Patient Privacy: *Patient information will never be disclosed or sold to an individual or company*. The information you provide herein is used solely by Zest Natural Medicine for administrative, diagnostic and/or treatment purposes, and will be treated in the strictest confidence.

Name:_____Today's Date:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone: (Home): _____ (Bus)_____

E-mail address: _____

Age:_____ Date of Birth: ____/_____/____ Gender: Female_____ Male_____

Married _____ Separated _____ Divorced _____ Widowed_____ Single_____ Partnership_____

Live with: Spouse_____ Partner_____ Parents_____ Children_____ Friends_____ Alone_____

Occupation:_____ Hours per week_____ Retired_____

Employer:_____

Work Address:_____

Do you have any family members that are patients at Zest Natural Medicine? _____

Name of next of kin or other to contact in an emergency:_____

Relationship to you:_____ Phone # _____

Address:_____

How did you first hear of us?

From a Patient	Radio/TV	Newspaper
Facebook	From a Medical Student	Internet / Website

Other: _____

FAMILY HISTORY

Do you have a family history of any of the following? *(Please circle all that apply)*

Cancer	Diabetes	Heart Disease	High Blood Pressure	Stroke
Kidney Disease	Epilepsy	Arthritis	Glaucoma	Hives
Tuberculosis	Asthma	Anemia	Mental Illness	Hay Fever

Any other relevant family history?

_____

_____

_____

CHILDHOOD ILLNESSES/ VACCINATIONS

(Please circle all that apply)

Did you have the following:	Diseases (D)	Get Immunized (I)	Neither (N)

Measles:	D I N	Chicken Pox:	D I N	Mumps:	D I N	Rubella:	D I N
Tetanus:	D I N	Whooping Cough:	D I N	Hemophilus (Hib):	D I N	Hep B:	D I N
German measles:	D I N						

Any vaccine reactions? _____

HOSPITALIZATION, SURGERY, IMAGING

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_____Year_____ _____Year_____

_____Year_____ _____Year_____

_____Year_____ _____Year_____

ALLERGIES

Are you hypersensitive or allergic to any drugs?_____

Any foods?_____

CURRENT MEDICATIONS

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping Pills	Y N
Steroids	Y N	Laxatives	Y N	Antihistamines	Y N

Please list any prescription and OTC medications, vitamins or other supplements you are taking:

_____ _____

_____ _____

_____ _____

GENERAL

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum Weight: _____ When: _____

Go on diets often? Y N Eat out often? Y N Drink/ eat refined sugar? Y N

When during the day is your energy the best? _____ When is it worst? _____

Do you exercise? Y N If yes, what kind?_____ How often?_____

TYPICAL FOOD INTAKE

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

To drink:_____

SLEEP

How long per night? _____ If you wake frequently, why?_____

Nightmares: Y N P Wakes refreshed: Y N P Must nap during the day: Y N P

Sleep walk: Y N P Grind teeth: Y N P Snore: Y N P

HOBBIES

Main interests and hobbies?_____

Watch television? **Y** **N** If yes how many hours? ____ Do you read? **Y** **N** If yes, how many hours? ____

SOCIAL LIFE

Enjoy job: Y N P Hours worked per week: _____ Highest level of education: _____

Take vacations: Y N P Spend time outside: Y N P Active spiritual practice: Y N P

Quality of significant relationship: _____

History of physical, mental/emotional or sexual abuse: Y N P

If so, at what age and by whom: _____

FOR THE FOLLOWING, PLEASE CIRCLE

(Y) Current	(N) Never	(P) Significant in Past

Smoking: Y N P Packs per day? _____ Number of years? _____

Coffee: Y N P Cups per day if Yes/Past? _____

Soda pop: Y N P Ounces per day if Yes/Past? _____

Alcohol: Y N P How often? _____ How much if Yes/Past? _____

Recreational drug use? Y N P What substance (s) /how often? _____

Any Alcohol Addiction? Y N P

Drug Addictions? Y N P

Alcohol/Drug Treatment? Y N P

TOXIC EXPOSURES

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

_____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?

_____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing?

_____

Are you particularly sensitive to perfumes, gasoline or other vapors?

_____

Do you use pesticides, herbicides or other chemicals around your home?

_____

REVIEW OF SYSTEMS

Zest natural medicine
Providing Naturopathic Primary Care

Mental / Emotional

Treated for emotional problems	Y	N	P	Depression	Y	N	P
Mood Swings	Y	N	P	Anxiety or nervousness	Y	N	P
Considered or Attempted suicide	Y	N	P	Tension	Y	N	P
Poor concentration	Y	N	P	Memory problems	Y	N	P

Immune

Reactions to immunizations	Y	N	P	Reactions to vaccinations	Y	N	P
Chronic Fatigue Syndrome	Y	N	P	Chronic infections	Y	N	P
Chronically swollen glands	Y	N	P	Slow wound healing	Y	N	P

Endocrine

Hypo / hyperthyroid	Y	N	P	Heat or cold intolerance	Y	N	P
Hypoglycemia	Y	N	P	Diabetes	Y	N	P
Excessive thirst	Y	N	P	Excessive hunger	Y	N	P
Fatigue	Y	N	P	Seasonal depression	Y	N	P

Neurologic

Seizures	Y	N	P	Paralysis	Y	N	P
Muscle weakness	Y	N	P	Numbness or tingling	Y	N	P
Loss of memory	Y	N	P	Easily stressed	Y	N	P
Vertigo or dizziness	Y	N	P	Loss of balance	Y	N	P

Skin

Rashes	Y	N	P	Eczema, Hives	Y	N	P
Acne, Boils	Y	N	P	Itching	Y	N	P
Colour change	Y	N	P	Perpetual hair loss	Y	N	P
Lumps	Y	N	P	Night sweats	Y	N	P

Head

Headaches	Y	N	P	Head injury	Y	N	P
Migraines	Y	N	P	Jaw / TMJ problems	Y	N	P

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Eyes

Spots in Eyes	Y	N	P	Cataracts	Y	N	P
Impaired vision	Y	N	P	Wear glasses or contacts	Y	N	P
Blurriness	Y	N	P	Eye pain / strain	Y	N	P
Color blindness	Y	N	P	Tearing or dryness	Y	N	P
Double vision	Y	N	P	Glaucoma	Y	N	P

Ears

Impaired hearing	Y	N	P	Ringing	Y	N	P
Earaches	Y	N	P	Dizziness	Y	N	P
Frequent colds	Y	N	P	Nose Bleeds	Y	N	P
Stuffiness	Y	N	P	Hay fever	Y	N	P

Nose and Sinues

Sinus problems	Y	N	P	Loss of smell	Y	N	P

Mouth and Throat

Frequent sore throat	Y	N	P	Copious saliva	Y	N	P
Teeth grinding	Y	N	P	Sore tongue / lips	Y	N	P
Gum problems	Y	N	P	Hoarseness	Y	N	P
Dental cavities	Y	N	P	Jaw clicks	Y	N	P

Neck

Lumps	Y	N	P	Swollen glands	Y	N	P
Goiter	Y	N	P	Pain or stiffness	Y	N	P

Respiratory

Cough	Y	N	P	Sputum	Y	N	P
Spitting up blood	Y	N	P	Wheezing	Y	N	P
Asthma	Y	N	P	Bronchitis	Y	N	P
Pneumonia	Y	N	P	Pleurisy	Y	N	P
Emphysema	Y	N	P	Difficulty breathing	Y	N	P
Pain on breathing	Y	N	P	Shortness of breath	Y	N	P
Shortness of breath at night	Y	N	P	Shortness of breath when lying down	Y	N	P
Tuberculosis	Y	N	P				

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Providing Naturopathic Primary Care

Cardiovascular

Heart disease	Y	N	P	Angina	Y	N	P
High / Low Blood Pressure	Y	N	P	Murmurs	Y	N	P
Blood clots	Y	N	P	Fainting	Y	N	P
Phlebitis	Y	N	P	Palpitations / Fluttering	Y	N	P
Rheumatic Fever	Y	N	P	Chest Pain	Y	N	P
Swelling in ankles	Y	N	P				

Gastrointestinal

Trouble swallowing	Y	N	P	Heartburn	Y	N	P
Change in thirst	Y	N	P	Abdominal pain or cramps	Y	N	P
Change in appetite	Y	N	P	Belching or passing gas	Y	N	P
Nausea / vomiting	Y	N	P	Constipation	Y	N	P
Ulcer	Y	N	P	Diarrhea	Y	N	P
Jaundice (yellow skin)	Y	N	P	Bowel Movements: How often? _____			
Gall Bladder disease	Y	N	P	Is this a change?	Y	N	
Liver Disease	Y	N	P	Black stools	Y	N	P
Hemorrhoids	Y	N	P	Blood / Mucus in stools	Y	N	P

Urinary

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

Musculoskeletal

Joint pain or stiffness	Y	N	P	Arthritis	Y	N	P
Broken bones	Y	N	P	Weakness	Y	N	P
Muscle spasms or cramps	Y	N	P	Sciatica	Y	N	P

Blood/ Peripheral Vascular

Easy bleeding or bruising	Y	N	P	Anemia	Y	N	P
Deep leg pain	Y	N	P	Cold hands / feet	Y	N	P
Varicose veins	Y	N	P	Thrombophlebitis	Y	N	P

Male Reproductive

Venereal disease	Y	N	P	Discharge or sores	Y	N	P

Gonorrhea	Y	N	P	Testicular masses	Y	N	P
Chlamydia	Y	N	P	Testicular pain	Y	N	P
Syphilis	Y	N	P	Prostate disease	Y	N	P
Genital warts	Y	N	P	Impotence	Y	N	P
Herpes	Y	N	P	Hernias	Y	N	P
Are you sexually active?	Y	N		Premature ejaculation	Y	N	P
Sexual orientation: _____				Erectile dysfunction	Y	N	P
Do you use a form or protection?	Y	N	P	Birth control: Type _____			

Female Reproductive/ Breasts

Age at first menses?_____				Date of last annual exam / PAP _____			
Age at last menses? (if menopausal) _____				Are cycles regular	Y	N	
Length of cycle _____ days				Bleeding between cycles	Y	N	P
Duration of menses _____ days				Pain during intercourse	Y	N	P
Painful menses	Y	N	P	Clotting	Y	N	P
Heavy or excessive flow	Y	N	P	Discharge	Y	N	P
PMS	Y	N	P	Birth control	Y	N	P
If yes, what are your symptoms?				What type: _____			

_____

_____

Number of pregnancies:_____ Number of live births: _____ Number of miscarriages: _____ Number of abortions: _____

Difficulty conceiving	Y	N	P	Menopausal symptoms	Y	N	P
Venereal Disease	Y	N	P	Endometriosis	Y	N	P
Gonorrhea	Y	N	P	Ovarian cysts	Y	N	P
Chlamydia	Y	N	P	Cervical Dysplasia	Y	N	P
Syphilis	Y	N	P	Abnormal PAP	Y	N	P
Genital warts	Y	N	P	Sexual difficulties	Y	N	P
Herpes	Y	N	P				
Are you sexually active?	Y	N	P	Sexual orientation: _____			
Do you do breast self-exams?	Y	N	P	Breast lumps	Y	N	P
Breast pain / tenderness	Y	N	P	Nipple discharge	Y	N	P

Is there anything else you would like to add or comment on?

_____
_____
_____
_____
_____

Cancellation Policy:
We will call to confirm 48 - 72 hours prior to your scheduled appointment and will require a return confirmation phone call from you.

Appointments cancelled with less than 24 hours notice may be charged $50.00. Missed appointments will be charged the full appointment fee.

I understand and agree:

Signature_____ **Date:** _____

Printed Name:_____

Thank you for your time and effort.
We at Zest Natural Medicine look forward to providing you with the best possible care!

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 will go a long way in assisting our understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid us to assist your health needs.

Why did you choose to come to Zest Natural Medicine?

_____

_____

What do you know of our approach to wellness?

_____

_____

What three (3) expectations do you have from this visit?

1. _____

2. _____

3. _____

What *long term* expectations do you have of your Zest Natural Medicine doctor?

_____

What is your present level of commitment to address any underlying causes of your signs/symptoms that relate to your lifestyle? *(Rate from 0 to 10, with 10 being 100% committed)*

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

What behaviors/ habits do you currently engage in regularly that you believe support your health? (Please list)

_____

What behaviors / habits do you currently engage in regularly that you believe are self-destructive? (Please list)

_____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

_____

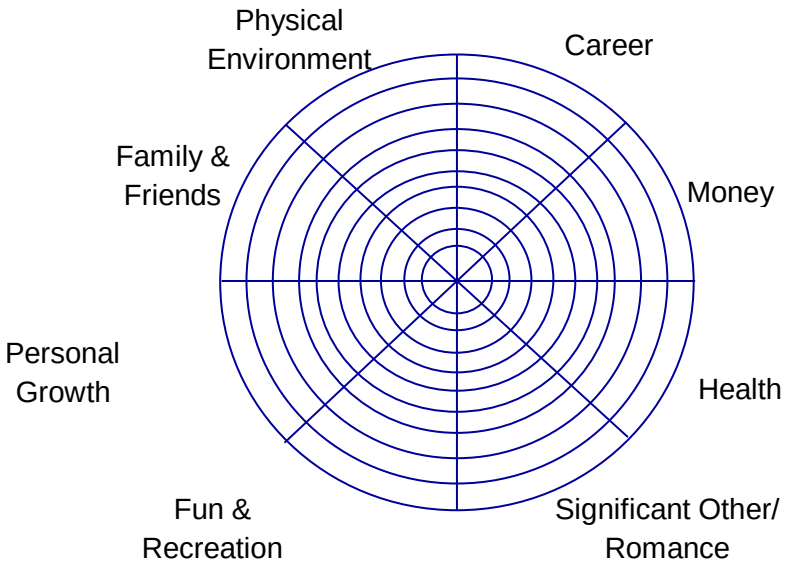
_____

Who will sincerely support you consistently with the beneficial lifestyle changes you will be making?

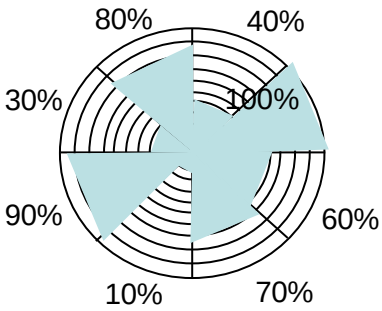
_____

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction as it relates to you. For example, if you are extremely happy and content with your career, then shade the entire pie section for career. Do the same for each pie section shading in from the center radiating outward.



Example



Are you currently receiving health care? Y N
If yes, where and from whom _____

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

What was the reason?_____

What are your most important health concerns? List as many as you can in order of importance:
1)_____
2)_____
3)_____
4)_____
5)_____
6)_____

Do you have any known contagious diseases at this time? Y N
If yes, what ?_____

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PAYMENT AGREEMENT

Dear New Patient,

Welcome to Zest Natural Medicine. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Pleae read and initial the following statements:

_____ Payment for all services and medicinary items is due at the time of the visit. We accept cash, checks, Visa and MasetrCard. Returned checks will e subject to a $35 NSF fee.

_____ Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention from your physical will incur a fee. Phone calls and emails regarding a new health issue, regardless of the time of attention required, will also incur a fee. Your physical will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment. Phone and email charges are not billable to insurance.

_____ You will be charged a Missed Appointment Fee of $50.00 for any missed appointments or late cancellations (less that 24 hours notice).

Your health care provider may prescribe medication, which may be purchased at Zest Natural Medicine or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies of Zest Natural Medicine and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ ____ / ____ / ____

Patient Signature (Parent/guardian signature if minor) Date

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E-MAIL AGREEMENT

E-Mail Authorization and Consent Agreement Between Zest Natural Medicine and Patient

I have been advised that:

- E-mail is never, ever appropriate for urgent or emergency problems.
- E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
- E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.
- There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.
- All e-mail correspondence will become a part of my medical record at Zest Natural Medicine. It is extremely important to include my name on each and every e-mail sent to Zest Natural Medicine and/or Dr. Kohler / Dr. Zeller.
- Since e-mail may not be monitored while my clinician is away on business or on vacation, I will follow-up by telephone or in person if I do not receive a response within a week.

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.

I have been provided with information about the use of Internet e-mail communications between my health provider, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at any time by contacting my clinician.

I designate that all e-mail correspondence coming from me or to me should be sent to the following Internet e-mail address:

Please print clearly:_____

Internet e-mail address (sample format: jdoe@aol.com)

Signature:_____Date:_____

Name:_____DOB:_____

Name of Physician (print):_____

Signature of Physician:_____

NOTICE OF PRIVACY POLICY

To our patients at Zest Natural Medicine:

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. **We are required by law to maintain the confidentiality of your health information.** We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health information to only certain individuals involved in you care or the payment for your care, such as family members and friends; We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Zest Natural Medicine, 1405 N. Dobson Road, Suite 9, Chandler, AZ 85224. Note: *We must respond to this request in 30 days.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Zest Natural Medicine, 1405 N. Dobson Road, Suite 9, Chandler, AZ 85224. You must provide us with a reason that supports your request for amendment. Note: *We must respond within 60 days. The Privacy Officer of the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice any time. To obtain a copy of this notice, contact Zest Natural Medicine.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Zest Natural Medicine. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information policies, please contact the office of Zest Natural Medicine at (480)-361-5108.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Zest Natural Medicine's Notice of Privacy Practices.

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ ____ / ____ / ____

Patient Signature (Parent/guardian signature if minor) Date

I authorize and agree that Zest Natural Medicine may disclose my protected health information to the following persons each of whom is directly involved in my care:

1. _____ 3. _____

2. _____ 4. _____

I acknowledge and agree that Zest Natural Medicine may disclose my protected health information to the persons set forth in this form and until I object to such disclosures, which must be provided in writing to Zest Natural Medcine.

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ ____ / ____ / ____

Patient Signature (Parent/guardian signature if minor) Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please specific): _____.