HEART & SOUL NATUROPATHIC
Joanna Dove, N.D., L. Ac.

Name: _____ Male/Female ____ Age: _____ Date of Birth: _____

SS# _____ Marital Status _____ Email Address: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: Home: (_____)_____-_____ Work: (___)_____-_____ Cell: (____)_____-_____

Occupation: _____ Employer: _____ OK to Call work?_____

Who referred you to us? _____

Name of your M.D._____ Phone: (__)____-_____

In an emergency notify: _____ Relationship: _____ Phone: ( )____-_____

Main problem you would like us to help you with: _____
_____
_____
How long ago did this problem begin: _____
Have you been given a diagnosis for this problem? If so, what?_____
What kinds of treatment(s) have you tried?_____
Have they helped alleviate the condition/problem? _____
Are you currently receiving treatment for your problem? _____ If so, please describe: _____
_____

PAST MEDICAL HISTORY:

Illnesses: _____
_____
_____
Surgeries: _____
_____
Significant Trauma: (i.e. motor vehicle accidents, falls, etc.): _____
_____
_____
Do you have or have you ever had, any infectious disease? _____ If so, please describe: _____
_____

Medicines: Include Prescription, over the counter drugs, vitamins, herbs, etc. taken within last 3 months:
_____
_____
_____

Average or typical Blood Pressure *(if known)*: _____ Pulse Rate: _____

FAMILY MEDICAL HISTORY (General Health) **Patient Name:_____**

Mother's (health): _____ Father's (health): _____
Sibling's (health): _____

Personal birth history (prolonged labor, forceps, cesarean, etc.) _____
Childhood health: _____ Location of upbringing: _____

Current emotional health: _____ Current quality of life: _____
Current relationship quality: _____ Current predominant emotion?_____
Stress level: _____ Have you had any unusual stresses recently (describe)? _____

Favorite time of year: _____ Worst time of year: _____
Hobbies and recreational habits: _____
Do you have a regular exercise program (describe)?_____

Have you traveled abroad in the past year (where, any illnesses)? _____

Please rank (scale of 1 to 10): Pain: ___ Fatigue: ___ Wellbeing: ___ Overall Energy: ___

Sleep:
What hours do you sleep? _____ Do you feel rested? ____ Do you have trouble falling asleep? ____
Do you have trouble staying asleep? ___ If so, what time do you awaken at night? _____

Diet: Please provide Diet Diary

PERSONAL MEDICAL HISTORY

Please check if you have ever had any of the following:

__Cancer	__Seizures	__Diabetes	__Heart Disease
__Hepatitis	__Rheumatic Fever	__Herpes	__Stroke
__HIV (AIDS)	__Weight problem	__Venereal disease	__High Blood Pressure
__Allergies	__Tuberculosis	__Addictive disorder	__Other Major Illness
__Asthma (yes / no)	__ Thyroid disease	__Mental Illness	_____
**use Inhaler?* __	__ Mononucleosis		

Please check if you have experienced any of the following in the last 3 months:

General:

__Poor appetite	__Localized weakness	__Peculiar taste/smell	__Sweat easily	__ Warm @ Night
__Fevers	__Insomnia	__Bleeding	__Change in Appetite	__ Bruising easily
__Fatigue	__Strong thirst	__Weight loss	__Night Sweats	
__Tremors	__Poor balance	__Weight gain	__Depression	
__Cravings	__Chills	__Joint pain	__Emotional changes	
__Headaches	__Sudden energy drop	__Hearing loss	__Day time flashes of Heat	

Skin & Hair:

__Rashes	__Itching	__Change in skin texture	__Ulcers	__ Nails Split
__Eczema	__Hair loss	__Dandruff	__Acne	__ Nail White Marks
__Recent moles	__Change in hair texture	__Hives	__Psoriasis	

Patient Name: _____

EENT + Head

__Dizziness __Eye Pain __Earaches __Migraine __Recurrent Sore
__Ringing in Ears __Glasses __Glaucoma __Eye Strain __Throat
__Gum problems __Sinus problems __Poor Vision __Grinding of Teeth __Sores on Lips
__Night Blindness __Headaches __Cataracts __Floaters __Mouth Ulcers
__Facial Pain __Blurred Vision __Concussions __Nose Bleeds __Toothache
__Color Blindness __Jaw Click __Poor Hearing __Spots in front of Eyes
__Silver Fillings __Dental Implants __Root Canals

Respiratory:

__Cough __Coughing Blood __Phlegm __Shortness of Breath __Painful Breathing
__Wheezing __Bronchitis __Asthma __Easily Winded

Cardiovascular:

__Blood Clots __Fainting __Cold Hands __Low Blood Pressure
__Phlebitis __Dizziness __Swelling of Hands __Shortness of Breath
__Chest Pain __Swelling of Feet __Irregular Heartbeat __Difficulty Breathing
__Cold Sweats __Cold Feet __High Blood Pressure __ Palpitations

Gastrointestinal:

__Nausea __Bloating __Blood in Stools __Abdominal Pain
__Belching __Constipation __Black Stools __Vomiting
__Diarrhea __Hemorrhoids __Bad Breath __Gastric Ulcers
__Indigestion __Parasites __Intestinal Gas How often do you have a BM? #___/day

Genito-Urinary:

__Painful Urination __Urgent Urination __Scanty Urination __Frequent Urination
__Blood in Urine __Impotence __Unable to Hold Night Urination: #____
__Genital Sores __Kidney Stones __Discolored Urine How often do you Urinate? #___/ day

Gynecology & Pregnancy *(females only):*

__Irregular period Duration of Flow _____ # of Pregnancies __ __Difficult Births
__Clots Date of last Menses _____ # of Births ___ __Fertility problems
__Light Flow Age of 1st Menses _____ # of Miscarriages __ __Breast Lumps
__Heavy Flow ___ Breast Tenderness # of Abortions __ __Vaginal Discharge
__PMS ___ Painful Periods # Premature Births__ __Vaginal Sores
__ Birth Control Pill
*if yes # __ yrs

Neuro-Psychological:

__Seizures __Areas of Numbness __Concussion __Loss of Balance
__Dizziness __Lack of Coordination __Depression __Mood Swings
__Stress __Poor Memory __Anxiety __Irritability
__Disorientation __Migraines __Easily Angered

Musculo-Skeletal:

__Neck Pain __Back Pain __Joint Pain __Muscle Spasms
__Scoliosis __Shoulder Pain __Knee Pain __Muscle Cramping
__Hip Pain __Arthritis __Muscle Weakness __Muscle Soreness
__Recent Sprains __Weak Joints __Foot/Ankle Pain Injury/Scar Site(s) _____
_____

Patient Name: _____

TEST HISTORY

Blood Tests:

When was your last Full Blood Test? _____ Who ordered this Test? _____
*please provide a copy of the test

Were there any problem areas? _____

Urine Tests:

When was your last Urine Test? _____ Results:_____

Procedures:

Have you ever had a Colonoscopy? ____ When? _____ Results: _____

Have you had a chest X ray? ____ When? _____ Results: _____

Other Procedures (ex. Endosopy, Biopsy) _____

Allergy Test:

Have you had any Allergy Testing? _____ When _____ What Type of Test? _____

What are you allergic to? (please list)

Medications:	Airborne:	Food Allergies:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Allergies: _____
_____

Female Test:

Date of last PAP Exam: _____ Results: _____

Male Test:

Date of last Prostate Exam: _____ Results: _____

Any other problems you would like us to be aware of? _____
_____
_____
_____

THANK YOU!

HEART & SOUL NATUROPATHIC INC.
910 E. LYNDALE AVENUE
HELENA, MT 59601

Informed Consent to Health Care

I hereby request and consent to the performance of the following diagnostic techniques and treatment modalities of Naturopathic and Traditional Chinese Medicine on me (or on the patient named below, for whom I am legally responsible): acupuncture and other oriental medical procedures: injection and IV therapy; pulse evaluation; manual palpation on a variety of areas on my body; muscle, orthopedic and neurologic testing; modes of physical therapy such as massage, hot/cold therapy; electrical or magnetic stimulation; blood draws or finger sticks as needed for laboratory testing; prescriptions of herbal, homeopathic and naturopathic formulary medicines; dietary supplements and food plans; exercise regimens and lifestyle counselling.

I have had the opportunity to discuss the nature and purpose of Naturopathic and Traditional Chinese Medicine medical procedures with Heart and Soul Naturopathic. I understand that, although these procedures have helped millions of people, no guarantee of cure or improvement in my condition is given or implied. I now know that these modalities are self-empowering and it is up to me to help improve my health by following the directions and recommendations that I have been given.

I understand and am informed that, as in the practice of conventional medicine, in the practice of Naturopathic and Traditional Chinese Medicine, there are some risks to treatment. I understand that, while unlikely, possible risks include but are not limited to: bleeding, bruising, puncture pain or other strong sensations at the location of needle insertion, nerve pain, burns, aggravation of symptoms and appearance of new symptoms. I do not expect the naturopathic physician to be able to anticipate and explain all risks and complications and during the course of treatment, I wish to rely on the practitioner's judgement based on the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend for 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.

Patient: Patient's Representative:

(Print)_____ (Print)_____
Name Name & Relationship

_____ _____
Signature Signature

Date _____ Date _____

Heart & Soul Naturopathic Inc.
910 East Lyndale Avenue Suite C
Helena, MT 59601 406-442-2928

Notices of Privacy Practices Acknowledgement & Patient Consent Form

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 patients 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 Name (please print) _____ DOB _____

Patient Signature _____ Date _____

Patient Compliance Assurance Notification

To Our Valued Families and Patients:

The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees 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 problems of improper disclosure of PHI.

We also know that we are not perfect! Because of this fact, our intent is to listen to our employees and our patients 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!