

# Stillpoint Center *Integrative Medicine*

Dear New Patient:

Thank you for choosing Stillpoint Center for Integrative Medicine (SCIM) as your healthcare provider. Our staff is dedicated to making your experience a most satisfying one. SCIM's team of healthcare practitioners will assure that you receive care that is specifically tailored to your health needs.

The enclosed information is necessary in order for us to complete your in office file and for our participation in your health care. You are encouraged to make copies of these documents for your records. **NOTE: The following forms must be completed, signed, and received by our office prior to scheduling an appointment.** We apologize for any inconvenience this may cause, but we need to accommodate other patients waiting to be scheduled. **You may fax these forms; the originals must be delivered to the center.**

- **Patient Information Form** (*return to office*)
- **Office Policies and Procedures** (*return to office*)
- **Health History Questionnaire** (*return to office*)
- **Universal Health Association Membership Application** (*return to office*)
- **Credit Card Authorization** (*return to office*)
- **Patient Consent Form** (*return to office*)

If you have copies of recent medical and laboratory reports, please provide them to our office at least one day prior to your appointment. If you cannot provide them prior to your appointment, you may bring them with you.

Please don't hesitate to contact us should you have any questions. We look forward to assisting you.

Appointment Date \_\_\_\_\_ Time \_\_\_\_\_ (PST)

**Stillpoint Center for Integrative Medicine**  
**41660 Ivy Street, Suite A**  
**Murrieta, CA. 92562**  
**(951) 461-4800 - phone**  
**(951) 461-4560 – fax**

**Revised 8-08**

# Stillpoint Center *Integrative Medicine*

## *(Office Policies and Procedures)*

### **Hours:**

- Monday & Friday: 9AM–4PM (PST)
- Tuesday through Thursday: 9AM–5PM (PST)
- Office visits are by appointment only.

### **Consultation Fees, Test Kits, and In-Office Therapies:**

We offer a 15% cash discount to patients paying in full. We accept check, mastercard, and visa. For patients needing a payment plan we accept CareCredit (see below).

### **CareCredit:**

**CareCredit** ([www.carecredit.com](http://www.carecredit.com)) is a medical financing service available through our office that you can put towards office consultations, laboratory testing, and in-office therapies. Our practice is listed as **Universal Health Association** under **General Medicine** on the **CareCredit** website.

### **Appointments:**

- Payment is due at the time of your consultation. Methods of payment are: Visa, MasterCard, Discover, CareCredit, and check. No cash please.
- First appointment: All initial paperwork must be completed, signed, and received by office before your appointment will be scheduled. You may fax these forms, but the originals will need to be delivered to the center on the day of your appointment.
- First appointment: If paying by check for a phone consultation, include the check with your mailed paperwork.
- **Follow-up consults may be scheduled as *brief/focused, detailed, and comprehensive/complex* depending on your particular situation.**
- Patients who forget their appointment or cancel less than 2 business days prior to their appointment will be required to pay for the missed visit. Please understand that a missed appointment could have gone to a patient on the waiting list. The 48-hour reminder call from SCIM is a courtesy reminder only and not a guaranteed affirmation of your appointment.
- Consultations with other healthcare providers and/or any research requested by the patient are billable services and will be charged at the hourly rate.
- Scheduled consultations that include review of lab tests require that laboratory test results be received at least 24 hours prior to appointment.

### **Medical Letters, Narrative Reports, Chart Note Copying, etc.**

Medical letters to schools, insurance companies, disability, as well as narrative reports and chart note copying for insurance purposes, etc. are a billable service. If your insurance company requires additional information we will attempt to bill them prior to sending the requested information. Unfortunately, some insurance companies feel that paying for this service is not an allowable. If this occurs than any fees will be your responsibility.

**Office Consultations:**

- Please check in 15 minutes before your scheduled appointment.
- Patients who are late may lose part of their time, and may be billed at the rate of the scheduled appointment.
- **Please do not wear any scented products, as many of our patients are chemically sensitive. These include lotions, cologne, perfume, hair spray, etc.**

**Phone Consultations:**

- **There is no price difference for phone consultations. Each phone consultation is treated like any other consultation – the time spent with your doctor is the same whether it is in person (in the office) or over the phone. The phone consultation is for the patient’s convenience. If you would rather have an office consultation then let the office staff know your preference.**
- Your doctor will call you at the time of your scheduled consultation.
- All appointments are scheduled for the Pacific Standard Time zone.
- We require patients outside of the USA to call the office at the time of their scheduled phone consultation. If this is not possible, than phone consultation phone bill charge will be billed to the patient.

**Cancellations:**

- As a courtesy, our office will call you to confirm your appointment 2 business days in advance.
- If you cannot keep a scheduled appointment, you must notify us a minimum of 2 business days prior to your scheduled time, or you will be charged for the missed appointment.
- If your appointment is on Monday, please notify our office no later than noon on the previous Thursday.

**Prescription Request:**

- Prescriptions originating from a consultation are processed at no charge. However, refills of these original prescriptions requested by you that are approved by your doctor without consultation may incur a processing charge per prescription.
- Requests for a new prescription or a change in prescription type or transfer to a different pharmacy or multiple refills may incur a prescription processing charge.

**Questions and Follow-up:**

- Please direct e-mails, faxes or letters regarding you or your child’s care to the Center’s administrative assistants ([info@mystillpoint.com](mailto:info@mystillpoint.com)). Questions must be brief and concise. The office staff and/or clinic physicians will determine if a phone or office consult is needed to answer your question(s). Otherwise, a member of our office staff will respond to your inquiry. When leaving a voice mail message, please be brief and concise and always include your name and phone number, including the area code.
- Please Note: We try to accommodate questions regarding treatment clarification at no charge. Simply put, if you have a quick question about a supplement or diagnostic test we recommended or a therapy reaction you may be experiencing, then by all means contact us. However, if the response to a question you submit requires doctor research and/or review, you may be billed for the time involved at the doctor’s hourly rate.

**Follow-up Consultations:**

- We generally recommend that all patients minimally have an office consultation with their respective clinic doctor every 3 months to 6 months.
- If prescription medication is being provided by your clinic doctor for yourself or your child than a office consultation is required in the following manner:
  - **Every 3 to 6 months – Southern California region**
  - **Every 6 to 12 months – Central and N. California, Out of State.**
- The reason for these office visits is for the doctor to physically see you or your child and provide a physical examination.

**Payment:**

- Payment is due at the time of your consultation. Methods of payment are: Visa, MasterCard, Discover, CareCredit, and check. No cash please.
- If paying by check for a phone consultation, include the check with your mailed paperwork.
- If you are unable to pay by credit card, a check must be provided prior to your appointment in the amount due for the scheduled time. In the event that your consultation exceeds or falls short of the scheduled time, adjustment to payment will be made on the same day via Electronic Funds Transfer (EFT).

**Insurance:**

- For patients that have seen the medical director, a “Superbill” receipt (form detailing diagnostic codes and fees) can be provided to you after each visit. This receipt can be submitted to your insurance carrier for reimbursement. Some services may not be covered by certain health insurance plans. It is your responsibility to know what your insurance plan covers. We are not responsible for unpaid claims by your insurance company for services we provide. SCIM does not accept insurance liens, assignments, or any reimbursement from your insurance carrier.
- SCIM healthcare practitioners are **non-participating** Medicare, Medi-Cal, Champus, and Tri-Care providers. They can treat these patients who privately contract outside of these programs on a cash basis only. Standard receipts can be provided. However, diagnostic code receipts called “Superbills” cannot be provided as these organizations will not allow for patient reimbursement. **There is a waiver on the last page of this document titled “Patient Private Contract” that must be completed if you are a member with the above insurance plans.**

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**Acceptance of Policies and Procedures**

By completing the following you agree to the policies and procedures detailed above.

Patient (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature (patient or responsible party): \_\_\_\_\_

If signed by party other than patient, print name: \_\_\_\_\_

## Patient Private Contract (Medicare/MediCal/Tricare)

\_\_\_\_\_  
(Patient Name or Legal Guardian)

With: Kurt N. Woeller, D.O.  
41660 Ivy Street, Suite A  
Murrieta, CA 92562

Under Code 1128 of the Social Security Act,  
*Dr. Woeller has requested exclusion from participation in the Medicare Program*

I have voluntarily decided to privately contract outside the Medicare Part B program for the professional services of osteopathic medicine, even if such items and services would otherwise be covered by **Medicare/MediCal/TriCare**. Neither my family nor heirs nor estate will file any Medicare Part B forms for these services nor require Dr. Kurt Woeller, D.O. or his office staff to do so.

*I hereby waive my entitlement to Medicare Part B benefits for these services.*

By signing this contract, I also agree that:

I am responsible for payment of office fees for services.  
Medicare will make no reimbursements for any items or services.

No Medicare payment limits are applicable.

Medigap plans and other supplemental plans **will not make payments** for these items and services since Medicare will make no payment.

I may have such services provided by another physician for which Medicare payment would be made.

Osteopathic Manipulative Medicine is a covered Medicare service and other participating physicians may choose to bill Medicare for these osteopathic services.

I acknowledge that a legal representative or I signed this agreement at a time when I was not facing any medical emergency or urgent healthcare situation.

\_\_\_\_\_  
Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Kurt N. Woeller, D.O.

\_\_\_\_\_  
Date



**The Universal Health Association**

*Universal Health Association*  
41660 Ivy Street, Suite A  
Murrieta, CA. 92562  
951-461-4800 \* 951-461-4560 (fax)  
[www.universalhealthassociation.org](http://www.universalhealthassociation.org)

The purpose of the Universal Health Association (UHA) is to protect the rights of patients to obtain and the rights of health practitioners to provide a wide array of cutting-edge healthcare services, therapies and diagnostics at a reasonable price, while protecting patient's healthcare practitioners from frivolous legal actions by those who do not appreciate the unique diagnostic and therapeutic options that we provide.

In addition to conventional medical care, Stillpoint Center for Integrative Medicine offers its discerning clientele access to cutting-edge diagnostic testing and therapies. To offer these services while protecting doctors and other health care practitioners from unreasonable liability, it would be necessary to carry very costly medical liability insurance. This cost typically would be passed on to patients in the form of substantially increased fees. The UHA offers a solution to this potential cost spiral.

A growing segment of the American population (and others around the world) demand access to both conventional, as well as cutting-edge healthcare services. However, a doctor may be found "negligent" for utilizing diagnostic procedures and/or treatments that are not considered to be conventional: those defined as "standard" and "customary" within his/her community.

Members of the UHA (which includes all patients, staff members, doctors, and other health care practitioners), through their by-laws, agree to limit the scope and extent of legal remedies against fellow members of the Association. All complaints against other members, including healthcare practitioners, must be initiated with the UHA. By becoming a member of the UHA you agree to the Association's by-laws, including its grievance procedures as set forth in Article XXVII (Grievances). For convenience, your healthcare provider has agreed to pay your \$5 lifetime membership fee to the UHA. UHA by-laws are provided on the internet at [www.universalhealthassociation.org](http://www.universalhealthassociation.org) and are available in printed form at Stillpoint Center for Integrative Medicine.

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**MEMBERSHIP APPLICATION**

**Name:** \_\_\_\_\_  
**Business Address:** \_\_\_\_\_  
**Business Phone:** \_\_\_\_\_  
**Home Address:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_  
**e-mail:** \_\_\_\_\_

**MEMBERSHIP CERTIFICATION**

I, (print name) \_\_\_\_\_, have been informed of the benefits and responsibilities of the membership in the Universal Health Association. I have been informed of the by-laws under which the Association operates and understand the nature of those by-laws, that include but are not limited to, the use of administrative remedies and Arbitration to resolve disputes. In consideration for the benefits of membership, I agree to join the Universal Health Association as of the date below. I also agree to abide by all of the Association's by-laws, rules and regulations as they exist now and as they may be amended in the future.

**Executed on (date)** \_\_\_\_\_ **at (City and State)** \_\_\_\_\_

**Name (print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Note: Membership information is held in confidence and not provided, leased, or resold to any third party or entity, unless otherwise required by law. Its use is solely for Association business and communicating to members.**

# Stillpoint Center *Integrative Medicine*

## Patient Contact Information

(PLEASE PRINT CLEARLY)

Patient Name \_\_\_\_\_  
Last First Middle initial

Home address \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Driver's License # \_\_\_\_\_ State \_\_\_\_\_

Primary phone: Daytime ( ) \_\_\_\_\_ Evening ( ) \_\_\_\_\_

Cell phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Email address \_\_\_\_\_

Employed by \_\_\_\_\_

Occupation \_\_\_\_\_

What name do you prefer to be called?

Who referred you to our office?

### In case of emergency contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Work phone ( ) \_\_\_\_\_

### For children under 18 years of age:

Mother's full name \_\_\_\_\_

Father's full name \_\_\_\_\_

School attending \_\_\_\_\_ City \_\_\_\_\_

### For office use only:

# Stillpoint Center *Integrative Medicine*

## ***(Credit Card Authorization)***

I, (print name) \_\_\_\_\_ authorize Stillpoint Center for Integrative Medicine (SCIM) , located at 41660 Ivy Street, Suite A - Murrieta, California to bill my credit card as listed below.

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**Name on Credit Card** \_\_\_\_\_

### **Credit Card Details**

Visa            Card # \_\_\_\_\_ Exp date \_\_\_\_\_

MasterCard    Card # \_\_\_\_\_ Exp date \_\_\_\_\_

Discover       Card # \_\_\_\_\_ Exp date \_\_\_\_\_

Driver's License # \_\_\_\_\_ State: \_\_\_\_\_

### **Patient Information**

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (include area code): \_\_\_\_\_

### **Authorization**

\_\_\_\_\_  
Card Holder's Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Today's Date

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This authorization may be revoked at any time when the following stipulations have been performed.

1. Patient has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Patient's account is paid in full.

# Stillpoint Center *Integrative Medicine*

**THIS FORM IS REQUIRED BY LAW AND SERVES TO PROTECT YOUR  
RIGHT TO PRIVACY.**

Stillpoint Center for Integrative Medicine (SCIM) protects the privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, or telephone number. SCIM will not disclose this information without your authorization, except as permitted by law.

Our **Notice of Privacy Practices** provides information about how your protected health information may be used or disclosed. You have the right to request that we restrict how protected health information about you is used or disclosed. Please review the Notice of Privacy Practices before signing this consent.

By signing this form, you consent to our use and disclosure of your protected health information as indicated in the Notice of Privacy Practices. Please note that your personal information is **not** shared with third parties such as financial, credit, or marketing companies. Use is restricted to procedures that are relevant to your care.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

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Print name

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Signature

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Date

# Stillpoint Center *Integrative Medicine*

Effective Date: June 1, 2005

Please Note: In order to comply with the numerous state, Federal, and local laws that govern medical information privacy, this document is provided. Stillpoint Center for Integrative Medicine (SCIM), its healthcare practitioners, and all associated personnel will do everything possible to maintain the privacy of your medical information as required by law. Under no circumstances will SCIM disclose your personal or medical information to any outside parties.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## **WHO WILL FOLLOW THIS NOTICE.**

This notice describes SCIM practices and that of:

- Any health care professional authorized to enter information into your patient chart.
- All employees, staff and other clinic personnel.

## **OUR PLEDGE REGARDING MEDICAL INFORMATION:**

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the clinic, whether made by clinic personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

## **We are required by law to:**

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

## **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.**

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other clinic personnel who are involved in taking care of you at the clinic. Different departments of the clinic also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

**For Health Care Operations.** We may use and disclose medical information about you for clinic operations. These uses and disclosures are necessary to run the clinic and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and service about many clinic patients to decide what additional services the clinic should offer, what services are not needed, and whether certain new treatments are effective.

We may also disclose information to doctors, nurses, technicians, medical students, and other clinic personnel for review and learning purposes. We may also combine the medical information we have with medical information from other clinics to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are, and to evaluate the performance of our staff in caring for you. We may also combine medical information

**Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the clinic.

**Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**Research.** Under limited circumstances, we may use and disclose medical information about you for research purposes. Note: Under no circumstances will your name be associated with your medical data. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the clinic.

**As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.

## **SPECIAL SITUATIONS**

**Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the address below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the clinic. To request an amendment, your request must be made in writing and submitted to the address below. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by or for the clinic; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the address below. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the address below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

#### **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the clinic. The notice will contain on the first page, in the top right-hand corner, the effective date.

#### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with the clinic, call 800-831-8798. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

#### **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

# Stillpoint Center *Integrative Medicine*

## *(Health History Questionnaire)*

(Please Print)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Pressure (if known) \_\_\_\_\_ Body Fat% (if known) \_\_\_\_\_

Primary Health Concerns:

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When did your health concerns begin?

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Medication Allergies? \_\_\_\_\_

Other Allergies (ie. Molds, Chemicals) \_\_\_\_\_

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Current Medications You Are Taking \_\_\_\_\_

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Current Supplements You Are Taking \_\_\_\_\_

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**Past and/or Current Medical History: (please circle)**

Arthritis	Asthma	Cancer	Diabetes	Hepatitis
High Blood Pressure	Heart Disease	Leukemia	Migraine Headaches	Paralysis
Rheumatic Fever	Chronic Fatigue	Fibromyalgia	Chemical Sensitivities	Lymes
Menstrual Irregularities	Thyroid Disease (low/high)	Stroke	Seizure	
Kidney Disease	Celiac Disease	Venereal Disease	Autoimmune Disease (i.e. MS, Lupus,	
Rheumatoid)	Lung Disease (i.e. pneumonia, tuberculosis, etc.)			

Other:

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**Surgical History:**

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**Family Medical History:**

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**Habits:**

Alcohol intake per week \_\_\_\_\_ Tobacco \_\_\_\_\_ packs/day – Yrs. Quit \_\_\_\_\_

Cups of caffeinated coffee/day \_\_\_\_\_ Cups of caffeinated Teas/day \_\_\_\_\_

Colas or sodas \_\_\_\_\_ cans/day Antacids taken \_\_\_\_\_/week

Laxatives \_\_\_\_\_/week

Do you use caffeine as a “pick-me up” drink, or to “get going in the morning” Yes\_\_ No\_\_

Travel history: Traveled/lived outside the USA? Yes\_\_ No\_\_ If Yes, where have you traveled/lived \_\_\_\_\_

Developed an illness as a result of your travels? \_\_\_\_\_

**Dental History:**

Orthodontics? Yes\_\_ No\_\_ If yes, explain \_\_\_\_\_

Braces? Yes\_\_ No\_\_ Did you have any complications with your braces? Yes\_\_ No\_\_ If yes, explain

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Mercury Fillings? Yes\_\_ No\_\_ How many \_\_\_\_\_ Root Canals? Yes\_\_ No\_\_ How many

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Previous Gum Inflammation (Gingivitis)/Infections? Yes\_\_ No\_\_

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

Please Describe Your Hobbies: \_\_\_\_\_

Please check any of the following that you have experienced in the last 30 days:

\_\_\_ Do you feel nauseous?

\_\_\_ Do you feel bloated?

\_\_\_ Do you have heartburn?

\_\_\_ Do you have constipation?

\_\_\_ Do you have gas?

\_\_\_ Do you belch after meals?

\_\_\_ Do you have abdominal/intestinal pain?

\_\_\_ Do you get bloated after meals?

\_\_\_ Do you have diarrhea?

\_\_\_ Are your stools compact and hard to pass?

\_\_\_ Do your bowel movements alternate between constipation and diarrhea?

**Please use this space below to share additional information with us regarding your health concerns.**

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## **WOMEN'S HEALTH & PRECONCEPTION QUESTIONNAIRE**

### **FEMALE REPRODUCTIVE HISTORY**

Are you currently pregnant? \_\_\_ If yes, how many weeks? \_\_\_

Date of last menstrual period? \_\_\_\_\_

### **CHILDREN:**

Sex / Age / Health problems (autism, asthma, allergies, congenital etc)

\_\_\_ / \_\_\_ / \_\_\_\_\_

\_\_\_ / \_\_\_ / \_\_\_\_\_

\_\_\_ / \_\_\_ / \_\_\_\_\_

How many:

Perinatal Deaths: \_\_\_\_\_

Dates: \_\_\_\_\_

Miscarriages: \_\_\_\_\_

Dates: \_\_\_\_\_

Premature Births: \_\_\_\_\_

Dates: \_\_\_\_\_

Therapeutic Terminations: \_\_\_\_\_

Dates: \_\_\_\_\_

Stillbirths: \_\_\_\_\_

Dates: \_\_\_\_\_

Small baby at term: \_\_\_\_\_

Dates: \_\_\_\_\_

Problems during pregnancy:

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Did you breastfeed?

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Problems with breastfeeding:

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**INFERTILITY:** (Y/ N) \_\_\_\_\_ Years: \_\_\_\_\_

Female: \_\_\_\_\_ Male: \_\_\_\_\_

Previous fertility treatments used:

Type:	Duration/ no. times:	Result:
_____ /	_____ /	_____
_____ /	_____ /	_____
_____ /	_____ /	_____

Current fertility drugs eg. Clomid, Danazol, Heparin etc

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Any further information about past/ present fertility treatment:

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### FEMALE GYNECOLOGICAL HISTORY

Have you ever or do you currently suffer from any of the following:

(P = past, N = now)

	P	N		P	N
Amenorrhea (no periods)	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>
Anovulation (no ovulation)	<input type="checkbox"/>	<input type="checkbox"/>	Pain on intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	Painful periods	<input type="checkbox"/>	<input type="checkbox"/>
Cervical dysplasia	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual tension	<input type="checkbox"/>	<input type="checkbox"/>
Cystitis	<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>
Fibrocystic breasts	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
Genital ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal irritation	<input type="checkbox"/>	<input type="checkbox"/>
Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal yeast infections	<input type="checkbox"/>	<input type="checkbox"/>
Ovulation pain	<input type="checkbox"/>	<input type="checkbox"/>	Water retention	<input type="checkbox"/>	<input type="checkbox"/>

**CONTRACEPTION:**

Type:

Dates:

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

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

**MENOPAUSE:**

Are you menopausal (ie no menses for at least one year)? \_\_\_\_\_

Date of last menstrual period? \_\_\_\_\_

Please circle any symptoms relating to menopause that you are experiencing

Hot flashes

Vaginal dryness

Lack of libido

Brain fog

Memory loss

Night sweats

Depression

Anxiety

Palpitations

Are you taking HRT (hormone replacement therapy ? \_\_\_\_\_ If yes, what type and dose?

\_\_\_\_\_

**MALE REPRODUCTIVE HISTORY & FERTILITY STATUS**

Have you had a sperm count? \_\_\_\_\_

Number (million) \_\_\_\_\_

% Malformed sperm? \_\_\_\_\_

% Immotile sperm \_\_\_\_\_

Clumping? \_\_\_\_\_

In the past have you had any of the following (circle):

Erectile dysfunction

Testicular cancer

Low Libido

Varicocele

Urethritis

Vasectomy reversal