Chaney Integrative Family Medicine

Electronic Mail Consent Form

I, _____, am an established patient of Dr. Amanda H. Chaney. I wish to participate in medical electronic mail ("e-mail") with Dr. Chaney. I understand that this e-mail will not be entirely secure/private, although Dr. Chaney will take every precaution to protect my privacy. All computer files and Internet transactions are protected through a password system.

I understand that my e-mail correspondence will be printed and placed in my medical record for documentation purposes.

I also understand that this mode of communication is to be used for non-urgent questions or communication only. Any urgent messages or needs will be relayed using regular telephone communications. Dr. Chaney has informed me that e-mail may not be checked on a daily basis. It may take up to three (3) working days to receive a response to my e- mail query.

I also understand that if my messages require more than just a quick response from Dr. Chaney, I will either be billed for her time or she may reply that I need to schedule an appointment.

_____ Signature _____ Date

_____ Date of Birth

_____ Printed Name

CHANEY INTEGRATIVE FAMILY MEDICINE Name: _____

Health History Questionnaire Date of Birth: _____ Today's Date: _____

Address: _____ City, ST: _____ Zip: _____

Phone Number: _____ (Home) _____ (Work) _____ (Mobile)

Email Address: _____

Emergency Contact: _____ Phone: _____ Referred by: _____

Reason for visit: _____ Date condition began (be specific): _____

What are your expectations and goals for the visit? _____

_____

What prior experiences have you had with complementary and alternative medicine? _____

_____

Health Concerns (Please rank by priority) Example: Headache – August 2000 – 3x/week – mild/mod/severe

Concern	Onset	Frequency	Severity

Current Medications (include nonprescription drugs as well. List all herbs, vitamins and supplements on page 8).

Name of Medication	Dosage (mg)	How Often?	ReasonTaken

Drug Allergies/Reactions/Sensitivities (drug, food, environment):

_____

_____

Vaccinations (date):

Pneumonia _____ Hepatitis B _____ Tetanus _____ Rubella _____

Influenza _____ Other _____

Medical History
Surgeries: Date/Operation

_____

_____

_____

Other Hospitalizations, Injuries or Illnesses:
Date/Reason

_____

_____

_____

Illnesses (√ past and/or present)

☐	Arthritis	☐	High Cholesterol	☐	Stroke
☐	Alcoholism	☐	Kidney Disease	☐	Thyroid Disease
☐	Diabetes	☐	Liver Disease	☐	AIDS
☐	Heart Disease	☐	Lung Disease	☐	Hepatitis
☐	High Blood Pressure	☐	Stomach Ulcers	☐	Cancer (Type) _____
				☐	Other _____

Have any of your relatives had the following? Place appropriate letter for family members in box

F = Father M = Mother S = Sister B = Brother A = Aunt U = Uncle GM = Grandmother C = Child

	No	Yes	If yes, which family member	Age at Diagnosis
Heart Disease	☐	☐	_____	_____
High blood pressure	☐	☐	_____	_____
Diabetes	☐	☐	_____	_____
Cancer	☐	☐	_____	_____
Depression	☐	☐	_____	_____
Anxiety	☐	☐	_____	_____
Osteoporosis	☐	☐	_____	_____
Kidney disease	☐	☐	_____	_____
Alcoholism/Substance abuse	☐	☐	_____	_____
Headaches	☐	☐	_____	_____
Inflammatory bowel disease	☐	☐	_____	_____
Thyroid disease (goiter, high/low)	☐	☐	_____	_____
Hay fever, asthma, eczema	☐	☐	_____	_____
Seizure/epilepsy	☐	☐	_____	_____
Glaucoma	☐	☐	_____	_____
Anemia	☐	☐	_____	_____

	Current Age	Age @ Death	Cause of Death		Current Age	Age @ Death	Cause of Death
Father				Spouse			
Mother				Children			
Brothers							
Sisters							

Social History

□ Married □ Partnered □ Single □ Divorced (year _____) □ Widowed (year _____)

Present relationship (# yrs) _____ Previous relationship (# yrs) _____

Present Occupation _____ yrs _____ Education _____

Previous Occupation _____ yrs _____ Partner's Occupation _____

Persons currently living in your home _____

Do you have a living will? □ No □ Yes (please provide copy)

Do you use tobacco? □ No (if quit, when? _____) □ Yes (how long?) _____

Do you want to quit? □ No □ Yes In what form do you use tobacco? _____ How much? _____

Do you exercise? □ No □ Yes How many times a week? _____ How long? _____

Do you drink alcohol? □ No (If quit, when? _____) □ Yes For how many years? _____

What do you drink? _____ How much? _____ How often? _____

Have you ever used "street" (illegal) drugs? □ No □ Yes Intravenous Drugs? □ No □ Yes

Are you concerned about exposure to AIDS or other sexually transmitted diseases? □ No □ Yes

Have you ever been tested for HIV? □ No □ Yes (date/result _____)

Do you want to be tested? □ No □ Yes

Have you ever been treated for drug/alcohol abuse? □ No □ Yes

What are the major stressors in your life? _____

_____

What do you do to relieve stress? _____

What do you do for fun?_ _____

What interests/hobbies do you have? _____

Do you have a spiritual or religious practice? _____

What brings you joy? _____

What is most important to you? _____

What causes the greatest challenges to you? _____

What do you do well? _____

What are your greatest fears and deepest sorrows? _____

_____

Do you have any insight into your illness? _____

_____

What does health mean to you? _____

_____

If you could change on thing in your life, what would it be? _____

_____

_____

√ **Present (P) or Past as appropriate**

General

Recent weight change:
_____ lbs (gain or loss?)

Childhood/other Illnesses
P or Past
□ □ Chicken pox
□ □ Childhood hyperactivity
□ □ German measles
□ □ Measles
□ □ Mononucleosis
□ □ Mumps
□ □ Polio
□ □ Malaria
□ □ Tuberculosis

Skin Problems

P or Past
□ □ Eczema
□ □ Psoriasis
□ □ Dandruff/dry scalp
□ □ Dry, itchy skin
□ □ Hives or rashes
□ □ Bruise easily
□ □ Soft/brittle nails
□ □ Perspire easily
□ □ Night sweats
□ □ Fever
□ □ Cold sores/herpes
□ □ Sores in mouth
□ □ Gum problems
□ □ Grinding teeth
□ □ Cold hands, and feet

Head and Neck

P or Past
□ □ Change in vision
□ □ Eye infections
□ □ Floaters
□ □ Double vision
□ □ Cataracts
□ □ Glaucoma
□ □ Hearing loss
□ □ Ringing in ears
□ □ Frequent nosebleeds
□ □ Nasal/sinus congestion
□ □ Sore throat
□ □ Persistent hoarseness
□ □ Tonsilitis
□ □ Goiter
□ □ Difficulty swallowing
□ □ Loss of Smell
□ □ Neck Lumps
□ □ Tearing

Heart and Circulation

P or Past
□ □ Tightness/pain in chest
□ □ Palpitations
□ □ Ankle/foot swelling
□ □ Heart murmur
□ □ Rheumatic fever
□ □ High blood pressure
□ □ Varicose veins/phlebitis
□ □ Shortness of breath when lying down
□ □ Leg pain with walking
□ □ Heart disease list: _____

Nervous System

P or Past
□ □ Migraine/headache
□ □ History of head injury
□ □ Dizziness
□ □ Seizures/convulsions
□ □ Numbness/tingling
□ □ Paralysis
□ □ Stroke
□ □ Weakness
□ □ Tremors/shakes
□ □ Difficulty with memory
□ □ Difficulty with writing
□ □ Difficulty with walking
□ □ Difficulty with speaking
□ □ Tired upon awakening
□ □ Insomnia
□ □ Difficulty sleeping
□ □ Nightmares/vivid dreams
□ □ Depression/unhappiness
□ □ Crying spells
□ □ Trouble concentrating
□ □ Exhaustion/fatigue
□ □ A wish to be dead and away
□ □ Nervousness/anxiety
□ □ Panic attacks
□ □ Stress
□ □ Nervous breakdown
□ □ Seasonal Allergies

Blood

P or Past
□ □ Anemia
□ □ Easy bruising/bleeding
□ □ Blood transfusion(s)
□ □ Swollen glands
□ □ Leukemia
□ □ Heat or Cold Intolerance
□ □ Positive TB skin test
□ □ Thyroid Disorder
□ □ Blood Transfusion When? _____

Lungs

P or Past
□ □ Daily cough
□ □ Blood in sputum
□ □ Allergies
□ □ Exposure to TB
□ □ Bronchitis
□ □ Hay Fever
□ □ Wheezing/asthma
□ □ Emphysema
□ □ Pneumonia
□ □ Pleurisy
□ □ Shortness of breath
□ □ Loud snoring
□ □ Falling asleep while working

√ **Present (P) or Past as appropriate**

Bones and Joints

P or Past

□ □ Arthritis
□ □ Joint Pain
□ □ Swollen joints
□ □ Red or warm joints
□ □ Joint Stiffness
□ □ Back pain/injury
□ □ Sciatic pain
□ □ Scoliosis
□ □ Gout
□ □ Osteoporosis
□ □ Rheumatism
□ □ Morning joint stiffness

Stomach and Bowels

P or Past

□ □ Decreased appetite
□ □ Hypoglycemia
□ □ Nausea/vomiting
□ □ Heartburn/indigestion
□ □ Abdominal pain/bloating
□ □ Use antacids
□ □ Belching
□ □ Flatulence (gas)
□ □ Ulcers
□ □ Gallbladder disease
□ □ Gallstones
□ □ Change in bowel habits
□ □ Diarrhea
□ □ Frequent loose stools
□ □ Constipation
□ □ Black or bloody stools
□ □ Hemorrhoids
□ □ Colon problems/colitis
□ □ Jaundice/hepatitis
□ □ Anorexia/bulimia
□ □ Hiatal hernia
□ □ Poor eating habits

Kidneys and Bladder

P or Past

□ □ Hernia in groin
□ □ Blood in urine
□ □ Kidney stones
□ □ Nighttime urination
_____x per night
□ □ Frequent daytime urination
□ □ Stream weak/slow
□ □ Difficulty starting stream
□ □ Discomfort on urination
□ □ History of urinary infection
□ □ Loss of bladder control
□ □ Loss of sexual interest
□ □ History of venereal disease
□ □ Practice Birth Control
Method_____
Sex satisfactory Yes/No

Men

P or Past

□ □ Penile sores or discharge
□ □ Testicular pain/lumps
□ □ Impotence
□ □ History of venereal disease
□ □ Herpes
□ □ Prostate infection/enlarged
□ □ Burning urination
□ □ Dribbling urination
□ □ Nocturnal emission
□ □ Vasectomy

Women

P or Past

□ □ Irregular periods
□ □ Severe menstrual cramps
□ □ Vaginal spotting
□ □ Heavy menstrual flow
□ □ Clotting
□ □ Vaginal discharge
□ □ Itching
□ □ Hot flashes
□ □ Pain with intercourse
□ □ Bleeding with intercourse
□ □ Yeast infection
□ □ Genital burning
□ □ Herpes
□ □ Infertility
□ □ Ovarian cyst
□ □ Uterine fibroids
□ □ Age of menopause ____
□ □ Complications of pregnancy
□ □ Pelvic inflammatory disease
□ □ Tubal ligation
□ □ PMS-physical
□ □ PMS-emotional

Breast

□ □ Lumps in breasts
□ □ Nipple discharge
□ □ Had mammogram
Date of last exam
_____

Menstrual History

Age @ onset _____
Last period _____
days between periods _____
days period lasts _____
Cycles Regular? _____
Last pap _____
Circle: Normal/abnormal
Number of pregnancies _____
Number of miscarriages _____
Number of abortions _____
Birth control pill
Circle: Yes/No

Health Maintenance

Examination		If yes, when? Month/Year			If yes, when? Month/Year
Pap/pelvic exam (females)	□ Yes □ No	_____	Mammogram (females)	□ Yes □ No	_____
Prostate Specific Antigen (Male)	□ Yes □ No	_____	Blood pressure check	□ Yes □ No	_____
Urinalysis	□ Yes □ No	_____	Chest x-ray	□ Yes □ No	_____
Cardiovascular stress test	□ Yes □ No	_____	Glaucoma screening	□ Yes □ No	_____
Eye Exam	□ Yes □ No	_____	Flexible sigmoidoscopy	□ Yes □ No	_____
Colonoscopy	□ Yes □ No	_____	Test of stool for blood	□ Yes □ No	_____
Bone density test (Dexa Scan)	□ Yes □ No	_____			

Sleep

How many hours sleep do you average? _____ Do you ever have trouble falling asleep? _____

Do you feel rested when you awaken? □ Yes □ No Do you feel tired or irritable during the day? _____

Do you ever wake up during the night and can't fall back to sleep? □ Yes □ No

Has your partner ever complained that you snore? □ Yes □ No Do you take naps during the day? □ Yes □ No

Safety

Do you use regular sunscreen? □ Yes □ No If yes, what brand? _____

Do you routinely wear a seatbelt? □ Yes □ No What time of day is your energy the best? _____ the worst? _____

Support

Do you enjoy your work? _____ Do you take vacations? _____

Friends/support network _____

Have you ever seen a psychotherapist? If so, please explain: _____

_____

_____

What have been the pivotal events in your life? _____

_____

_____

_____

What are your health and lifestyle goals for the present and for the next 3-5 years? _____

_____

_____

_____

_____

Nutrition Evaluation Food Diary

Please list all foods and drinks that you have consumed in the previous 24 hours. Included meals, snack, beverages and condiments.

Food Item How Prepared (baked, Fried, Etc.)

_____

_____

_____

_____

_____

_____

_____

Is this a typical day? Please describe.

_____

_____

_____

How many servings of fruit do you eat/drink each day? _____ (serving = 1 small piece fruit, 12/ cup juice, ½ cup canned/chopped fruit or ¾ dried fruit)

How many servings of vegetables do you consume each day? _____ (serving = ½ cup raw/cooked, 1 cup fresh green leafy, ¼ cup dried)

What are your sources of protein? _____

Are you currently on a special diet? If yes, please explain. _____

_____

_____

What type of oil or spreads do you add to your food? _____

What kind of oil do you cook with? _____ Do you eat refined sugar? □ Yes □ No

Do you salt your food? □ Yes □ Heavily □ Moderately □ Not at all

Who prepares your meals? _____ How often do you eat out? _____

How often do you eat fast food? _____ Do you drink coffee? □ Yes. How much? ___ □ No

How would you describe your relationship with food? _____

_____

_____

Do you drink black/green tea? □ Yes. How much? ___ □ No

Do you drink cola or other sodas? □ Yes. How much? ___ □ No

How many glasses of water do you drink a day? Do you drink □ tap □ spring □ well □ filtered □ distilled

Vitamins and Supplements

What vitamins/minerals/supplements are you taking now? Please bring all of your supplements and medications to your first appointment.

Brand or Other Name (Manufacturer)	***Reason***	***When Started***	***Dosage per day***
Example – St. John's Wort (Nature's Way	Feeling down	2 months ago	2 capsules

Chaney Integrative Family Medicine
DR. AMANDA H. CHANEY, N.D.

FINANCIAL AGREEMENT

Thank you for trusting Chaney Integrative Family Medicine where we are committed to providing the best health care possible. The following statement explains our financial policy. Please read the policy, sign and return to us prior to your treatment. Your payment is due at the time services are provided.

Naturopathic Medicine may be covered by some PPO plans. Please check with your insurance company to determine if this is a covered benefit. Chaney Integrative Family Medicine does not submit billing claims. A superbill will be provided for you to send into your insurance company for reimbursement. Most HMOs do not reimburse for services provided by Naturopathic Doctors.

Returned Checks
For checks returned to us as unpaid by your bank, you will be charged a $25.00 fee. Any legal fees that we incur to secure past due balances will be added to your account.

Missed Appointments
Please provide at least 24 hours notice of cancellation as a courtesy. Please help us to serve you better by keeping scheduled appointments.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered to me at Chaney Integrative Family Medicine are charged directly to me, and that I am personally responsible for payment on date of service. Chaney Integrative Family Medicine is not a participant in Medicare or HMO insurance plans. Chaney Integrative Family Medicine does not guarantee that you will receive reimbursement from your insurance carrier.

I have read and agree to the financial terms and cancellation policy above.

Date _____ Signature of Patient _____

Signature of Patient Representative or Legal Guardian _____

Relationship to Patient _____

Chaney Integrative Family Medicine
DR. AMANDA H. CHANEY, N.D.

INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Dr. Amanda H. Chaney of Chaney Integrative Family Medicine, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

***Common diagnostic procedures*: Including but not limited to general physical exams, blood, saliva, stool and urine lab work.**

***Minor office procedures*: e.g., dressing a wound.**

***Medicinal use of nutrition*: therapeutic nutrition and nutritional supplements.**

***Botanical medicine*: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, or suppositories.**

***Homeopathic medicine*: the use of highly dilute quantities of naturally occurring elements to gently stimulate the body's healing responses.**

***Lifestyle counseling and hygiene*: promotion of wellness, including recommendations for exercise, sleep, contraception and stress reduction.**

I understand that treatment by a naturopathic medical doctor is intrinsically different from treatment by a conventional medical doctor. Naturopathic medicine is intrinsically safer than other systems of medicine, though there are potential risks in what we do as well. The care we provide may, or may not, be directed at a specific disease or disorder. It may be preventative in nature, designed to improve overall health and well-being, and restore the body's innate healing ability.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from procedures.

***Potential benefits*: restoration of health and the body's maximal functional 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 doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.**

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Chaney Integrative Family Medicine regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
Privacy Notice: Chaney Integrative Family Medicine is required by law to respect your privacy by following specific HIPPA guidelines. A "Notice of Privacy Practices" document is available upon request.

Date _____ Signature of Patient _____

Signature of Patient Representative or Legal Guardian _____

Relationship to Patient _____