Demographic Patient Information

Patient Name: _____ **Date:** _____

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

Age: _____ Birth date: _____ Gender: ☐ female ☐ male ☐ Other Social Security #: _____

City/State of birth: _____

Please fill all & check primary contact choice:

☐ Phone (home) _____

☐ Phone (work) _____

☐ Phone (cell) _____

☐ Email _____

May we leave personal/medical information at this place of contact? ☐ yes ☐ no

Occupation/Employer: _____

Employer phone: _____

Employer address:

Partner status: ☐ Single ☐ Partnered ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

Spouse Name: _____

Spouse birth date: _____ Spouse SS#: _____

Spouse Employer: _____

If patient is a student, name of school/college: _____

Whom may we thank for referring you? ☐ Friend: _____ ☐ Internet ☐ Radio ☐ Drive by ☐ Insurance Co. ☐ Provider: _____

Emergency contact name: _____ Relationship: _____

Phone (home/cell): _____

Email Communication:

I would like the ability to discuss my personal health matters via email communication. I give my permission for Dr. Keesha providers and staff to discuss personal health matters, understanding that email may not be a confidential mode of communication.

Preferred email account:

Insurance Information

Insured through: Self Spouse Parent Other:_____ Subscriber name: _____

If not listed above, please list Subscriber birth date: _____ SS#: _____ Phone: _____

Insurance company: _____ ID#: _____ Group#: _____

If insurance is through employment, please indicate employer name: _____

Secondary insurance name: _____ ID#: _____ Group#: _____

Please list other medical providers currently caring for you:

Name: _____ Specialty: _____ Contact info: _____

Name: _____ Specialty: _____ Contact info: _____

Name: _____ Specialty: _____ Contact info: _____

Rights and Responsibilities:

Our promise to you: Our mission is to empower you to learn the patterns of behavior that inform your wellness choices. We promise to listen carefully, think deeply and kindle insight into directions (therapies, treatments, services) that will nourish sustainable health. We promise to be considerate about your time and thoughtful regarding your finances. We thank you for allowing us to journey with you on this path to transformation and look forward to growing with you!

We ask in return for your authenticity and courage to step outside of usual thinking and behavioral patterns. A key component of success is the willingness to incorporate diet, lifestyle and relationship changes. We ask you to be honest with what are realistic changes to begin with, and to wholeheartedly embrace the possibility that your health and life can look and feel exactly how you want it to, although this requires both effort and time and there are no guarantees from our clinic or providers that this will happen.

(Signature) _____ Date _____

(Name of minor if above is parent/guardian) _____ Relationship: _____

HIPAA Acknowledgement: SEE ATTACHED STATEMENT OF PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect.

I acknowledge that I have been provided a copy of and have read and understand Dr. Keesha's HIPAA Privacy Notice containing a complete description of my rights, and the permitted uses and disclosures, under HIPAA. While Dr. Keesha has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Dr. Keesha. _____ ***initial***

You have the right to revoke this authorization, in writing, at any time, except to the extent that Dr. Keesha has taken action in reliance on it. A revocation is effective upon receipt by Dr. Keesha of a written request to revoke and a copy of the executed authorization form to be revoked. _____ ***initial***

ADDITIONAL HIPAA DISCLOSURE AUTHORITY		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person indicated below: (circle)		
Any member of my immediate family	**YES**	**NO**
Spouse only	**YES**	**NO**
Other (please specify):	**YES**	**NO**

_____ _____ _____

Client signature Print name Date

Consent to Treat:

Having come to Dr. Keesha for evaluation or treatment, I (or my authorized representative on my behalf) hereby consent to and authorize Dr. Keesha medical providers and other staff members involved in my care to administer such diagnostic procedures, treatment or both as they may consider advisable to maintain my health and to assess and to evaluate and treat my injury or illness. I understand that the provider responsible for my care has the responsibility to explain to me the purpose, the benefits and the most common risks involved in the diagnosis and treatment of my illness or injury, as well as alternative available courses of treatment, and I understand that I have the right to refuse any suggested examination, test or treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____ _____ _____

Client signature Print name Date

Health History & Current Status

What are your main health concerns at this time? Order by importance to you:
1.
2.
3.
4.
What would you like to get out of this consultation today?
1.
2.
3.
What do you think you need to heal?

Please rate your overall level of health: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)
Please rate your overall level of stress: (Low) 1 2 3 4 5 6 7 8 9 10 (High)
Please assign a number value to your satisfaction with the following areas of your life; 1 is low & 10 is the highest:

Physical environment _____	Health _____	Fun & recreation _____
Romance/significant other _____	Career _____	Friends/family _____
Personal growth _____	Money _____	

Personal Medical History

Allergies: list all known allergies to medications, environment and food AND reaction.
1.
2.
3.
Birth History: ☐ Premature ☐ Breathing problems ☐ Breech ☐ C-section ☐ Vaginal birth ☐ Time of day: _____
Childhood health: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent) Place lived: _____
☐ Breastfed ☐ Formula ☐ Colic ☐ Illnesses: _____ Received antibiotics? ☐ Yes ☐ No
Height: _____ Weight: _____ Weight 1 year ago: _____ Maximum weight: _____ Age at that time: ____
Is there any possibility that you are pregnant? ☐ Yes ☐ No

List all previous surgeries & year:	Describe all serious illnesses & year diagnosed:
1.	1.
2.	2.
3.	3.
4.	4.

List all accidents and injuries (if not listed above):	List all hospitalizations:
1.	1.
2.	2.
3.	3.
4.	4.

Have you been under the care of a licensed heath care professional in the past year? ☐ Yes ☐ No
If so, for what reasons? _____
Indicate dates for the most recent (if ever) of the following preventative exams. Write "never" if you've never had this test.

Physical exam: _____	Eye exam: _____	Prostate/Gyn exam: _____
Full blood work: _____	Dental exam: _____	Mammogram: _____
Colonoscopy: _____	Fecal Occult Blood test: ___	Bone density: _____

Medication/Supplement/Herbal/Vitamin History

Preferred pharmacy name/city: _____ Phone: _____

Name	Dosage/Frequency	How long taken?	What for?	Who prescribed?

Family Medical History

List illnesses that have occurred in your blood relatives including: cancer, high blood pressure, heart disease, renal disease (kidneys), TB, bleeding tendencies, diabetes, stroke, mental disease, drug or alcohol addiction, glaucoma, psychiatric illness

Family Member	Current Age	Diagnosis	Age at diagnosis?	Current health or age at death
Father				
Mother				
Paternal g'father				
Paternal g'mother				
Maternal g'father				
Maternal g'mother				
Sibling				
Sibling				
Sibling				
Sibling				
Children				
Children				
Children				

Dietary Habits

Please list typical foods consumed on a regular basis Do you have any routines around eating? ☐ Yes ☐ No ☐ Sometimes

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluids: _____

Any food cravings? Please list: _____

Check which foods/substances you use & describe what kind, how much & how many times a week:

☐ Caffeine	☐ Alcohol	☐ Candy/sweets
☐ Carbonated beverages	☐ Tobacco (with history & quit date)	☐ Margarine
☐ Milk/ ice cream		☐ Fast food
☐ Cheese	☐ Fried foods	☐ Luncheon meats

If you use alcohol: Have you ever felt you should cut down? ☐ Yes ☐ No

Have people ever been annoyed with you or nagged you about your drinking? ☐ Yes ☐ No

Have you ever felt guilty about your drinking? ☐ Yes ☐ no

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐No

For the following questions, check all that apply to you:	
How Is Your Appetite?	☐ None ☐ Weak ☐ Normal ☐ Strong ☐ Irregular
How Does Food Affect You?	☐ Satisfied, Energized ☐ Unsatisfied, Still Hungry ☐ Fatigued, Sleepy
How Do You Eat?	☐ Sitting ☐ On The Go ☐ Snacking Throughout The Day
Temperature Preferences:	☐ Hot Food ☐ Cold Food ☐ Hot Drinks ☐ Cold Drinks ☐ Varies
Is Your Thirst:	☐ Extreme ☐ Changeable ☐ No Thirst ☐ Dry Mouth
Which Tastes Do You Prefer?	☐ Sweet ☐ Sour ☐ Salty ☐ Pungent ☐ Bitter ☐ Astringent
Do you follow a special diet?	Please describe &/or check all that apply: _____ ☐ Non-Vegetarian ☐ Vegetarian ☐ Vegan ☐ Raw Foods ☐ Low Fat Diet ☐ Low carb ☐ No carb ☐ Paleo ☐ APOE gene diet ☐ Elimination diet ☐ GAPS/SCD
Eating disorders or other issues with eating?	☐ Current ☐ Past Please describe:
Any food reactions or intolerances?	Please describe:

How many glasses of water do you consume each week?____

How many meals do you eat out per week? _____

When I eat meat, fish or poultry:

- ❑ I almost always have it fried or cooked with oil or another fat, or with gravy
- ❑ I almost always have it broiled, baked or stewed and without any gravy or fat
- ❑ I do both
- ❑ I don't eat meat, fish or poultry

On average, how often do you eat breakfast in a week? ___

How often do you choose organic foods?
☐ Always ☐ Sometimes ☐ Never

When I eat cooked vegetables:

- ❑ I almost always have them with butter, margarine or sauce; or cooked with butter, margarine oil or another fat.
- ❑ I almost always have them without any of the fats listed above.
- ❑ I do both.
- ❑ I don't eat cooked vegetables

Please circle any digestive symptoms that you experience:			
Abdominal Pain	Bloating	Heartburn	Overweight
Acid Reflux	Candida	Hiccups	Sudden Weight Loss
Aggravated By Spices	Eating Disorder	Hypoglycemia	Ulcers
Bad Breath	Food Allergies	Nausea	Underweight
Belching	Gas	Nutritional Deficiencies	Vomiting
Please circle any elimination symptoms that you experience:			
Anal Fissures	Crohn's Disease	Incomplete Evacuation	Oily Stools
Anal Itching/Burning	Diarrhea	Intestinal Pain/Cramping	Parasites
Blood In Stools	Difficulty Passing Stools	Irritable Bowel Syndrome	Rectal Prolapse
Colitis	Gallstones	Laxative Use	Smelly Stools
Constipation	Hemorrhoids	Mucus In Stools	Undigested Food In Stools

Daily Schedule						
	Time	Routine	Activity	Variation	Spiritual Practices	Exercise
Morning						
Mid-morning						
Lunch						
Mid-Afternoon						
Evening						
Late-evening						
Middle of the night						

Sleep patterns:	Rate ease of falling asleep: (Easy) 1 2 3 4 5 6 7 8 9 10 (Difficult) Rate ease of staying asleep: (Easy) 1 2 3 4 5 6 7 8 9 10 (Difficult)

Are you sexually active? ☐ Yes ☐ No Frequency? _____ Current method of birth control? _____
Have you ever contracted a sexually transmitted disease? ☐ Yes ☐ No If so, what & when? _____
Do you exercise regularly? ☐ Yes ☐ No Length of time? _____ Times per week? _____ Types _____
Body temperature: Do you generally run hot or cold? Please explain: _____

Adrenal Health Quiz: Please check the appropriate box if you frequently or currently have the symptom mentioned.

Headaches	☐ Yes ☐ No	Poor memory or concentration	☐ Yes ☐ No
Irritability	☐ Yes ☐ No	Bruise easily or find wounds heal slowly	☐ Yes ☐ No
Thyroid problems	☐ Yes ☐ No	Exercise more than one time each week	☐ Yes ☐ No
Palpitations	☐ Yes ☐ No	Need caffeine in the morning or after lunch	☐ Yes ☐ No
Allergies or asthma	☐ Yes ☐ No	Frequent/chronic infections	☐ Yes ☐ No
Dry, thinning skin	☐ Yes ☐ No	Energy is good all day	☐ Yes ☐ No
Unexplained hair loss	☐ Yes ☐ No	Low body temperature	☐ Yes ☐ No
Skip meals	☐ Yes ☐ No	**1 pt for each yes: TOTAL _____**	

Emotionally over-stressed	☐ Yes ☐ No	Get light-headed when sitting or standing	☐ Yes ☐ No
Tenderness across lower back	☐ Yes ☐ No	"Second wind" (high energy) at bedtime	☐ Yes ☐ No
Depression or down moods	☐ Yes ☐ No	Chronic or recurrent inflammation	☐ Yes ☐ No
Low blood pressure	☐ Yes ☐ No	**3 pts for each yes: TOTAL _____**	

Chronic pain	☐ Yes ☐ No	Symptoms of PMS ****See below**	☐ Yes ☐ No
Insomnia ***see below**	☐ Yes ☐ No	(breast tenderness, abdominal cramping, heavy periods, mood swings)	
Low blood sugar/hypoglycemia	☐ Yes ☐ No	Menopausal or perimenopausal ****See below**	☐ Yes ☐ No
(headaches, sleepy, mood swing if skipping meals)		(skipped periods, between 45-55 yrs old, hot flashes, vaginal dryness)	
		5 pts for each yes: TOTAL _____	

Ultimate total of all 3 sections: _____
If your score >10 you probably have some degree of adrenal dysfunction
If your score >20 it is highly probable that you have adrenal dysfunction
If your score >30 it is nearly certain that you have adrenal dysfunction

*** Insomnia: Complete if you experience insomnia**

Difficulty falling asleep	☐ Yes ☐ No	>20 min to fall asleep once lights are off	☐ Yes ☐ No
Racing mind at time of sleep	☐ Yes ☐ No	Second wind (high energy) at night	☐ Yes ☐ No
Trouble staying asleep	☐ Yes ☐ No	Trouble going back to sleep once awakened	☐ Yes ☐ No
Wake more than once per night	☐ Yes ☐ No	Frequently awaken between 2-3 am	☐ Yes ☐ No
Recall your dreams	☐ Yes ☐ No	Experience restless legs when trying to sleep	☐ Yes ☐ No
Have vivid or disturbing nightmares	☐ Yes ☐ No	Sleep/nap during daylight hours	☐ Yes ☐ No
Snore	☐ Yes ☐ No	Feel groggy or sleepy when you awaken	☐ Yes ☐ No
Been diagnosed with sleep apnea	☐ Yes ☐ No	Work "third shift" (work nights/sleep days)	☐ Yes ☐ No
Exercise late in the day	☐ Yes ☐ No	Depressed when weather is cloudy/overcast	☐ Yes ☐ No

Eat carb snacks before bed?	☐ Yes ☐ No	Take sleeping pills (natural or prescription)	☐ Yes ☐ No
(cake, cookies, ice cream)		Use coffee, caffeine or other stims/meds?	☐ Yes ☐ No
Eat nothing b/n dinner & bedtime	☐ Yes ☐ No	Children or pets sleep in your room	☐ Yes ☐ No
Drink alcohol in evenings/nights	☐ Yes ☐ No	Sinus/ allergies/ asthma worse at night	☐ Yes ☐ No
Sleep partner keeps you awake due to	☐ Yes ☐ No	History of concussive injury/ head injury	☐ Yes ☐ No
Snoring or restlessness	☐ Yes ☐ No	Insomnia related to your menstrual cycle	☐ Yes ☐ No
Menopausal or have had hysterectomy	☐ Yes ☐ No	**Total "yes" answers _____**	

****Pre & Peri Menopausal Women**			
Frequent/irregular periods	☐ Yes ☐ No	Moody or irritable during or before periods	☐ Yes ☐ No
Severe abdominal cramping w/ periods	☐ Yes ☐ No	Trouble sleeping due to racing mind/thoughts	☐ Yes ☐ No
Breast tenderness around periods	☐ Yes ☐ No	Trouble getting pregnant/ miscarriage(s)	☐ Yes ☐ No
History or current uterine fibroids	☐ Yes ☐ No	Anxiety or panic attacks	☐ Yes ☐ No
Depression or post-partum depression	☐ Yes ☐ No	Current/ past use (2 yrs) of birth control pills	☐ Yes ☐ No
Headaches/ migraines at time or period	☐ Yes ☐ No	History of no period for 3 months at a time	☐ Yes ☐ No
Cravings for sugar, fat, salt or chocolate	☐ Yes ☐ No	Bloating/ water retention with periods	☐ Yes ☐ No
Pain during intercourse	☐ Yes ☐ No	Family history of breast/ uterine/ ovarian cancer	☐ Yes ☐ No
endometriosis	☐ Yes ☐ No	**Total "yes" answers _____**	

****Post-Menopausal Women**			
Hot flashes	☐ Yes ☐ No	Your last menstrual period was >1 yr ago	☐ Yes ☐ No
Severe sweating at night	☐ Yes ☐ No	Concern for osteoporosis or hip/spinal fracture	☐ Yes ☐ No
Vaginal dryness	☐ Yes ☐ No	Trouble sleeping due to mind racing/thoughts	☐ Yes ☐ No
Vaginal thinning	☐ Yes ☐ No	Get anxiety or panic attacks	☐ Yes ☐ No
Reduced libido	☐ Yes ☐ No	Family history of breast/ uterine// ovarian cancer	☐ Yes ☐ No
Pain during intercourse	☐ Yes ☐ No	Take hormone replacement (pills, cream, patches)	☐ Yes ☐ No
History of hysterectomy	☐ Yes ☐ No	**Total "yes" answers _____**	☐ Yes ☐ No

Toxicity & Inflammation Scales

Please check mark if your work or home environment exposes you to the following:			
☐ Hazardous substances	☐ Stress	☐ Loud noise	☐ Carbon monoxide
☐ Structure built before 1975	☐ Mold	☐ Heavy lifting	☐ Born outside the U.S.
☐ Motor vehicle emissions	☐ Asbestos	☐ Air pollution	☐ Exposed to infectious person in last 2 weeks
☐ Second hand smoke	☐ Radiation	☐ Pesticides	☐ Eaten in a fast food restaurant
☐ Recent travel outside the U.S.	☐ Chemicals	☐ Sun & UV light	in last 2 weeks

This questionnaire gives an indication of your toxicity and inflammation levels based on common signs and symptoms. Periodically, you may be asked to submit this questionnaire again to examine progress during and after treatments. Point scale: 0 = Never or almost never have the symptom

1 = Occasionally have it, effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

HEAD	___ Headaches ___ Dizziness ___ Insomnia ___ Faintness	**HEART**	___ Chest pain ___ Irregular or skipped heartbeat ___ Rapid or pounding heartbeat	**ENERGY LEVEL**	___ Fatigue/low energy ___ Restlessness ___ Hyperactivity ___ Crave certain foods
____ Total		____ Total		____ Total	
EARS	___ Itchy ears ___ Ringing in ears or loss of hearing ___ Earaches/infections ___ Drainage from ear	**LUNGS**	___ Asthma, bronchitis ___ Chest congestion ___ Shortness of breath ___ Difficulty breathing	**WEIGHT**	___ Underweight ___ Overweight ___ Difficulty losing weight ___ Crave certain foods
____ Total		____ Total		____ Total	
EYES	___ Bags or dark circles under eyes ___ Watery or itchy eyes ___ Swollen/red/sticky eyelids ___ Blurred or tunnel vision (excluding near/far-sight)	**SKIN**	___ Acne or brown age or brown "liver" spots ___ Hives, rashes, cysts or boils ___ Eczema or psoriasis ___ itchy skin/dermatitis ___ hair loss, thinning ___ body odor ___ excessive sweating	**OTHER**	___ PMS ___ Frequent colds, flu ___ Chemical or enviro-mental sensitivities ___ Food allergies/ sensitivities
____ Total		____ Total		____ Total	
NOSE	___ Stuffy nose ___ Sinus congestion/ infection ___ Constant sneezing ___ Hay fever/allergies ___ Excess mucus formation	**JOINTS/ MUSCLES**	___ Pain or aches in joints or lower back ___ Stiffness or limitation of movement ___ Arthritis ___ Pain or aches in muscles		Please add the numbers from each section and write the section total in the spaces provided. Then add all the section totals together and put that total in the space below: _____ **GRAND TOTAL** Interpreting your Grand Total score: 15 or lower: Low toxicity level 16 – 49: Moderate toxicity level 50 or higher: High level of toxicity
____ Total		____ Total			
MOUTH THROAT	___ Chronic coughing ___ Sore throat/hoarseness loss of voice ___ Gagging, frequent need to clear throat ___ Swollen tongue, gums, lips ___ Swollen lymph nodes ___ Canker sores, mouth ulcers	**MENTAL/ EMOTIONAL**	___ Poor memory ___ Difficulty concentrating ___ Mood swings ___ Depression ___ Anxiety, fear or nervousness ___ anger, irritability or aggressiveness ___ Insomnia		
____ Total		____ Total			

REVIEW OF SYSTEMS

Check all the symptoms that are of concern to you at this time that you want to discuss with the practitioner. On the comments line, please indicate if any checked symptoms are *current* or *past* and describe any area in which you have experienced a severe episode and indicate if that episode was in previous 6 months or prior to 6 months ago.

HEAD	☐ Headaches ☐ Dizziness ☐ Fainting spells ☐ Loss of balance ☐ Difficulty remembering ☐ Difficulty thinking clearly ☐ Thinning or loss of hair Comments:
EYES	☐ Blurry ☐ Dry ☐ Tic/twitch ☐ Itchy ☐ Red ☐ Watery ☐ Cataracts ☐ Color blindness ☐ Burning ☐ Contacts/ glasses For ___ Years ☐ Farsighted ☐ Nearsighted ☐ Glaucoma ☐ Eye strain ☐ Mucus ☐ Night blindness ☐ Pain/soreness in eyes ☐ Poor/loss of vision ☐ Sensitive to light ☐ Floaters Comments:
EARS	☐ Earaches/pain ☐ Excess Earwax ☐ Hearing loss ☐ Ringing ☐ Sensitivity To Sound ☐ Discharge Comments:
NOSE	☐ Loss of smell ☐ Bleeding ☐ Pain ☐ Discharge ☐ Post-nasal drip ☐ Sinus congestion ☐ Frequent Colds ☐ Nasal Polyps ☐ Deviated Septum Comments:
MOUTH	☐ Excessive thirst ☐ Loss of taste ☐ Strange taste ☐ Bad breath ☐ Lip ulcers or lesions ☐ Dry/cracking lips ☐ Tongue pain ☐ Bleeding gums ☐ Receding gums ☐ Tooth pain ☐ Cavities ☐ Tooth sensitivity ☐TMJ ☐ Dry mouth ☐ Excess saliva Comments:
THROAT/ NECK	☐ Pain ☐ Swollen glands ☐ Stiffness ☐ Lumps ☐ Difficulty Swallowing Comments:
HAIR & NAILS	☐ Dandruff ☐ Dry ☐ Hair Loss ☐ Oily ☐ Brittle, Break Easily ☐ Dry, Rough ☐ Ridged ☐ Oily ☐ Pale ☐ Pink ☐ Smooth Comments:
SKIN	☐Acne ☐ Boils ☐ Bruises Easily ☐ Clammy ☐ Dry ☐ Eczema ☐ Fungal Infections ☐ Itching ☐ Psoriasis ☐ Rashes/Hives ☐ Scars ☐ Sensitive ☐ Skin Eruptions ☐ Changing or bleeding moles Comments:
PERSPIRATION	☐ Spontaneous Or Without Exertion ☐ Excessive ☐ Rarely ☐ Nighttime ☐ Cold Sweats ☐ Unusual Odor Comments:
RESPIRATION	☐ Asthma ☐ Bronchitis ☐ Cough ☐ Cough With Blood Or Phlegm ☐ Emphysema ☐ Pneumonia ☐ Shortness Of Breath ☐ Tuberculosis ☐ Wheezing Comments:

CIRCULATION	☐ Blood Clots ☐ Calf pain ☐ Swollen ankles ☐ Varicose veins ☐ Cold hands/feet ☐ Puffy eyes Comments:

Cardiovascular	☐ Arteriosclerosis ☐ Chest Pain ☐ Coronary Disease ☐ Heart Murmur ☐ Hypertension ☐ Heaviness Or Tightness In Chest ☐ High Blood Pressure ☐ High Cholesterol ☐ Low Blood Pressure ☐ Hypotension ☐ Palpitations ☐ Irregular Heart Beat ☐ Bradycardia ☐ Tachycardia ☐ Pacemaker ☐ Congenital Heart Defect(s): _____ Comments:
Digestion	☐ Pain ☐ Burning indigestion ☐ Belching ☐ Regurgitation ☐ Vomiting ☐ Excessive gas ☐ Heavy bloating after meals ☐ Hemorrhoids ☐ Constipation (<1 BM/day) ☐ Diarrhea ☐ Both constipation & diarrhea ☐ Bloody stool Comments:
Urination	Frequency: _____/ Day Color: _____ ☐ # Of Times At Night _____ ☐ Burning/ Painful ☐ Loss of urinary control ☐ Dribbling ☐ Blood in urine ☐ Foamy ☐ Frequent ☐ Profuse ☐ Retention ☐ Scanty ☐ Urgent ☐ Bedwetting ☐ Kidney/Bladder Infections ☐ Kidney/Bladder Stones ☐ Congenital Kidney Problems ☐ Frequent Urinary Tract Infections (UTI) ☐ Pain in kidney/groin area Comment:
Muscles & Joints	☐ Swelling in joints ☐ Pain/ache in joints ☐ Stiff joints ☐ Persistent muscle/bone pains ☐ Tremors/tics in muscles ☐ Muscle weakness/atrophy ☐ Numbness Comments:
Nerves	☐ Loss of taste, smell or touch ☐ Tingling sensations ☐ Tremors in limbs ☐ Uncoordinated muscle/limbs ☐ Neuropathic pain Comments:
Male System	☐ Prostate gland swollen/painful ☐ low sperm count ☐ Low motility ☐ Genital sores or lesions ☐ Genital discharge ☐ Erectile function difficulty ☐ Change in libido Comments:
Female System	☐ Irregular cycle ☐ Heavy/prolonged bleeding ☐ Vaginal discharge ☐ Painful menses ☐ Fibroids ☐ Missed menses or spotting ☐ discharge ☐ PMS or menopausal symptoms ☐ Ovarian cyst ☐ Pregnancies #: _____ ☐ Miscarriages/abortions #: _____ ☐ Unsatisfactory sex/change in libido ☐ Genital sores ☐ Last menstrual period date _____ ☐ Last menstrual period date: _____ Comments:
Breasts	☐ Swelling ☐ Redness ☐ Lumps ☐ Nipple discharge ☐ Tenderness/pain Comments:

Envisioning Your Own Health

Please take a few minutes to go inside of yourself to answer these last questions so that we may better design a program to fit your unique needs. Thank you for your careful consideration. It is very much appreciated.

1. What are you doing in your life that brings you peace and harmony?

2. What do you want your spiritual life to look like?

3. What does your spiritual life currently look like?

4. If you could design your perfect state of wellness and balance, what would your life look like?

5. What would you have to give up to achieve this life?

6. How can we best support you to meet your dreams?

7. What does it look like when you are spiraling down emotionally?

8. How do you bring yourself back out?

9. Have you noticed patterns that repeat themselves in your life (only the names, places & occurrences have changed names)?

10. Do you know your purpose in life?

11. Do you have vivid dreams?

12. Please assign a number value to your satisfaction with the following areas of your life; 1 is low and 10 is the highest:

Physical environment _____ Career _____Fun and Recreation _____Health _____Money _____Romance/Significant other_____

Personal Growth_____Friends/Family_____

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never

compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington (HIPAA). This includes issues relating to your treatment, payment and our medical operations. Your personal health information will never be otherwise given to anyone-even family members- without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collection Protected Health Information

We will only request personal information needed to provide our standard of quality integrative medical care, implement payment activities, conduct normal medical practice operations and comply with the law. This may include your name, address, telephone numbers, social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of our Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines and emails.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We value you for being a patient at Dr. Keesha. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.