



Tahoe Center of Natural Medicine

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

Name: _____ Date: _____
 S.S.#: _____ (this is needed if any labs are ordered) Sex: M F Age: _____
 Date of Birth: _____ Single: _____ Married: _____ Significant Partnership: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Occupation: _____ Hours per Week: _____
 Employer: _____ Address: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____
 Name: _____ Phone: _____ Relationship: _____

How did you hear about us?

Yellow Pages: _____ Internet: _____ Ad: _____ Other (please describe): _____

Who referred you, so we may thank them! _____

Signature (patient/parent/guardian)

History Questionnaire

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

What were you seen for?

What are your most important health problems?

1. _____
2. _____
3. _____
4. _____

Current Medications:

Over-the-Counter & Prescriptions

Current Vitamins & Herbs

Allergies: Please list any food, drug or other allergies: _____

What hospitalizations and or surgeries have you had and when: _____

What x-rays, CAT scans, MRI's, EKG's have you had and when: _____

Childhood Illnesses: Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles
 Other: _____

Have family members had any of the following? If yes, please specify which relative:
 Cancer _____ Diabetes _____ Heart Problems _____ Stroke _____
 High Blood Pressure _____ Asthma, Hay Fever, Hives _____ Osteoporosis _____

Height ____ Weight ____ Weight 1 Year Ago ____ Maximum Weight ____ When? ____

Please note past or present conditions by marking the appropriate box:

<u>Past</u>	<u>Present</u>	<u>Condition</u>	<u>Past</u>	<u>Present</u>	<u>Condition</u>
Neck			Mouth and Throat		
<input type="checkbox"/>	<input type="checkbox"/>	Swollen	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat
<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Sore Tongue
Skin			<input type="checkbox"/>	<input type="checkbox"/>	Gum Problems
<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	Eczema, Hives	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Acne, Boils	Respiratory		
<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Color Change	<input type="checkbox"/>	<input type="checkbox"/>	Spitting Blood
<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
Head			<input type="checkbox"/>	<input type="checkbox"/>	Pleuisy
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
Eyes			<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Tearing or Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Pain on Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Changing Vision	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	Bowel Movements:		
Ears			How often? _____		
<input type="checkbox"/>	<input type="checkbox"/>	Ringling	Is this a change ____?		
<input type="checkbox"/>	<input type="checkbox"/>	Earache	Urinary		
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Pain on Urination
Nose and Sinuses			<input type="checkbox"/>	<input type="checkbox"/>	Increased Frequency
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Inability to hold urine
<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Frequent infections
<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones

<u>Past</u>	<u>Present</u>	<u>Condition</u>
Cardiovascular		
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Murmurs
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
Endocrine		
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid
<input type="checkbox"/>	<input type="checkbox"/>	Heat or Cold Intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hunger
Musculoskeletal		
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain or Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Broken Bone
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Spasms/ Cramps
<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Cold hands/feet
<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
Habits		
<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise?
<input type="checkbox"/>	<input type="checkbox"/>	Eat 3 meals per day?
<input type="checkbox"/>	<input type="checkbox"/>	Sleep well?
<input type="checkbox"/>	<input type="checkbox"/>	Awaken rested?
<input type="checkbox"/>	<input type="checkbox"/>	Average 6-8 hrs of sleep
<input type="checkbox"/>	<input type="checkbox"/>	Use tobacco?
<input type="checkbox"/>	<input type="checkbox"/>	Use alcoholic beverages?

<u>Past</u>	<u>Present</u>	<u>Condition</u>
Gastrointestinal		
<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Change in Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Change in Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Belching/ Passing Gas
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
Emotional		
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety or Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Tension
Neurological		
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Numbness or Tingling
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Memory
Male Reproductive		
<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Testicular Masses
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Disease
<input type="checkbox"/>	<input type="checkbox"/>	Sexual Difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Discharge or Sores
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
Are you sexually active?		
Yes ___ No ___		

Female Reproductive

Length of Cycle _____
 # of Menstrual Days _____
 Are cycles regular? Yes ___ No ___

<u>Past</u>	<u>Present</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Between Periods
<input type="checkbox"/>	<input type="checkbox"/>	Painful Menses
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Flow
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal Symptoms
Are you sexually active? Yes ___ No ___		
Do you use birth control? Yes ___ No ___		
If so what kind? _____		

Number of Abortions _____
 Number of Live Births _____
 Number of Miscarriages _____
 Number of Pregnancies _____

<u>Past</u>	<u>Present</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Conceiving
<input type="checkbox"/>	<input type="checkbox"/>	Sexual Difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Pain During Intercourse
<u>Breasts</u>		
Lumps Yes ___ No ___		
Pain or Tenderness Yes ___ No ___		
Nipple Discharge Yes ___ No ___		
Do you do self exams? Yes ___ No ___		



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).

In the state of California our doctors on staff, Dr. Christina Campbell N.D., D.C. and Dr. Stephenie Riley N.D. are both 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 Printed Name

Patient/Guardian Signature

Date



Financial Policy

We are a cash-based practice. At this time we are unable to accept 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.

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.

First Office Call: \$185 - 225 *(This does not include required tests or supplements.)*

Return Office Call: \$65 – 145 *(Price ranges on time and complexity.)*

Re-establishing Care: \$145 - 185
Patients not receiving care for a period greater than 3 years will require an extended return office call to re-establish healthcare baselines.

Phone Consultations: \$30.00 Minimum *(Rate increases with time and complexity)*
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



Financial Disclaimer

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

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

A Super Bill with all diagnostic and procedural information is provided for you to submit to your insurance for possible reimbursement.

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

Patient/Guardian Printed Name

Patient/Guardian 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 in 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.

Patient/Guardian Printed Name

Patient/Guardian Signature

Date