

Tahoe Center of Natural Medicine, 600 N. Lake Blvd., POB 5024, Tahoe City, CA 96145  
Phone: 530.583.0002 Fax : 530.583.0044

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female

Marital Status:  Single  Partnered  Married  Separated  Divorced  Widowed

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us?

Local ad, \_\_\_\_\_  Referral, \_\_\_\_\_  Other, \_\_\_\_\_

**Financial Agreement:** *I agree full financial responsibility for services rendered at Tahoe Center of Natural Medicine and understand that payment is required in full at time of service unless prior arrangements were agreed to in advance. Notice of 24 hours is necessary for cancelled appointments. We reserve the right to charge for a missed appointment.*

Signature (patient/ parent/ guardian): \_\_\_\_\_

**HEALTH HISTORY QUESTIONNAIRE**

*All questions contained in this questionnaire are strictly confidential and will become part of your medical record.*

**PERSONAL HEALTH HISTORY**

Primary Care Physician: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

When, where and for what did you last receive medical/ health care?

What are your most important current health concerns (listing the most important concern as #1)?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please list allergies to any food, drugs or other known allergies: (ie, penicillin, antibiotics, sulfa drugs, aspirin, latex, etc)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Any Medical Problems currently being managed by another physician, please include physician's name:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Major injuries, including broken bones:**

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**Hospitalizations/ Surgeries:** (please indicate year, reason and location)

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**Special Studies:** (please indicate any x-rays, CAT scans, MRI's, EKG's you have had and when)

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**Childhood Illness:**    Measles    Mumps    Rubella    Chickenpox    Rheumatic Fever    Polio

**Immunizations/ dates:**    Tetanus, \_\_\_\_\_    Pneumonia, \_\_\_\_\_    Hepatitis, \_\_\_\_\_

Chickenpox, \_\_\_\_\_    Influenza, \_\_\_\_\_

MMR (Measles, Mumps, Rubella), \_\_\_\_\_

**Do you use any of the following?**

Laxatives    Pain relievers    Antacids    Cortisone    Hormones    Sleeping aids

Tranquilizers    Thyroid medication    Antidepressants

**List all prescription and over-the counter drugs you are taking on a routine (daily, weekly, monthly) basis:**

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**List all vitamins and supplements you are taking on a routine (daily, weekly, monthly) basis:**

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**FAMILY HEALTH HISTORY**

Do you have a family history of any of the following? (please indicate relationship)

Cancer, \_\_\_\_\_    Diabetes, \_\_\_\_\_    Stroke, \_\_\_\_\_

Heart Disease, \_\_\_\_\_    High Blood Pressure, \_\_\_\_\_

Asthma, \_\_\_\_\_    Hayfever, \_\_\_\_\_    Hives, \_\_\_\_\_

Osteoporosis, \_\_\_\_\_    Other, \_\_\_\_\_

**HEALTH HABITS**

What is your average energy level on a scale of 1-10, 10 being the optimal energy level you think you should have? \_\_\_\_\_

Number of hours you sleep nightly? \_\_\_\_\_   Hours of sleep you would like to get per night, ideally? \_\_\_\_\_

Weight (lbs): Current: \_\_\_\_\_   One year ago: \_\_\_\_\_   Ideal: \_\_\_\_\_   Max (adult): \_\_\_\_\_   Min: \_\_\_\_\_

YES   NO

     Do you exercise?

     Do you have a good support system?

     Do you have a spiritual practice?

     Do you follow any particular diet?

     Do you exclude any foods from your diet?

     Do you consume caffeine daily?

     Do you use tobacco?

YES   NO

     Do you wake rested?

     Do you wake during the night?

     Do you consume alcohol?

     Have you been treated for alcoholism?

     Do you use recreational drugs?

     Have you been treated for drug abuse?

## REVIEW OF SYSTEMS

*Please check the boxes of symptoms that you are currently experiencing, or have experienced in the past 6 months:*

**CONSTITUTIONAL:**

<input type="checkbox"/> Generally don't feel well	<input type="checkbox"/> Unexplained Weight Change	<input type="checkbox"/> Unexplained Fever
<input type="checkbox"/> Weakness/ Fatigue	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Chills
<input type="checkbox"/> Fluid Retention		

**ALLERGIC/ IMMUNOLOGIC:**

<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Hives	<input type="checkbox"/> History of vaccines reactions
<input type="checkbox"/> Food Intolerances/ allergies/ reactions		<input type="checkbox"/> Autoimmune Disease
(circle any) Consistent exposure to: Chemicals/ Pollution/ Heavy Metals/ Toxins		
(circle any) Sensitivity to: Sugar/ Caffeine/ Chemicals/ Perfume/ Medicines		

**NEUROLOGICAL:**

<input type="checkbox"/> Serious Head Injury	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Migraines
<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Tremors	<input type="checkbox"/> Paralysis/ Muscle Weakness	<input type="checkbox"/> Fainting/ dizziness

**ENDOCRINE:**

<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Low Blood Sugar
<input type="checkbox"/> Hyper/ hypothyroid	<input type="checkbox"/> Hot or cold intolerance	<input type="checkbox"/> High Blood Sugar

**HEMATOLOGIC/ LYMPH:**

<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> History of blood transfusions, year _____
<input type="checkbox"/> Blood Clotting Disorder	<input type="checkbox"/> Anemia

**MENTAL HEALTH:**

<input type="checkbox"/> Relationship/ personal/ employment difficulties	<input type="checkbox"/> General dissatisfaction with life
<input type="checkbox"/> History of Abuse ( <i>Physical, Emotional or Sexual</i> )	<input type="checkbox"/> History of Chemical Dependency ( <i>Drugs/Alcohol</i> )
<input type="checkbox"/> Depression	<input type="checkbox"/> Nervous/Anxious
<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Irritable/Angry
	<input type="checkbox"/> Difficulty Sleeping

**EYES:**

<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Blurred/ double vision	<input type="checkbox"/> Tearing or dryness
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Corrective lenses

**EARS/ NOSE/ THROAT:**

<input type="checkbox"/> Frequent ear infections/ earaches	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> History of Antibiotic Use	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Stuffy Nose/ Sinus problems	<input type="checkbox"/> Post Nasal Drip	<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Canker Sores	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Bleeding Gums
<input type="checkbox"/> Gingivitis	<input type="checkbox"/> Dentures	<input type="checkbox"/> Change in sense of taste
<input type="checkbox"/> Persistent Hoarseness	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Goiter

**CARDIOVASCULAR:**

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Leg Pain on Walking	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Ankle/Leg Swelling
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Chest Tightness/Pressure	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Angina	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Enlarged Heart	<input type="checkbox"/> Heart disease	
Date of Last Chest X-ray _____	Date of Last EKG _____	

**RESPIRATORY:**

<input type="checkbox"/> Frequent Cough/ colds	<input type="checkbox"/> Coughing phlegm	<input type="checkbox"/> Coughing blood
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Asthma	<input type="checkbox"/> Difficultly/ pain upon breathing
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Shortness of breath, at night	<input type="checkbox"/> Shortness of breath, lying down	<input type="checkbox"/> Shortness of breath, on exertion
<input type="checkbox"/> Bronchitis		

**GASTROINTESTINAL:**

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Changes in appetite/ thirst	<input type="checkbox"/> Daily passing gas/ belching
<input type="checkbox"/> Change in Bowel Habits	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Indigestion/Heartburn	<input type="checkbox"/> Gas/Bloating	<input type="checkbox"/> Undigested Food in Stool
<input type="checkbox"/> Nervous Stomach	<input type="checkbox"/> Gall Bladder disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Jaundice/Hepatitis/ Liver Disease	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Hernia
<input type="checkbox"/> Black or Bloody Stool	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Food Intolerance
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	# Bowel Movements/day _____
Date of Last Colonoscopy _____		

**SKIN:**

<input type="checkbox"/> Rashes	<input type="checkbox"/> Multiple Skin Tags	<input type="checkbox"/> Bleed or Bruise Easily
<input type="checkbox"/> Persistent Itch	<input type="checkbox"/> Eczema, hives	<input type="checkbox"/> Hair/Nail Changes
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Acne, boils
<input type="checkbox"/> Changing Skin Lesion(s), changing skin color		

**MUSCULOSKELETAL:**

<input type="checkbox"/> Arthritis/Joint Pain	<input type="checkbox"/> Bursitis/Tendonitis	<input type="checkbox"/> Gout
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Muscle Cramps	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Restless Legs	Date of Last Osteoporosis Screen _____	

**GENITOURINARY:**

<input type="checkbox"/> Bladder Problems/ infections	<input type="checkbox"/> Frequent kidney infection	<input type="checkbox"/> Increased frequency of urination
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Wake at night to urinate	<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Pain/ difficulty with urination	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Sexually Active
<input type="checkbox"/> Practice Safe Sex Methods	<input type="checkbox"/> Recent HIV Screen	<input type="checkbox"/> Chronic urinary tract infections
<input type="checkbox"/> History of sexually transmitted disease	Date of Last STD testing _____	
Please circle sexual preference(s):    Heterosexual    Homosexual    Bisexual    Monogamous		

**MEN ONLY:**

<input type="checkbox"/> Discharge from Penis	<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> Libido/ sexual difficulties
<input type="checkbox"/> Testicular masses/ pain	<input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Hernia
<input type="checkbox"/> Stream Weak or Slow	<input type="checkbox"/> Fertility Problems	<input type="checkbox"/> Vasectomy
Date of Last Prostate Exam _____		Do you do regular testicular self-exams?    Yes    No

**WOMEN ONLY:**

Age at onset of menstruation _____	Date of Last Menstrual Period _____	
Onset of Menopause: _____		
<input type="checkbox"/> Regular Periods	<input type="checkbox"/> Vaginal Discharge	Number of Pregnancies _____
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Breast Masses	Number of Live Births _____
<input type="checkbox"/> Painful Periods	<input type="checkbox"/> Breast Discharge	Number of Miscarriages _____
<input type="checkbox"/> Heavy Periods	<input type="checkbox"/> History of Breastfeeding	Number of Terminations _____
<input type="checkbox"/> Spotting	<input type="checkbox"/> Libido Changes	<input type="checkbox"/> Identified Fertility Problems
History of Abnormal PAP	Date of Last PAP _____	<input type="checkbox"/> Hormone Replacement Therapy
Type of Birth Control _____	Do you do regular self-exams?    Yes    No	
Date of Last Mammogram _____		

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**INFORMED CONSENT FOR NATUROPATHIC TREATMENT**

I acknowledge that I am accepting treatment from a licensed Naturopathic Doctor (N.D) at the Tahoe Center of Natural Medicine. I understand that there are intrinsic differences between the care of Naturopathic Doctors (N.D.'s) and Medical Doctors (M.D.'s).

Stephenie Riley is licensed by both the States of Washington and California as a Naturopathic Doctor. In the State of California, Naturopathic Doctors are licensed to diagnose and treat disease and have limited prescriptive rights.

I hereby authorize the Naturopathic Doctors of Tahoe Center of Natural Medicine to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

**Common diagnostic procedures:** e.g. venipuncture, Pap smears, urine analysis.

**Minor office procedures:** e.g. ear lavage, skin scraping, skin cryotherapy.

**Medicinal use of nutrition:** e.g. therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

**Botanical medicine:** e.g. botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.

**Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.

**Lifestyle counseling and hygiene:** diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.

**Physical medicine:** e.g. massage, hot and cold therapy, stretching, manipulation, electrical muscle stimulation, and therapeutic ultrasound.

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

*Potential risks include but are not limited to:* allergic reactions and other side effects to prescribed herbs and supplements; aggravation of pre-existing symptoms; discomfort, pain, infection, burns, nausea, light headedness; inconvenience of lifestyle changes, injury from injections, venipuncture, or other procedures. Please notify Tahoe Center of Natural Medicine if you experience any symptoms which may be secondary to the above procedures.

*Potential benefits include but are not limited to:* restoration of health and the body's maximal functional capacity without the use of drugs or surgery; 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.

At this time, it is my decision to pursue Naturopathic treatment. I do understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution to any or all of the conditions I may have.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Tahoe Center of Natural Medicine, or any of its personnel, 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.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or my representative, or unless it is required by law.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician/Witness

\_\_\_\_\_  
Date



**PATIENT CARE FINANCIAL POLICY**

**We are a cash-based practice.** At this time we are unable to accept, nor do we bill, insurance for any of our in-house services. Full payment of all charges is required at time of service. We accept payment by cash, check, and credit card. Checks denied for insufficient funds will incur a fee of \$35.00.

At this time we are not contracted with any insurance providers, and are services are not covered by insurance in California. As a courtesy, we will provide you with a Super Bill for services rendered. This can be submitted to your insurance company for review of possible benefits. The provided Super Bill, and any insurance submission for possible reimbursement, are the sole responsibility of the patient. ***Copies of Super Bills can not be reproduced if lost, please maintain copies for your own files.***

In the cases of financial hardship, special circumstances for payment may be considered. Such arrangements must be made in advance with the front office.

<b>First Office Call:</b>	\$225 - 250	<i>(This does not include required tests or supplements)</i>
<i>Chiropractic Only:</i>	\$90	
<b>Return Office Call:</b>	15-minute: \$60	<i>Chiropractic Follow-up Only: \$50</i>
	30-minute: \$85	
	45-minute: \$115	
	60-minute: \$155	

**Re-establishing Care:** \$175 - 225  
*Patients not receiving care for a period greater than 2 years will require an extended return office call to re-establish healthcare baselines.*

**Phone Consultations:** Charged accordingly with in-office visits.  
*The phone consultation fee is not charged if you are calling for clarification of an on-going medical therapy, or when the doctor has specifically requested you call with a treatment status. If you have any questions or concerns regarding this charge, feel free to ask at the time of your call.*

**Emails:** At this time we do not conduct patient communication via email.

**Cancellations:** We require a minimum of 24 hours for any changes to your scheduled appointment. *We reserve the right to charge for missed appointments, or appointments cancelled with less than 24 hours notice.*

**Supplements:** Nutritional supplements, herbs, homeopathics and other products are often recommended as a part of your treatment plan. We do carry most of the products we recommend at competitive prices, although you are free to purchase from any source you choose. However, products available to health care providers are often of a higher quality not found in many of over-the-counter brands.

**Other Tests:** We do not mark-up any outsourced testing services offered through our offices. For all out-of-office tests you will pay the lab directly, providing you with the lowest cost possible.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date



**Tahoe Center  
Of Natural Medicine**

PO Box 6869 • 600 North Lake Blvd • Tahoe City, CA 96145 • Phone 530-583-0002 • Fax 530-583-0044

**FINANCIAL DISCLAIMER**

I claim full responsibility for services rendered at the Tahoe Center of Natural Medicine (TCNM). I understand that payment is required within full at the time of service, unless other arrangements have been made.

If other arrangements have been made, I am held responsible for making monthly payments until my bill is paid in full.

A Super Bill with diagnostic and procedural information is provided for you to submit to your insurance company for possible reimbursement. At this time I understand there is no official insurance reimbursement for naturopathic care. TCNM does not submit to insurance on the behalf of the patient, it is the sole responsibility of the patient. The Super Bill is provided at the time of service, they can not be reproduced later and should be maintained for your own records.

**It is our policy we receive 24-hour cancellation notice. If we do not, we reserve the right to charge the full fee for a missed appointment.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**PRIVACY RULE CONSENT**

By signing this form, you are giving Tahoe Center of Natural Medicine permission to use and disclose your protected health information for the purposes of treatment and payment associated with your care.

We have a “Notice of Privacy Practices” that provides more detailed information regarding how we may use and disclose your health information. You have the right to review this document I detail at any time. You have the right to request restrictions on how we may use and disclose your health information. We are not required by law to agree with your request, but we will do whatever we can to accommodate requests that are reasonable. You also have the right to revoke this consent in writing at any time, unless your health information has already been used or disclosed in reliance on this consent for the diagnosis, treatment or payment for the medical services for which you sought treatment.

A copy of our “Notice of Privacy Practices” may be obtained by contacting our offices at 530-583-0002, or in writing at POB 6869, Tahoe City, CA 96145. Please note that our “Notice of Privacy Practices” may be changed as needed to comply with Federal Law.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date