Congratulations on taking the next step to your health and wellness!

Please find the new patient paperwork enclosed. Please note that there are **11 pages to complete** in total. There are a total of 3 pages of consent forms and 8 pages of health history forms. (I am known for being thorough!)

It is my philosophy to address the whole person: mind, body, and spirit. I have trained extensively in tools that act deeply on all of these levels, promoting the greatest state of wellness. I am committed to meeting you where you are and supporting you to reach your health goals.

How many times have you kicked yourself because you've forgotten to share something important with your doctor during your visit? It's natural. This form is designed to allow you to think things over before you answer, so you don't forget anything. I know there are a lot of pages; I welcome you to cozy up with a cup of tea to really enjoy the process!

As you can imagine, the holistic approach is enhanced *dramatically* when the practitioner has a complete picture of the client physically, mentally, emotionally, and spiritually. I ask for your support, cooperation, and patience as you complete this health history questionnaire. You may find that some of the information is difficult to recall. And that's okay. I only ask that you do your best. The more information you provide, the better I will be able to serve your needs.

Please make sure that you complete the following health history form in its entirety. ***Please type or print legibly.*** When you've finished, please scan & email me your paperwork (taking a picture of each page with your cell phone and emailing it works great, too). Please send it in **at least 24 hours before** your scheduled appointment. The sooner you send it in, the longer I will have to review your case.

Just a reminder that **our appointment will be a phone appointment**! I will call you at our scheduled time on the number you provided at scheduling. If there is a better number to reach you, please just let me know. Also, please allow me a few minutes in case if I am running behind with another patient! (Though, I do my best to be on schedule!)

E-mail: drjessica@lockportwellness.com

Thank you for your support and thoroughness! I really look forward to working with you on your wellness journey! Time for us to get to work!

Dr. Jessica

Jessica Grewal, ND

P.S. If you have had any recent (within the past year) blood work and/or imaging from your primary care provider, **please email a copy of those labs as well!**

Financial Responsibility & Informed Consent Agreement

Please initial each line, indicating your understanding and compliance with the policies of Lockport Wellness:

_______ I understand that payment for all services and supplements is due at the time of the visit. I understand that acceptable forms of payment include cash, check, Visa, MasterCard, and Discover and that returned checks will be subject to a $35.00 NSF fee.

_______ I understand that I will be charged a 'Missed Appointment' fee of $50.00 for any missed appointments or cancellations of less than 72 hours notice.

_______ I understand that some wellness practitioners, including naturopathic doctors, are not currently licensed or regulated in New York State. I understand that unlicensed professionals, including naturopathic doctors, cannot diagnose or treat disease or order labs/imaging.

_______ I understand that the practice of herbs and recommendations of supplements is unregulated in New York State. As such, I understand that New York State has made no determination regarding the competence of any practitioner at Lockport Wellness to practice herbology or provide supplement recommendations.

_______ I understand that the wellness plan provided by a practitioner at Lockport Wellness is not medical advice, nor can the practitioners at Lockport Wellness give medical advice.

_______ I agree to be under the care and supervision of a licensed medical professional while working with my practitioner at Lockport Wellness.

_______ I understand that the recommendations made by a practitioner at Lockport Wellness may be different from those offered by licensed healthcare providers, and I am at liberty to seek other opinions.

_______ I understand that the services and recommendations of a practitioner at Lockport Wellness are his/her own and I agree to hold harmless Lockport Wellness for any services or recommendations provided by any given practitioner.

I have read and understand the above-stated policies and will comply with them in all respects.

____
Client Name. (please print)

____ Date _____________
Client Signature. (or parent/guardian, if minor)

Electronic Communication Consent

In between visits, communication with clients is very important to us, and sometimes, very necessary. With the advent of the 21st century, many clients prefer electronic communications; unfortunately, not all of these forms of communication can guarantee privacy, nor are they HIPAA compliant. We want to communicate with you using the form(s) you prefer.

Please initial each line of communication you authorize. By initialing, you are indicating you understand each statement that follows and authorize permission of that form of communication:

______ **E-mail.** I understand that this form of communication is not HIPAA compliant, and thereby does not guarantee privacy. I authorize communication of detailed medical information with Lockport Wellness, its contractors and employees, via the e-mail address below.

Email Address: ____

______ **Voicemail.** I authorize Lockport Wellness, its contractors and employees, to leave voicemails with detailed medical information on the following phone number(s). Please list in order of preference.

Cell Home Work (please circle) ______ - ______ - ____________

Cell Home Work (please circle) ______ - ______ - ____________

Cell Home Work (please circle) ______ - ______ - ____________

______ **None.** I do not authorize Lockport Wellness, nor its contractors or employees, to e-mail or leave voicemails with detailed medical information. I prefer to be contacted by phone or written letter, and these forms of communication alone.

I have read and understand the above-stated policies and authorize the form(s) of communication that I have initialed next to.

____
Client Name. (please print)

____ Date ____________
Client Signature. (or parent/guardian, if minor)

HIPAA Privacy Notification

I consent to the use or disclosure of my identifiable health information by practitioners contracted or employed by Lockport Wellness for the purposes of diagnosis or treatment, obtaining payment for health care bills, or to conduct health care operations. I understand that diagnosis or treatment at Lockport Wellness may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Lockport Wellness is not required to agree to the restrictions that I may request. However, if Lockport Wellness agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time except to the extent that Lockport Wellness has taken action in reliance on this consent.

My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer, a health care clearinghouse, or any other similar source. This identifiable health information relates to my past, present and future physical and mental health or condition and identifies me, or where there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Lockport Wellness' Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations. The Notice of Privacy Practices is also provided at the front desk and on the center's web site at www.lockportwellness.com. This Notice of Privacy Practices also describes my rights and the duties of my practitioners with respect to my identifiable health information.

Lockport Wellness reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

I have read and understand the above-stated HIPAA Privacy Notification.

____

Client Name. (Please Print)

____ Date ____________

Client Signature. (or parent/guardian, if minor)

Personal Information

Name ____ Date __________________

Age ______ Date of birth _________________ Sex: Male Female

Address ____________________________________ City ___________________ State ____ Zip ______

Telephone (Home) _________________ (Work) ___________________ (Cell)______________________

Email ____

Emergency Contact _________________________________ Relationship ______________________

Telephone (Home) ___________________ (Work) ___________________ (Cell)__________________

How did you hear about Dr. Miller? ____

<u>HEALTH HISTORY</u>

Please list all previous diagnoses you have received from your doctor(s).

____

____

____

Who is your current Primary Care Provider? ____

When did you last see this provider? __________________

Please list any other members of your health care team (i.e. specialists, therapists, etc.).______________________

____

____

If you had a magic wand, what are the five things you would change about your physical, mental, and/or emotional health? List in order of importance.

1. ____
2. ____
3. ____
4. ____
5. ____

In your opinion, what would be the best ways to track your progress for the above concerns? (i.e. What changes would tell you that something is working?).

1. ____
2. ____
3. ____
4. ____
5. ____

What are three expectations for your first visit?

1. ____
2. ____
3. ____

What are your long-term expectations for our work together? ____

____

____

____

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

____

____

____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive or take away from your health?

____

____

____

What obstacles do you foresee getting in the way of change in your life? What obstacles do you foresee getting in the way of following the wellness suggestions (i.e. nutritional, lifestyle changes, and supplements) that Dr. Miller will make?

____

____

____

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making? ____

____

____

What do you love to do? ____

____

____

How do you rate your overall health? Excellent Good Fair Poor

What is your present level of commitment to address any underlying causes of your complaints that relate to your life-style? Rate from 0 to 10, 10 being 100% committed.

(0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

HOSPITALIZATION

What hospitalizations or surgeries have you had? When did they occur?

____

____

____

HEALTH STUDIES ***Please bring a copy of all labs with you to your visit.***

When was your last blood test? ____________ What type of test? ____

What is your blood type (i.e. A, B, AB, or O; indicate + or - f you know your exact type)? ____________

Any other tests recently? ____

Any abnormalities with your blood work? ____

MEDICATIONS

List all prescription drugs, OTC medications, vitamins, herbs, and supplements you are taking currently with dosage:

____

____

____

____

Are you allergic to any medications or other substances? Y N

If yes, please list ____

____

What happens when you have an "allergy attack"? ____

CHILDHOOD ILLNESSES. Please check conditions you've had in your childhood.

Measles ___ Eczema ___ Whooping cough ___ Diphtheria ___ Roseola ___ Chickenpox ___

Polio ___ Asthma ___ Rheumatic Fever ___ Scarlet Fever ___ Mumps ___

Frequent ear infections or colds as a child? _____ Rubella (German Measles) ___

Any difficulties with your birth or your mother's pregnancy with you?___________________________________

IMMUNIZATIONS

Polio	Y N	Pertussis	Y N
Tetanus	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Other _____________________________	

FAMILY HISTORY

Please list ages, any major health problems, and if deceased, what they died from and at what age.

Mother ____

Father ____

Your Sisters ____

Your Brothers ____

Mother's Side:

Grandfather ____

Grandmother ____

Father's Side:

Grandfather ____

Grandmother ____

SOCIAL HISTORY

Occupation ____ Work hours_________________________

Marital Status: Married ___ Separated ___ Divorced ___ Single ___ Widowed ___ Partnered ___

With whom do live: Spouse ___ Parents ___ Relatives ___ Friends ___ Alone ___ Other ___

Do you have the support of family and friends to make positive changes in your life? ___________________

Have you traveled outside the U.S? ________ Where and when? _______________________________________

____

Military Status: When did you serve? ______________ Where? ____

Do you have a religious or spiritual practice? Yes No If yes, which? ________________________________

If yes, how active of a role are these beliefs in your life? Very active Somewhat active Not very active

In what areas of your life do you experience stress? Work Family Life Social Life Financial

Please list the most significant stressful/traumatic events of your life **past and present** (including childhood events):

____

____

____

____

____

HEALTH HABITS

Do you drink alcohol? ____ If yes, which types of alcohol? ____

If yes, how much alcohol do you consume each week? ____

Do you use tobacco or have you in the past? ___________ If so, how many packs/day? ______________________

Total number of years smoking? _____ If you've quit, total number of years since stopped smoking? ___________

Do you now or have in the past used marijuana or other drugs? _______

If yes, which drugs, how often, and for how long? ____

____

List any long-term health problems that have resulted from taking these drugs ______________________________

Do you exercise? _____ How often? (Hours/day and days/week) ____

Circle any of the following that you do on a regular basis: Jog Swim Walk Bicycle Garden

Yoga Stretch Weight lift Hike Other _______________________

Do you make time for rest, relaxation during the day and/or before bed? _______ How often? _______________

How do you relax? ____

DIET

Number of meals eaten per day: 1 2 3 more than 3

How is your appetite? ______________________________ Approximately what % of meals are eaten out: ______%

Where do you usually buy your food? ___________________Who cooks the food you eat? ___________________

List the primary foods included in your diet. ____

____

List the foods excluded from your diet. ____

____

List any of the following (and relative amounts) you eat regularly: Coffee, caffeinated teas, highly seasoned foods, processed foods, preservatives, refined foods or foods you suspect may be harmful to your health:________________

____

____

List any of the foods you crave, regardless of their nutritional value (including sweets, chocolate, salty, sour, bread, rich/fatty foods, etc.): ____

____

____

Are you satisfied with your diet as it is now? Yes No If not, why not? ____________________________

____

SLEEP

Do you have trouble falling asleep? Yes No If yes, what keeps you up? ______________________

Do you sleep straight through the night? Yes No If not, what time do you usually wake? ____________

Average number of hours you sleep ____________ Do you wake feeling refreshed? Yes No

Do you have recurring dreams or nightmares? Yes No If yes, what is the theme? ______________________

What position do you usually sleep in? ________________________________

Is there a position you cannot sleep in? Yes No If yes, which one? ___________________________________

How many pillows do you sleep on? _____ Any nights sweats? Yes No

What time of day is your energy the **highest**? ____________________ **Lowest**? ____________________

HOME ENVIRONMENT AND OTHER ENVIRONMENTAL EXPOSURES

Circle any of the following you routinely use at home:

Gas heat Oil heat Electric heat Wood stove Air conditioning Electric blanket T.V.

Distilled / Filtered / Spring / Well / Tap water

Is your home well ventilated? Yes No What about your work environment? Yes No

Is your home excessively damp or moist? Yes No What about your work environment? Yes No

Please circle any of the following you feel most bothered by:

Sunshine Lack of sunshine Dampness Dryness Cold Heat Dust/Mold Cat/Dog hair

Car fumes Poor air/ventilation Fluorescent lighting Chemicals Perfumes

Do you consider yourself as chemically sensitive? Yes No

Do you consider yourself as sensitive in general? (i.e. sensitive to other's comments, the news, etc) Yes No

REPRODUCTIVE HEALTH—GENERAL

Are you currently sexually active? Yes No Have you been sexually active in the past? Yes No

Current forms of contraception? ____

My sexual partners are: Male Female

Sexual desire: 0 1 2 3 4 5 6 7 8 9 10 (please circle one, 0 = none)

Any sexual problems? ____

FEMALE REPRODUCTIVE HEALTH

Age when menstrual periods began __________ Did you have a normal puberty? ______________________

Are you currently having periods? Yes No If no, explain. ______________________________

Date of last period ____________________ Regular: Yes No

Periods usually last _________ days (average) Period every ________ days.

Quality of blood? (i.e. dark red, bright red, clots) ______________________________________

Amount of flow (i.e. # of pads or tampons/day) ______________________________________

List any **menstrual** symptoms (including pain, cramping). ______________________________

____

List any **premenstrual** symptoms (including breast tenderness, acne, mood swings). __________________

____

Have you ever used birth control pills? _____ For how long? ____________ What kind? ________________

Have you ever used an I.U.D.? ________ For how long? ____________ What kind? ________________

Hormone replacement therapy? ________ For how long? ____________ What kind? ________________

Date of last PAP smear ____________ Have you ever had an abnormal PAP? Yes No

If yes, when and were you given a diagnosis? ______________________________________

Do you currently, or have had in the past, problems with infertility Yes No

If yes, explain ____

Number of: pregnancies ______ births ______ miscarriages ______ abortions ______

Any complications of pregnancy? _______ If yes, explain ______________________________

Have you had any of the following concerning your breasts: Pain Lumps Infection Nipple discharge

MALE REPRODUCTIVE HEALTH

Have you had any of the following: Testicular pain Prostate problems Hernia Discharges Sores

Have you had a prostate exam? _______ If so, when? ______________

MEDICAL HISTORY

Please circle: O= occasionally Y = condition you have now N = never had this problem P= condition you have had in the past

GENERAL

Weight ___________

Weight one year ago____________

Maximum weight _____________

When?__________________

Height _________________

Last physical exam? _______________

ENERGY

Fatigue	O	Y	N	P

SKIN

Rashes	O	Y	N	P
Eczema, hives	O	Y	N	P
Itching	O	Y	N	P
Color change	O	Y	N	P
Lumps	O	Y	N	P

HEAD

Head aches	O	Y	N	P
Head injury	O	Y	N	P

EYES

Impaired vision	O	Y	N	P
Eye pain	O	Y	N	P
Tearing/dryness	O	Y	N	P
Double vision	O	Y	N	P
Glaucoma	O	Y	N	P
Cataracts	O	Y	N	P

EARS

Impaired hearing	O	Y	N	P
Ringing	O	Y	N	P
Earache	O	Y	N	P

NOSE and SINUSES

Frequent colds	O	Y	N	P
Nose bleeds	O	Y	N	P
Stuffiness	O	Y	N	P
Hay fever	O	Y	N	P
Sinus problems	O	Y	N	P

MOUTH and THROAT

Frequent sore throat	O	Y	N	P
Sore Tongue	O	Y	N	P
Gum problems	O	Y	N	P
Hoarseness	O	Y	N	P
Dental cavities	O	Y	N	P
Amalgam fillings		Y	N	P

Last dental exam? _________________

RESPIRATORY

Cough	O	Y	N	P
Sputum	O	Y	N	P
Spitting up blood	O	Y	N	P
Wheezing	O	Y	N	P
Asthma	O	Y	N	P
Bronchitis	O	Y	N	P
Pneumonia	O	Y	N	P
Pleurisy	O	Y	N	P
Emphysema	O	Y	N	P
Trouble breathing	O	Y	N	P
Pain on breathing	O	Y	N	P
Short of breath	O	Y	N	P
At night	O	Y	N	P
Lying down	O	Y	N	P
Tuberculosis	O	Y	N	P

CARDIOVASCULAR

Heart disease	O	Y	N	P
Angina	O	Y	N	P
Hypertension	O	Y	N	P
Murmurs	O	Y	N	P
Rheumatic fever	O	Y	N	P
Chest pain	O	Y	N	P
Swelling in ankles	O	Y	N	P
Palpitations	O	Y	N	P

URINARY

Pain on urination	O	Y	N	P
Increased frequency	O	Y	N	P
Frequency at night	O	Y	N	P
Unable to hold urine	O	Y	N	P
Frequent infections	O	Y	N	P
Kidney stones	O	Y	N	P

EXTREMITIES

Deep leg pain	O	Y	N	P
Cold hands/feet	O	Y	N	P
Varicose veins	O	Y	N	P
Thrombophebitis	O	Y	N	P
Nail Fungus	O	Y	N	P
Restless legs	O	Y	N	P

EMOTIONAL

Anxiety, panic	O	Y	N	P
Depressed, hopeless	O	Y	N	P
Mood swings	O	Y	N	P
Weeping	O	Y	N	P
Compulsions	O	Y	N	P
Excessive anger	O	Y	N	P
Restless, bored	O	Y	N	P

GASTROINTESTINAL

Belching/gas	O	Y	N	P
Gall bladder	O	Y	N	P
Heartburn	O	Y	N	P
Indigestion	O	Y	N	P
Liver problems	O	Y	N	P
Jaundice	O	Y	N	P
Vomiting	O	Y	N	P
Vomiting blood	O	Y	N	P
Blood in stool	O	Y	N	P
Change in thirst	O	Y	N	P
Change in appetite	O	Y	N	P
Binge eating	O	Y	N	P
Abdominal cramps	O	Y	N	P
Hemorrhoids	O	Y	N	P
Constipation	O	Y	N	P
Diarrhea	O	Y	N	P

MUSCULOSKELELTAL

Joint pain, stiffness	O	Y	N	P
Arthritis	O	Y	N	P
Broken bones	O	Y	N	P
Muscle spasms	O	Y	N	P
Weakness	O	Y	N	P

NECK

Lumps	O	Y	N	P
Swollen glands	O	Y	N	P
Goiter	O	Y	N	P

BLOOD

Easy bruising	O	Y	N	P
Anemia	O	Y	N	P

ENDOCRINE

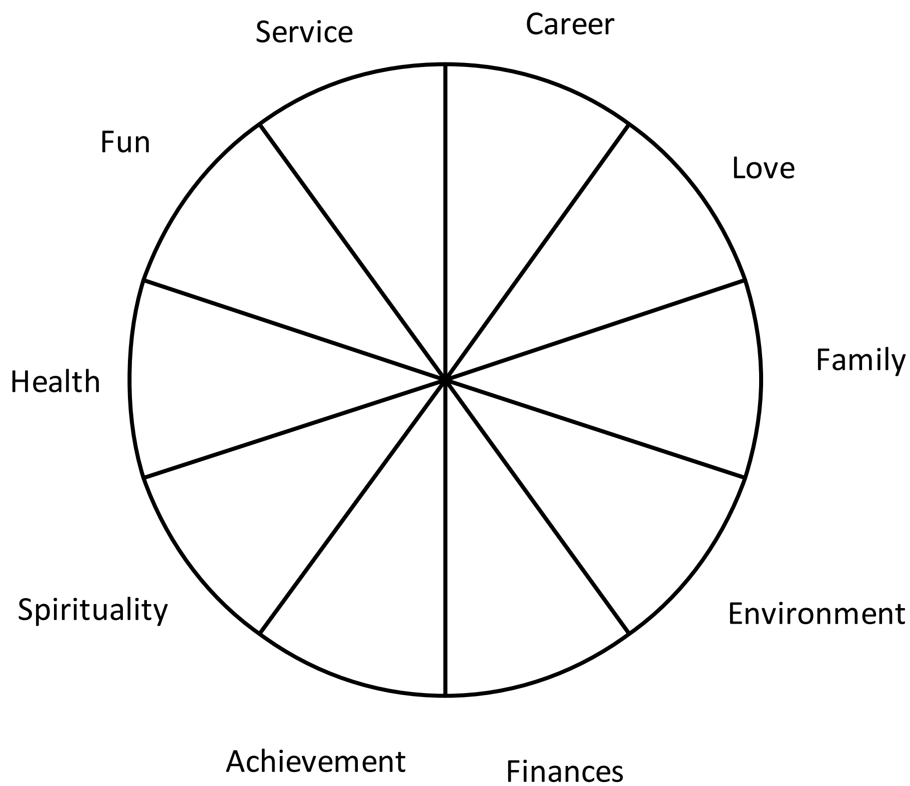
Hypothyroid	O	Y	N	P
Hyperthyroid	O	Y	N	P
Low blood sugar	O	Y	N	P
Diabetes		Y	N	

NEUROLOGICAL

Fainting	O	Y	N	P
Seizures	O	Y	N	P
Paralysis	O	Y	N	P
Numbness/tingling	O	Y	N	P
Memory loss	O	Y	N	P

WHEEL OF LIFE

Vitality and health are a balance of many factors. Using the pie graph below please shade your level of satisfaction in each area as it relates to you. For example: if you are extremely happy in your job, shade the entire pie shape for "Career." Do the same for each area, starting from the center point radiating outwards.



Last page...you did it! Well done!

Only one thing left! Please scan and e-mail to: drjessica@lockportwellness.com