ALLEN NATURAL MEDICINE

NEW PATIENT PACKET

- welcome to our clinic -

FIRST VISIT CHECKLIST

Completed Intake Form

Please bring the completed intake forms with you to your appointment. If you would like to send us your forms *before the day of your appointment*, you may scan and email them to: MonikaAllenND@gmail.com

Bring Lab and Imaging Reports

If you have notes or reports from previous doctors visits that you feel might help us in treating you, please bring them to your first appointment.

List of Current Medications/Supplements

This includes over-the-counter and prescription medication, herbs, vitamins, supplements & homeopathics.

Plan to Arrive on Time for Your Appointment

There is complimentary tea available in our reception area.
Payment is expected at the Time of Service Cash, check, Mastercard, Visa and Discover are all accepted. We do not bill insurance.

ALLEN NATURAL MEDICINE

Teen Health Intake (ages 13 – 17)

Patient Information

Date: _____

LEGAL Name:_____ Nickname: _____

Date of Birth:_____ Gender:_____ Year/Grade in school:_____

Parent/Guardian's Name: _____

Physical Address:_____
apt/unit

City:_____ State:_____ Zip:_____

Phone: (home):_____ (mobile):_____ (work):_____

*Please **circle number**(s) where we may leave messages*

Name of Clinic where your health records are kept: _____

Has another family member been a patient at our clinic? []No [] Yes, if yes who? _____

Reason for your visit today: _____

Emergency Contact

Contact Name:_____ **Relationship:**_____

Phone (home):_____ **(mobile):**_____ **(other):**_____

Our clinic will verify this contact information whenever you come in for an appointment. However, if your circumstances change, it is your responsibility to give us your new contact information.

Signature_____ **Date** _____

Teen Health Intake Context of Care Review

Successful *health care* and *preventive medicine* are only possible when the physician has a complete understanding of the patient, physically, mentally, and emotionally. The nature of your responses to the following questions, as well as your thoughtfulness and honesty, will go a long way toward improving our understanding of you and will greatly aid us in addressing your health needs.

What three expectations do you have from your visit to this clinic?

1)

2)

3)

Are you currently receiving healthcare? [] No []Yes

If yes, where and from whom? _____

If no, when and where did you last receive health care? _____

What was the reason? _____

What are your most important health problems? List in order of importance.

1)

2)

3)

PERSONAL MEDICAL HISTORY:

Childhood Illnesses: please *circle* any that apply, **now** or in the **past**:

Mononucleosis	Rubella	Mumps	Measles
Diphtheria	Chicken Pox	Pertussis	Tuberculosis
Typhoid Fever	Scarlet Fever	Strep Throat	

Ear Infections []No []Yes Approximate number of times:_____

Tonsillitis []No []Yes Approximate number of times:_____

Number of colds each year: _____

Number of flu each year: _____

Other Recurrent, Chronic, or Severe Illness(es): _____

_____

PERSONAL MEDICAL HISTORY Cont.:

Major Surgery / Operations (& Year): _____

_____

Major Accidents or Falls: _____

Hospitalizations (Other than above):_____

Exposure to toxic chemicals, pesticides, paints, lead, mercury? If **yes**, what type & when: _____

_____

Any history of psychological trauma? [] No [] Yes, Age: _____ Explain: _____

FAMILY MEDICAL HISTORY: Indicate any *known* health conditions; and *age at death* if applicable.

Mother:_____

Father:_____

Maternal Grandparents:_____

Paternal Grandparents:_____

Siblings:_____

Other blood relatives w/ significant illnesses:_____

REVIEW OF SYSTEMS: *Please check (X) if any of the following has **occurred within the last 2 months.***

CONSTITUTIONAL [] Weight Loss [] Weight Gain [] Fever	RESPIRATORY [] Wheezing [] Shortness of breath	SKIN [] Rashes [] Itching
EYES [] Changes in Vision [] Impaired Vision	GASTROINTESTINAL [] Nausea [] Vomiting [] Constipation [] Abdominal pain [] Bloody/Black stool [] Loss of bowel control	HEMATOLOGIC [] Bruises, frequent or easily [] Cuts do not stop bleeding
HENT [] Headaches [] Dizziness [] Thyroid problems		NEUROLOGICAL [] Memory difficulties [] Seizures [] Loss of Balance [] Lightheadedness or Faintness
CARDIOVASCULAR [] Chest pain [] Irregular Heartbeat [] Rapid Heart Rate [] Fainting [] Swelling of Legs [] Other	GENITOURINARY [] Urgency of urination [] Inability to urinate [] Leakage of urine [] Impotence [] **Possibly Pregnant**	PSYCHIATRIC [] Anxiety [] Depression [] Physical Abuse [] Sexual Abuse
Please elaborate on the condition/s you have marked above, and/or include other pertinent conditions that are not listed:		

MEDICATIONS and SUPPLEMENTS that you are CURRENTLY TAKING

[] Refer to the list I have provided *Please continue list on the back if you should need more room*

DRUG NAME	DOSAGE	PHYSICIAN or SELF

ALLERGIES to MEDICATIONS or SUBSTANCES *(Latex, Tape, Novocain, etc.)*

DRUG or SUBSTANCE	REACTION	DATE

Do you have **food allergies** or **environmental sensitivities?** [] No [] Yes, If **yes**, list allergy & reaction:

_____

Do you use tobacco? [] No [] Yes #/Packs per day:_____ Number of years: _____

Do you drink alcohol? [] No [] Yes Drinks per day:_____ Drinks per week: _____

DIET

Do you consume caffeine? [] No [] Yes Do you consume soda/pop? [] No [] Yes

Do you follow a specific diet? []**No** [] **Yes** *(If **yes**, please circle)* Vegetarian Vegan Paleolithic Anti-inflammatory Blood-type Atkins Low-fat/low cal Gluten-free Dairy-free Other:_____

What do you typically eat for Breakfast? _____

What do you typically eat for Dinner? _____

EXERCISE

What form of exercise:_____ Duration:_____ # of Days per week:_____
mins/hrs

HOBBIES

How do you enjoy your free time?:_____

STRESS

On a scale of 1 – 10 (1 = none, 10 = extreme) please describe your psychological/emotional stress levels:

School:_____ Personal:_____

Having been explained the risk of treatment, I do hereby request and consent to the performance of wellness care and related procedures upon the above-named patient (my dependent or myself). I wish to rely on the doctor to exercise judgment for my best interest during the course of treatment. I will inform the doctor who is treating me of sensitive areas or adverse conditions I may have prior to, during, or after treatment. I intend this consent to cover the entire course of this treatment.

We thank you for your patience, cooperation and thoroughness in completing this form.

Patient's Signature:_____ Date: _____

Parent/Guardian's Signature:_____ Date: _____

Please initial in the spaces provided after reading the following:

CONSENT TO TREAT

_____ I give permission to all health care providers involved in my care to administer such examination, treatment, testing and procedures as they deem necessary in the course of my care.

RELEASE OF INFORMATION

_____ I understand that as part of my health care, health care providers create and maintain health records that may include my health history, symptoms, examination and test results, diagnoses, treatment and any plan for care including future treatment. I understand that this information serves as a basis for planning my treatment and care and is a tool for routine health care operations including assessing quality and reviewing competency of our staff and/or other health care providers.

FINANCIAL RESPONSIBILITY

_____ I agree to pay all charges for my health care treatment. Payment for all services and medicinary items is due at the time of the visit. If charges to my account are not paid after reasonable notice, the account shall be deemed delinquent. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default. The doctors at The Clinic are not contracted providers with *any* insurance plans. If your plan has coverage for out-of-network naturopathic care we will provide you with the appropriate paperwork and coding to submit your own insurance claim.

APPOINTMENT CANCELLATION POLICY

_____There is no charge if your appointment is cancelled 24 hours in advance of your scheduled appointment time. Please remember that appointment times are set aside for you. If you are unable to keep your appointment, kindly let the clinic know so that someone else may use this time. ***Appointments missed or cancelled without 24-hour notification will be charged a Missed Appointment Fee.***

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT - HIPPA

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for use and disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request or refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

Patient's Representative(s): (the following must be filled out)

* I hereby authorize the following individuals to have access to my healthcare information:

_____, Relationship to Patient _____

_____, Relationship to Patient _____

TERM

This consent will be in effect for one year from the date signed.

Printed Name of Patient _____ Birth Date _____

Patient/Responsible Party's Signature _____

Responsible Party's Relationship to Patient _____ Date _____

Witness _____ Date _____

*** If you would like a copy of this form, once signed, please ask the receptionist ***

Patient Compliance Assurance Notification

To our valued families and patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to insure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you, for being one of our highly valued patients!