/age of death:

SOCIAL HISTORY AND LIFESTYLE

Please list all persons and pets currently living with you:				
HABITS	**Yes**	**No**	**Details**	
Current tobacco use	☐	☐	Packs per day:	
Past tobacco use	☐	☐	Packs per day:	When did you quit?
Alcohol consumption	☐	☐	How often? Types:	
Recreational drug use	☐	☐	Types:	
Exposure to toxic chemicals, solvents, other harmful toxins	☐	☐	If yes, please explain:	
Caffeine use (circle all): Coffee, tea, soda, energy drinks	☐	☐	Cups per day?	
Regular exercise	☐	☐	How often? Activities:	
STRESS				
Current stress level: ☐ Low ☐ Medium ☐ High Source of stress: ☐ Job ☐ Financial ☐ Family/Relationship ☐ Other				
SLEEP				
Problems falling asleep?	☐	☐	What keeps you awake?	
Problems staying asleep?	☐	☐		
Do you wake feeling refreshed?	☐	☐		
Do you snore or have sleep apnea?	☐	☐		
NUTRITION				
Do you follow a particular diet?			Are there foods that you avoid eating? Why?	
How many meals do you typically eat in a day?			Where do you buy food? Who cooks the food you eat?	
Describe your typical breakfast: Lunch: Dinner: Snacks& Sweets: Drinks:				
Are you thirsty?	☐	☐	How much water do you drink a day:	
Mark any of the following that you consume regularly: ☐ Highly seasoned foods ☐ Processed foods ☐ Soda ☐ Candy				
List foods you crave:			List foods to which you have a reaction:	
Are you satisfied with your diet?	☐	☐	If no, why not?	

FEMALE HEALTH INFORMATION

DO HAVE A HISTORY OF ANY OF THE FOLLOWING:	Yes	No		Yes	No
Pelvic Inflammatory Disease	☐	☐	Fibroids	☐	☐
Chronic yeast or vaginal discharge	☐	☐	Urinary tract infections	☐	☐
Loss of bladder control	☐	☐	Breast cancer or benign tumors	☐	☐
Blood in urine	☐	☐	Painful urination	☐	☐
Chronic vaginal itching or burning	☐	☐	History or current STD If yes, which ones?	☐	☐

MENSTRUAL HISTORY

Date of last period:			Age at first period:
Did you have a normal puberty?	☐	☐	If no, why?
Are your periods currently regular?	☐	☐	Days between periods: Length of flow: Days of heavy bleeding: light: spotting:
Date of last PAP:			Date of last breast exam:
Were the results normal?	☐	☐	Date of last mammogram:
History of abnormal PAPs?	☐	☐	Abnormal findings:
Have you had your bone density checked?	☐	☐	If yes, when? Results:

MENSTRUATING WOMEN: Please mark any of the following symptoms you experience before (B), during (D) or after (A) your menstrual cycle. If you do not have a cycle, please mark symptoms you are currently experiencing.

B	D	A	Symptom	B	D	A	Symptom	B	D	A	Symptom	B	D	A	Symptom
☐	☐	☐	Cramping or pain	☐	☐	☐	Headache	☐	☐	☐	Bloating	☐	☐	☐	Weight gain
☐	☐	☐	Constipation	☐	☐	☐	Breast tenderness	☐	☐	☐	Increased appetite	☐	☐	☐	Sweet cravings
☐	☐	☐	Depression	☐	☐	☐	Nervous tension	☐	☐	☐	Irritability	☐	☐	☐	Mood changes
☐	☐	☐	Forgetfulness	☐	☐	☐	Anxiety	☐	☐	☐	Confusion	☐	☐	☐	Crying
☐	☐	☐	Heart pounding	☐	☐	☐	Insomnia	☐	☐	☐	Fatigue	☐	☐	☐	Insomnia

Mother's age at menopause: Sister(s):	Mother's age if she has not yet begun menopause:

MENOPAUSAL WOMEN: If you are currently peri-menopausal or menopausal, do you experience any of the following symptoms? Please indicate yes (Y), no (N) or past (P).

Y	N	P	Symptom	Y	N	P	Symptom	Y	N	P	Symptom	Y	N	P	Symptom
☐	☐	☐	Hot flashes	☐	☐	☐	Insomnia	☐	☐	☐	Vaginal dryness	☐	☐	☐	Memory loss
☐	☐	☐	Fatigue	☐	☐	☐	Decreased libido	☐	☐	☐	Weight gain	☐	☐	☐	Mood changes

OBSTETRIC HISTORY

Are you currently pregnant?		☐	☐	
Are you trying to conceive?		☐	☐	
Have you had problems with infertility?		☐	☐	If yes, please explain:
Any pregnancy complications?		☐	☐	If yes, please explain:
# of pregnancies:	Births:			Miscarriages: Abortions:
Are you currently breast feeding?		☐	☐	If yes, how often:

SEXUAL HEALTH	Yes	No		Yes	No
Are you currently sexually active?	☐	☐	If yes, current contraception?		
Have you ever used birth control pills?	☐	☐	If yes, how long?		
Have you ever used and IUD?	☐	☐	If yes, how long and what kind?		
Are you content with your libido/sex life?	☐	☐	Any vaginal dryness or painful intercourse?	☐	☐
GASTROINTESTINAL HEALTH					
Number of bowel movements per day:			Is your stool loose or formed?		
Do you tend to constipation or diarrhea?			Stool have an unusual color or odor? If yes, explain:	☐	☐
Recent changes in bowel habits?	☐	☐	Any blood or mucous in stool?	☐	☐
Recent changes in appetite?	☐	☐	Any abdominal pain or upset stomach?	☐	☐
Any excessive gas or bloating?	☐	☐	Any heartburn? Or Reflux?	☐	☐
Any loss of bowel control?	☐	☐	Any nausea or vomiting?	☐	☐
Do you have hemorrhoids?	☐	☐	Have you had a colonoscopy? When?	☐	☐
Have you been diagnosed with IBS?	☐	☐	Do you have Inflammatory Bowel Disease?	☐	☐
WEIGHT HISTORY					
Are you content with your current weight?	☐	☐	If no, what is your ideal weight?		
Does your weight fluctuate?	☐	☐	If yes, give highs and lows:		
Any family history of weight problems?	☐	☐	If yes, who?		
What factors do you feel contribute to your changes in weight if any (nutrition, exercise, hormones, etc.)?					
EARS, EYES, NOSE AND THROAT					
Please indicate current(C) or past(P) symptoms	C	P		C	P
Loss of consciousness	☐	☐	Vertigo or dizziness	☐	☐
Loss of hearing	☐	☐	Ringing or buzzing in ears	☐	☐
Sinus problems	☐	☐	Loss of smell	☐	☐
Chronic congestion or nasal discharge	☐	☐	Ear infections	☐	☐
Frequent sore throats	☐	☐	Difficulty swallowing	☐	☐
Eye glasses or contacts	☐	☐	Loss of vision	☐	☐
Excessive tearing or dry eyes	☐	☐	Double or blurred vision	☐	☐
Light sensitivity	☐	☐	Sores in mouth, lips or gums	☐	☐
Tooth pain	☐	☐	Mercury fillings	☐	☐
RESPIRATORY HEALTH					
Chronic cough	☐	☐	Difficulty breathing	☐	☐
Bronchitis	☐	☐	Asthma or Emphysema	☐	☐
Tuberculosis or pneumonia	☐	☐	Date of last chest x-ray:		

CARDIOVASCULAR HEALTH					
Please indicate current(C) or past(P) symptoms	C	P		C	P
Chest pain	☐	☐	Heart palpitations	☐	☐
Heart murmur	☐	☐	Cold extremities	☐	☐
High or low blood pressure	☐	☐	Angina	☐	☐
Heart attack	☐	☐	Date of last ECG / EKG:		
MENTAL EMOTIONAL HEALTH					
Tension	☐	☐	Nervousness	☐	☐
Anxiety	☐	☐	Irritability	☐	☐
Depression	☐	☐	Inability to concentrate	☐	☐
Chronic procrastination	☐	☐	Eating disorder	☐	☐
ENDOCRINE HEALTH					
Fatigue	☐	☐	Heat or cold intolerance	☐	☐
Excessive hunger or thirst	☐	☐	Fever or excessive sweating	☐	☐
Hypoglycemia	☐	☐	Diabetes	☐	☐
Adrenal Fatigue	☐	☐	Thyroid conditions	☐	☐
Autoimmune disorder	☐	☐	Please Explain:		
MUSCULOSKELETAL HEALTH					
Chronic Headaches	☐	☐	If yes, how often?		
Numbness or tingling	☐	☐	If yes, where?		
Metal implants	☐	☐	If yes, where		

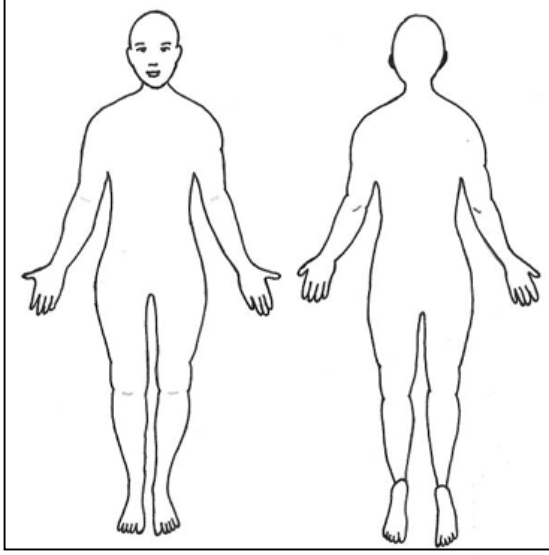
The above information is true to the best of my knowledge.
X_____ Date:_____
Signature of Patient or Person Legally Responsible

If you are interested in a **focused initial consultation only** and you would not like to discuss your health history, please complete the following:

I_____ understand that Dr. Kimberly Brown will not assess or address any extensive health issues. I am here solely on an acute care or informational visit. The doctor will not be responsible for anything we have not discussed. I understand I will need to make additional appointments to address any other health concerns.

X_____ Date:_____
Signature of Patient or Person Legally Responsible

Please use an X to indicate all areas you are experiencing pain or swelling:



Informed Consent & Office Policies

Dr. Kimberly Brown's commitment is to serve her patients with professionalism and genuine concern, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving you it may be necessary to share pertinent information with other Health Care Providers or Associates for the purpose of ordering laboratory tests, determination of fees, collection of fees, scheduling of your appointments or to obtain a second opinion. If any other uses or disclosures other than the ones listed above are needed, information will be released only with your written consent, as provided for by law.

All health and laboratory information will be given at scheduled office or phone appointments. Please be aware when scheduling phone appointments our normal fee's for service apply. If you need your labs and are unable to make an appointment we will fax them to another doctor, but will not send them to you directly unless you have already discussed them with the doctor.

Please be aware that Health and Safety Code section 109250, et seq., specifically prohibits the use of any unconventional remedy in the diagnosis, treatment, alleviation, or cure of cancer. If you have been diagnosed with cancer, we will be unable to treat you for this diagnosis.

Not all insurance policies will cover our services. We ask that you send us your insurance information before your visit as we can check your benefits. Labs, supplements, medical devices and prescriptions are not included fee's and maybe billed by other parties. It is your responsibility to make payment arrangements with them. All payment is expected at the time of service unless other arrangements have been agreed upon. Debit Cards, MasterCard, VISA, cash, and checks are acceptable forms of payment.

Please be advised that if for any reason you cannot keep your scheduled procedure or appointment, we require that you cancel at least 48 hours prior to your appointment. Failure to cancel within that time frame or failure to show up for the appointment will result in a fee of 50% of your appointment cost, which will be applied to your next appointment. This fee may change without notice.

Thank you for your cooperation. We look forward to assisting you on your path to wellness.

Sincerely,

Kimberly Brown ND, LAc

I have read and understand this form.

Signed: _____

Print Name: _____Date:_____

Informed Consent to Naturopathic Treatment and Care

I have had an opportunity to discuss the nature and purpose for naturopathic care and its procedures with the Doctor of Naturopathic Medicine named below and/or other office or clinic personnel.

I hereby request and consent to Naturopathic Medicine as an alternative treatment for my health conditions (or for those of the patient named below, for whom I am legally responsible) as performed by the Doctor of Naturopathic Medicine named below and/or other licensed Doctors of Naturopathic Medicine who may now, or in the future, treat me while employed by, working or associated with, serving as back-up for the Doctor of Naturopathic Medicine named below, whether they work at the clinic or office listed below or any other office or clinic. Treatments may include- but are not limited to- herbal medicine, homeopathic medicine, life style and nutritional counseling, naturopathic manual therapy, physical therapy, injection therapy, and hormone replacement.

I have been informed that in the practice of medicine there are some risks to treatment, including -- but not limited to -- side effects of medication, allergic reactions, and anaphylaxis. I do not expect the Doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely on the Doctor's judgment based upon the facts then known, to provide me with any care and procedures considered to be in course of my treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by it I agree to the procedures mentioned above. I indent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:
the

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by patient'srepresentative, if necessary, e.g. if patient is a minor or physically or legally incapacitate.

_____
Print Patient's Name

_____
Print Name of Patients Representative

_____
Signature of Patients Representative

(Include Relationship or Authority of Representative.)

_____
Date Signed

Name of Doctor treating this patient: **Dr. Kimberly Brown**

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: Kimberly Brown, Charmian Traynor

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

Dr. Kimberly Brown

Effective Date:_____

Acknowledgment of Privacy Policies

Dr. Kimberly Brown is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must 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 supporting your treatment.
We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.
You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or 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. The Effective Date at the top right-hand side of this page indicates the date of the most current NOTICE in effect.

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 Dr. Kimberly Brown at 408-357-3422. You may also send a written complaint to the US Department of Health and Human Services.

_____ _____

Patient Signature Date

_____

Printed Name