

CONFIDENTIAL EVALUATION AND HEALTH HISTORY

Please bring in or mail copies of the following labs you may have had within the last year:

1. Complete Blood Count

2. Chem Screen (cholesterol, blood sugar, liver enzymes, electrolytes, etc.)

GENERAL INFORMATION:

Date: _____

Name _____ M / F Age: _____ Birth Date: _____

Address (Include City/State/Zip): _____ Apt. _____

Phone: (h) _____ (w) _____ (cell) _____

Parent/Guardian: _____ Phone: _____

How did you hear about Prevention & Healing of Iowa?: Ad Another Patient Friend

Physician/Healthcare practitioner Books/Articles Class/Seminar Other

If you had a referral, who referred you? _____

What are your three main symptoms/concerns? 1. _____ Since When? _____

2. _____

3. _____

Are you open to: Herbs/Nutrition ____ Bodywork ____ Meditation ____ Exercise ____ Breathing Exercises ____

MEDICAL STATUS:

Primary Health Care Practitioner/Physician: _____ Phone: _____

Last time you saw your physician _____

Reason for your visit _____

Other Physicians Currently Seeing: _____

Dentist: _____ Phone: _____

General Health: Excellent Good Fair Poor Height: _____ Weight: _____ Blood Type: _____

Current Diagnosis or Medical Conditions: _____

Have you ever had a severe reaction from anything in your life? (This can be something you've eaten, medication you've taken, something in the environment, vaccines, an emotional reaction, etc.) Explain to what and the type of reaction.

Have you ever taken medication or received injections for longer than one month?

Have you ever had a reaction to anything which caused HIVES, FACE SWELLING, THROAT OR TONGUE SWELLING, DIFFICULTY BREATHING, OR FAINTING? (Explain to what and what type of reaction.)

Have you ever had your Thyroid tested: Y N Date: _____

TSH _____ Free T4 _____ Free T3 _____ Other _____

<i>Do you have allergies to:</i>	<i>Explain:</i>
Foods	
Pollens	
Medications	
Animals/Insects	
Other	

Current Medication/s:	Dosage	Reason
Current Vitamins or OTC products (please list ALL products)	Dosage	Reason
Other Supplements, etc.	Dosage	Reason

CURRENT AND PAST MEDICAL CONDITIONS:

Please check the ones that apply to you	Y	N	Date of Diagnosis	Please check the ones that apply to you	Y	N	Date of Diagnosis
Alcoholism				Gout			
Anemia				Heart Attack			
Asthma				Heart Disease			
Arthritis				Hepatitis (Jaundice)			
Autoimmune Disorder				HIV Positive			
Blood Diseases				High Blood Pressure			
Bleeding Problems				Hypoglycemia			
Broken Bones:				Irritable Bowel			
				Kidney Trouble			
				Liver Disease			
				Low Blood Pressure			
Cancer:				Malaria			
				Measles			
				Mononucleosis			
Car Accident/s with injury:				Mumps			
				Other Illness/Injuries (explain):			
Chemotherapy							
Chicken Pox							
Chronic Fatigue				Radiation			
Clotting Defects				Rheumatic Fever			
Colitis				Scarlet Fever			
Cysts/Tumors				Stitches for wound closure:			
Dental Issues							
Depression/Anxiety				Surgeries (explain & date):			
Diabetes							
Drug Addiction							
Eating Disorder							
Epilepsy				Thyroid Problems			
Exposed to Aids				Tuberculosis			
Fibromyalgia				Ulcer			
Gall Bladder Trouble				Whooping Cough			

Are vaccines up to date? _____

FAMILY HISTORY:

NAME AND AGE	IMPORTANT DISEASES, ALLERGIES, ILLNESSES, OR HOSPITALIZATION	LIVING	DECEASED (cause of death)
Mother			
Mother's Father			
Mother's Mother			
Father			
Father's Mother			
Father's Father			
Brothers			
Sisters			
Aunts			
Uncles			
Paternal Grandma			
Paternal Grandpa			
Maternal Grandma			
Maternal Grandpa			

HABITS:

Dietary Restrictions/Food Cravings/Intolerances: _____

Average Daily Meal Choices:

Breakfast: _____

Lunch: _____

Dinner: _____

Do you regularly skip meals: Y N _____

Do you get routine exercise: Y N What type: _____ How often: _____

Do you use tobacco products: Y N How Much: _____ How Long: _____

Do you use alcohol products: Y N How Much: _____ How Long: _____

Do you use caffeine products: Y N How Much: _____ How Long: _____

Do you have a history of substance abuse or use recreational drugs: Y N _____

Daily Water Intake: _____ Drink/bathe in well water? Y N

Do you crave or dislike any of the following:	Crave	Dislike		Crave	Dislike
Caffeine			Meats		
Carbohydrates			Salty		
Chocolate			Sour/Vinegar		
Coffee/Tea			Spicy/Hot Food		
Colas/Sodas			Sweets		
Dairy			Vegetables		

HEALTH QUESTIONNAIRE

(CHECK ALL THAT APPLY)

BODY TEMPERATURE	√	EMOTIONAL, continued	√	HEART	√
Hot Flashes		Mood Swings		Palpitations	
Hot most of the time		Depressed A Lot		Chest Pain	
Cold most of the time		Cry Often		Irregular Heartbeat	
Fevers		Worry A Lot		Heart Races	
Chills		Compulsive Behaviors		Heart Murmur	
		Phobias		Mitral Valve Prolapse	
CIRCULATION		Eating Disorders		Heart Attack	
Cold Hands		Nervous Breakdown		Pace Maker	
Cold Feet		Think About Suicide			
Numbness		Psychiatric Hospitalization		INTESTINAL/BOWEL	
Tingling		Counseling		Abdominal Cramping	
Dizziness				Bloating	
Light-Headed		ENERGY		Constipation	
Blackouts		Low		Diarrhea	
		Tire Easily		Loose Stools	
DIGESTION		Exhausted Easily		Urgency	
Stomach Pain		Chronic Fatigue		Strong Odor	
Acidity/Heartburn		Best Time of the Day:		Mucous	
Indigestion				Undigested Food	
Belching		Worst Time of the Day:		Blood	
Nausea/Vomiting				Burning/Itchy Rectum	
Poor Appetite		EYES		Regular (daily)	
Excessive Appetite		Pain		More than 2 times a day	
Ulcer		Red		Colitis	
Hiatal Hernia		Dry/Irritated		Irritable Bowel	
Anorexia		Watery		Cohn's Disease	
Bulimia		Swelling/Puffy		Diverticulitis	
Other:		Itchy		Hemorrhoids	
		Blurry Vision		Other:	
		Floaters			
EARS		Discharge		LUNGS	
Difficulty Hearing		Light Sensitive		Asthma	
Ringing in Ears		Other:		Emphysema	
Frequent Earaches				Difficulty Breathing	
Other:		GENITAL/SEXUAL		Shortness of Breath	
		Genital Infections		Chest Tightness	
		Sexual Dysfunction		Constant Cough	
EMOTIONAL		Infertility		Excessive Phlegm	
Angry Easily		Venereal Disease		Cough Up Blood	
Irritable		Herpes		Chronic Bronchitis	
Fearful Often		Excessive Sexual Desire		Frequent Colds	

Tense Often		Decreased Sexual Desire		Pneumonia	
LUNGS, continued	√	NEUROLOGICAL	√	PAIN, continued	√
Tuberculosis		Shaking/Trembling		Elbow	
Sinus Congestion		Seizures		Hand	
Post-Nasal Drip		Tics/Twitches		Bone	
Runny Nose		Double Vision		Burning	
Sneezing		Speech Difficulty		Neuralgia	
Hay Fever		Stroke		Moves Around	
Other:		Paralysis		Broken Bones	
		Loss of Muscle Function		Recent Injury	
MEN		Restless Leg Syndrome		Other Pain:	
Prostate Problems		Turrets Syndrome			
Testicular Swelling		Parkinson's Disease		PERIODS	
Testicular Pain		Other:		Regular	
Impotence				Irregular	
Premature Ejaculation		ORAL		Difficult	
		Sores in Mouth		Emotional	
MISCELLANEOUS		Bleeding Gums		Mood Swings	
Weak Knees		Bad Taste in Mouth		Depression	
Varicose Veins		Bad Breath		Weepy	
Broken Blood Vessels		Difficulty Tasting		Less Than 20 Day Cycle	
Bruise Easily		Difficulty Smelling		More Than 30 Day Cycle	
Hard to Stop Bleeding		Tooth Problems		Heavy Flow	
Nosebleeds				Light Flow	
Heal Slowly		PAIN		Flow Lasts More Than 5 Days	
Illness/Infection Often		Headache		Cramps	
Cysts/Tumors		Migraines		Bloating	
		Arthritis		Clotting	
Premature Graying		Joint Pain			
Hyperactive		Joint Swelling		PERSPIRATION	
Startle Easily		Joint Stiffness		Profuse	
Restless		Head		Hardly Ever	
Hard to Calm Down		Neck		Without Exertion	
		Upper Back		Night Sweats	
MUSCLES		Mid-Back		Cold Sweats	
Tense/Tight		Low Back			
Cramps,		Hip		SKIN	
Where:		Leg		Hives	
		Knee		Rashes	
Spasms,		Ankle		Boils	
Where:		Foot		Eczema	
		Heel		Psoriasis	
Weakness,		Shoulder		Itching	
Where:		Arm		Dry Skin	

SLEEP	√	URINATION	√	WOMEN	√
Hard to Fall Asleep		# of Times/Day:		Vaginal Itching	
Hard to Stay Awake		Too Frequent		Vaginal Discharge	
Hard to Go Back to Sleep		Decreased Volume		Chronic Yeast Infections	
Light		Excessive Volume		Cystic Breasts	
Restless		Pain or Burning		Endometriosis	
Night Owl		Hard to Start/Stop Flow		Uterine Fibroids	
Vivid Dreams		Bladder Control Problem		Breast Pain	
Disturbing Dreams		Urgency		Breast Swelling	
Nightmares		Cloudy Urine		Breast Lumps	
Hard to Wake in AM		Strong Smell		PMS	
		Blood in Urine		# of Pregnancies:	
		Urinary Tract Infection		# of Deliveries:	
		Kidney Infection		# of Miscarriages:	
		Kidney Disease		# of Abortions:	
THINKING					
Poor Memory		Frequent at Night		Pre-Menopause	
Forgetful		Retain Fluids		Menopausal	
Foggy-Headed		Swollen Ankles/Feet		Post-Menopause	
Poor Short-Term Memory		Swollen Hands		Birth Control Pills	
Poor Long-Term Memory		Swollen Face		Hormone Replacement Therapy	
Hard to Think Clearly		Other:		Hysterectomy	
Hard to Make Decisions					

Is there a history of trauma/abuse?: _____

Are there any family or relationship problems which are upsetting you? _____

Are there any work problems which are disturbing you? _____

Is there anything in your life which is difficult or disturbing to you which has not been mentioned so far? _____

What kind of things brings joy and happiness to your life? _____

Prevention & Healing of Iowa, L.L.C.
Office Policies and Procedures for Nurse Practitioners, Nurses

_____ **Initials**

Informed Consent

I, _____, have sought medical care at Prevention & Healing of Iowa (PHI). I do this of my own free will, because I believe that the functional, holistic approach to medicine that is practiced at PHI is more in keeping with my own philosophy of health and well-being.

The nurse practitioners (NPs) at PHI are board-certified, licensed in the State of Iowa, and will employ standard, orthodox drug therapy for medical management as well as refer you to physician specialists when indicated.

_____ **Initials**

Child Care

We ask that another adult come with parent(s) of children seen in our clinic. This allows us to provide optimal treatment and communication with the parent(s). The child's needs can be tended to by the other adult who may choose to take the child home as initial visits can be lengthy. There will be follow-up visits where it is not necessary to have the child/client along.

_____ **Initials**

Cancellation / Scheduling / Fee Structure / Telephone Policy

1. We must have this **signed/initialed** "Office Policies and Procedures for Nurse Practitioners, Nurses" form returned with your completed Health History form in order to schedule the initial visit.
2. **On average, 90 minute appointments are reserved for a new patient's initial two visits** with the nurse practitioners (NPs). See fee structure below. Depending on one's need, often NP visits necessitate one hour or more.
3. A 30 minute consult will be scheduled separately for the **initial nurse nutrition consult**.
4. You will receive a courtesy reminder phone call in advance of your appointment(s).

Therefore, **a cancellation on the day of your appointment is inconvenient to other patients waiting for an appointment and costly to us/the clinic.** If you need to cancel or reschedule, kindly do so **24 hours in advance** or you will be charged for that appointment.

There must be a VISA, Master Card, or Discover number on file. **If you do not use a credit/debit card, you will need to send a check for the initial consult fee along with this policy prior to reserving your first appointment.**

Name as it appears on credit card (print): _____

Credit Card #: _____

Type of credit card: VISA / Master Card / Discover/Debit

Date of Expiration: _____ **Card Verification Code (CVC2 Code)** _____

I agree to allow Prevention & Healing of Iowa to debit the above credit/debit card account the amount of the initial consult fee (\$350.00) in the event I do not show up for my prescheduled initial appointment and neglect to give 24 hours advance notice.

In addition, for existing clients, I agree to allow Prevention & Healing of Iowa to debit the above credit/debit card account **\$150.00** in the event I do not show up for my **prescheduled follow-up appointment(s) without giving 24 hour advance notice.**

Initials

Telephone Questions to the Practitioner

1. Since the practitioners are not in the office every day, it is possible you may not have a return call or voice mail response that same day.
2. Due to the volume of phone calls and each individual's differing degree of severity of health care needs, a reserved telephone appointment with the practitioners may be necessary at the rate below.
 - a. These telephone/email fees will be explained to you in advance of the phone consult and billed to your credit card account.

Initials

Fee Structure

Initial Consult with Carolyn Walker	60- 90 minutes with NP	\$350 (includes 30 minutes with RN nutrition consultant)
Follow Up Visits with Carolyn Walker (may include phone consults)	60minutes - 1 Hour (usual)	\$100 / 30 minutes, \$200 / hour
Nutrition Nurse (RN) Consultant --accepts checks/cash only	1 st 30 minutes Non-NP Consultation, extended or follow-up consults	No Charge when included in initial NP Consult fees \$50 / 30 minutes, \$100 / hour (minimum 1/2 hour)
Phone Consult / Email Time (CRW)	\$3.00 / minute	Depends on # of minutes
Correspondence / Letters to Insurance	\$25 per each 15 minutes	Depends on # of minutes
Copying	.25 per sheet	Depends on # of copies

Initials

Payment/Reimbursement of Services

Although Prevention & Healing of Iowa's NPs do not contract with health insurance carriers, we do provide the following to assist you in filing for reimbursement with your particular carrier:

1. A statement itemizing payment of services.
2. A medical claim form delineating services provided, by whom, with diagnostic and procedure codes.
3. A cover letter directing your insurance provider to direct reimbursement to you.
4. Should your insurance ultimately deny reimbursing your for our services, you may be able to submit medical expenses through an employer-sponsored flex spending plan.

I agree with the above informed consent, child care, cancellation / scheduling / fee structure / telephone / payment / reimbursement of services / email / copying policy.

Please Sign Here: _____ **Date:** _____

<u>OFFICE USE ONLY:</u>	
Date Received:	<input type="checkbox"/> HIPPA
Appt. Date: _____ Time: _____	<input type="checkbox"/> Vital Info. Form
	<input type="checkbox"/> Health History Form