California Naturopathic Clinic

6860 Brockton Ave., Suite 6 • Riverside, CA 92506 • PH: (951) 202-2340 • E: info@calnc.com

Adult Patient Intake Form

Today's date: _____

Personal Information

First name	Last name	Date of birth
Parent's/Guardian's first name	Parent's/Guardian's last name	Notes

Home address (number and street).	Apt. no.

City, state, and ZIP code.

Home phone number	Cell phone number	Email address

How were you referred?

☐ Internet search
☐ Facebook
☐ Word of Mouth _____
☐ Other _____

Contact Preferences

☐ I'd like to receive appointment reminders via email
☐ I'd like to receive your free wellness newsletter via email

Emergency Contact

Emergency contact name	Relationship	Phone number

Home address (number and street).	Apt. no.

City, state, and ZIP code.

Please list the main reason(s) for your visit today in order of importance.

_____ _____ _____ _____

Health History

Last blood work/testing (year): _____
Last physical exam (year): _____
Abnormal labs in the past: ☐ Yes ☐ No
Abnormal exam(s) in the past: ☐ Yes ☐ No

Please list any known allergies (environmental, drug, food).

_____ _____ _____ _____

If any of the following apply to you please indicate *dates*:

Hospitalization _____
Surgery _____
X-ray _____
Rectal exam _____
Mammogram _____
MRI _____
Colonoscopy _____
Bone scan _____
CT scan _____
Electrocardiogram _____
Endoscopy _____
Other _____

Please list any pharmaceutical and/or natural medications (including vitamins) that you are **currently** taking.

Medication	Dosage	Date began taking	Reason for taking

For the following conditions and symptoms, please indicate any that apply to you by checking "**C**" for current or "**P**" for past.

C	P		C	P		C	P	
☐	☐	Skin rash	☐	☐	Fatigue	☐	☐	Chest pain
☐	☐	Easy bleeding or bruising	☐	☐	Anemia	☐	☐	Heart palpitations
☐	☐	Varicose veins	☐	☐	Weakness	☐	☐	High blood pressure
☐	☐	Bone or joint disease	☐	☐	Dizziness or fainting	☐	☐	Gastrointestinal disorder
☐	☐	Mood swings	☐	☐	Numbness/tingling/paralysis	☐	☐	Heartburn
☐	☐	Anxiety or nervousness	☐	☐	Neurological disease	☐	☐	Hemorrhoids
☐	☐	Difficulty sleeping	☐	☐	Seizures	☐	☐	Abdominal pain or ulcers
☐	☐	Feel unsafe at home	☐	☐	Memory loss	☐	☐	Excessive thirst/hunger
☐	☐	Physical abuse	☐	☐	Headaches	☐	☐	Hypoglycemia
☐	☐	Frequent antibiotic use	☐	☐	Head Injury	☐	☐	Eating disorder
☐	☐	Frequent colds or flu	☐	☐	Dental problems	☐	☐	Parasites
☐	☐	HIV or AIDS	☐	☐	Cold sores	☐	☐	Liver disease
☐	☐	Lyme disease	☐	☐	Ear infections	☐	☐	Gallbladder disease
☐	☐	Rheumatic fever	☐	☐	Impaired hearing/vision	☐	☐	Kidney disease
☐	☐	Thyroid problems	☐	☐	Sinus problems	☐	☐	Problems with urination
☐	☐	Chronic pain	☐	☐	Difficulty breathing			

Family History

If you or anyone in your family has had any of the following conditions, please indicate who was affected (*self, mother, father, sister, brother, child*):

Cancer _____
Heart disease _____
Stroke _____
High blood pressure _____
Alcoholism or substance abuse _____
Attempted suicide _____
Diabetes _____
Asthma, hay fever, rashes _____
Osteoporosis _____
Depression _____
Autoimmune disease _____
Other _____

For Women Only

Last period _____
Last Pap smear _____
Age first period occurred _____
Number of pregnancies _____
Number of live births _____
Did you breast feed: ☐ Yes ☐ No

Please check **all** that apply to you:

☐ Hysterectomy _____
☐ Abnormal Pap smear
☐ Breast pain/lump/nipple discharge
☐ Sexual difficulties
☐ Frequent vaginitis/chronic yeast infections
☐ Abnormal vaginal discharge
☐ Endometriosis
☐ Polycystic ovary syndrome
☐ Sexually transmitted infections
☐ Pelvic inflammatory disease
☐ Uterine fibroids
☐ Impaired fertility
☐ Sexual abuse
☐ Regular self-breast exam
☐ Sexually active
☐ Use methods to prevent pregnancy and/or sexually transmitted infections:
Current _____
Past _____

If you are still having periods:
Average number of days of bleeding _____
Average number of days in cycle _____

Bleeding is:
☐ Regular (every 21-35 days)
☐ Irregular
☐ Light
☐ Medium
☐ Heavy (soak 1 or more pads or tampons every hour for at least 2 days)

Symptoms:
☐ Bleeding between periods
☐ Mood swings
☐ PMS
☐ Painful periods
☐ Breast tenderness

If you are no longer having periods:
☐ Hot flashes
☐ Dry skin
☐ Spotting
☐ Hair loss
☐ Incontinence
☐ Vaginal dryness
☐ Changes in memory
☐ Changes in libido
☐ Changes in mood
☐ Use Hormone Replacement
☐ Urinary tract infections

For Men Only

Please check **all** that apply to you:
☐ Prostate problem
☐ Prostate exam date: _____
☐ Difficulty starting urination
☐ Frequent urination
☐ Regular self-testicular exam
☐ Impaired fertility
☐ Sexual abuse
☐ Erectile dysfunction
☐ Changes in libido
☐ Abnormal discharge from penis
☐ Sexually transmitted infection
☐ Use methods to prevent sexually transmitted infections: _____
☐ Pain or lump in scrotum

Lifestyle History

Please check any that apply to you and fill in corresponding details:
☐ Exercise _____ hours per week
Activities _____
_____
_____
☐ TV and/or Computer _____ hours per week
☐ Tobacco use _____ packs per day
☐ Alcohol use _____ drinks per week
☐ Recreational drug use _____
☐ Employed outside the home
Occupation _____
Hours per week _____
Employer _____
Do you enjoy your work? ☐ Yes ☐ No
Level of life stress ☐ Low ☐ Ave. ☐ High

Height _____
Weight _____
Maximum weight _____
When? _____
Sleep _____ hours per night
Is this enough? ☐ Yes ☐ No
Meals per day _____
Bowel movements per day _____
Dietary restrictions _____
_____
☐ Heterosexual ☐ Homosexual ☐ Bisexual
☐ Married ☐ Relationship ☐ Single: _____
Name of spouse or partner: _____

Toxic exposure/Chemical sensitivity:
☐ Lead
☐ Mercury
☐ Solvents
☐ Sensitive to chemicals/perfumes
☐ Other _____

Major life changes in the last year _____
_____
_____

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Informed Consent and Request for Naturopathic Treatment

I understand that naturopathic evaluation and treatment may include, but is not limited to:

- Physical exam (general and female)
- Common diagnostic procedures (pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Dietary advice and therapeutic nutrition (use of foods, diet plans, nutritional supplements, and intravenous/ intramuscular injections)
- Herbs/natural medicines (prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, topical creams or other forms.
- Homeopathic remedies (often highly diluted quantities of natural occurring substances)
- Over the counter and prescription medications

I understand, and I am informed that in the practice of Naturopathic Medicine there are some risks and benefits with evaluation and treatment including, but not limited to the following:

- Potential risks: allergic reaction to prescribed herbs, supplements, prescription medications; and aggravation of pre-existing symptoms.
- Potential benefits: restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.
- Notice to pregnant women: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explains therapies and procedures to my satisfaction. I further acknowledge that no guarantees or services have been made to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent's (Guardian's) Name: _____

Parent's (Guardian's) Signature: _____ Date: _____

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Financial Policy

Appointments
New patients booking your first appointment must reserve your appointment time with a valid credit card number. [**Don't have a credit card?** That's okay. Call our office to book a same-day appointment (no credit card required-subject to availability). Or, stop by and book in-person by prepaying for your appointment.] Your card will not be charged before your appointment time. On the day of your visit, you may pay with cash, debit or credit card (we do not accept checks). We will keep your credit card number on file for return visits subject to our cancellation policy below.

Cancellations
If you need to change or cancel your appointment, you must call or email our office at least **24 hours** in advance of your scheduled appointment time (if the office is closed leave a message or email us). You may also cancel your appointment through our online booking site (the link is on our website at calnc.com). This applies to New Patient Visits, Return Patient Visits and all other therapies including IV therapy.

More than 24-hour cancellation notice = No charge
No cancellation notice/less than 24-hour notice = Your credit card on file will be charged the full visit price including for IV Vitamin Drips. Any pre-paid service (i.e., IV packages) will be reduced by 1 for each missed appointment for that service.

Payment Policy
Payment for services is due at the time services are rendered.

Insurance Reimbursement Policy
Naturopathic doctors' services may be covered by some PPO plans as out-of-network providers. ***We do not bill insurance companies directly.*** For submission of a claim for reimbursement on your own, a superbill providing a summary of the services rendered, diagnoses and charges applied, will be provided to you upon request.

By signing below, I have read and agree to the above policies.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent's (Guardian's) Name: _____

Parent's (Guardian's) Signature: _____ Date: _____

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations (HIPAA)

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent's (Guardian's) Name: _____

Parent's (Guardian's) Signature: _____ Date: _____

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Consent to receive "Text message" reminders for appointments from Full Slate appointment-booking site

I _____ agree to receive text message appointment reminders to my cell phone number_____ from California Naturopathic Clinic (CalNC). I understand I will receive no more than one (1) to two (2) messages per appointment. I understand that carrier message and data rates may apply to these messages. I understand that my consent to receive text appointment reminders is not a condition of purchasing services or products from CalNC or Dr. Dzvonick. I may choose to stop receiving text reminders at any time by texting "STOP" to 36070. I can find Full Slate's complete text message policy at: http://www.fullslate.com/sms

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent's (Guardian's) Name: _____

Parent's (Guardian's) Signature: _____ Date: _____