WELLSOURCE
Naturopathic Medical Center

Wellsource Naturopathic Medical Center, LLC
Wendy Wells, N.M.D
8595 E. Bell Rd D101 Scottsdale, AZ 85260
PH 480-607-0299 FAX 480-607-9985

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # (home):_____ (cell): _____

E-mail address: _____

Age: ____Date of Birth: _____ Gender: female_____ male____

Education: _____

Married: ___Separated: _____Divorced:____Widowed: ___Single:___ Partnership:_____

Live with: Spouse _____Partner _____ Parents _____ Children ____Friends ___ Alone ___

Occupation: _____Hours per week: _____Retired: _____

Employer: _____Work address: _____

How did you hear about our clinic – please check one

Online Search: □ Bing □ Chrome □ Firefox □ Internet Explorer □ Safari

□ Facebook □ Yelp □ Friend □ Family □ Advertisement

Has any other friend or family member already been a patient at the clinic? If then who?

_____

Next of Kin or other to reach in an emergency: _____

Relationship: _____Phone: _____

Address:

_____

CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of

1) Why did you choose to come to this clinic?

What do you know about the naturopathic approach?

Do you believe you can be healthy?

2) What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0 1 2 3 4 5 6 7 8 9 10 100%

4) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

5) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

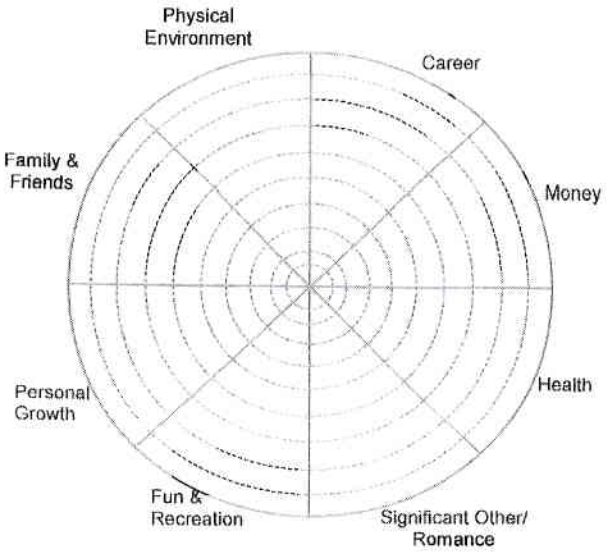
7) What would you do with your life if there were no limitations?

Wheel of Balance

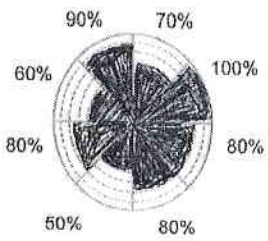
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Example:



Are you currently receiving healthcare? Y N

If yes, where and from whom: _____

If no, when and where did you last receive medical or health care? _____

_____

What was the reason? _____

What are your most important health problems?
List as many as you can, in order of importance:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

Do you have any known contagious diseases at this time? Y N

If yes, please list: _____

Family History

Do you have a family history of any of the following?_____

Check those applicable	Father	Mother	Sisters	Brothers	Other
Age (if living)					
Health G: good F: fair P: poor					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Epilepsy					
Mental Illness, Anxiety, Depr					
Asthma, Hayfever, Hives					
Anemia					
Kidney Disease					
Glaucoma					
Tuberculosis					
Thyroid disease					
Age (at death)					
Cause of death					

Any other relevant family history? _____

_____

What is your heritage: German _____ Nordic_____ Celtic _____ Other _____

Childhood Illnesses

Please circle whether you had any of these as a child:

Scarlet fever	Diphtheria	Rheumatic fever
Mumps	Measles	German measles

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_____year: _____ _____ year:

_____year: _____ _____ year:

_____year: _____ _____ year:

Allergies

Are you hypersensitive or allergic to:

Any drugs? _____Any foods? _____

Any environments or chemicals? _____

Current Medications

Do you take or use?

Laxatives	Y N	Pain relievers	Y N
Antacids	Y N	Cortisone	Y N
Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N
Sleeping pills	Y N		

Please list **ALL** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1)_____ 5) _____

2)_____ 6) _____

3)_____ 7) _____

4)_____ 8) _____

General

Height: _____Weight:_____ lbs. Weight 1 year ago: _____lbs.

Maximum Weight : _____ When:_____

When during the day is your energy the best? _____ worst? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

FOR THE FOLLOWING, PLEASE CIRCLE

Y= condition you have NOW **N=**NEVER had **P=**Significant problem in the PAST

Habits

Main interests and hobbies?_____

Do you exercise? Y N

If yes, what kind?_____ How often? _____

Average 6-8 hrs sleep?	Y N	Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awaken rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	Watch television?	Y N
Have a history of abuse?	Y N	how many hours?	_____
Any major traumas?	Y N P	Read?	Y N
		how many hours?	_____
		Phone/computer	Y N
		how many hours?	_____
Treated for drug dependence?	Y N P		
Use alcoholic beverages?	Y N P	Do you eat 3 meals a day?	Y N

Treated for alcoholism?	Y N P	Do you go on diets often?	Y N
Do you use tobacco?	Y N P	Do you eat out often?	Y N
Smoked previously?	Y N P	Do you drink coffee?	Y N P
How many years? _____		Drink black/green tea?	Y N P
How many packs per day? _____		Do you drink cola/other sodas?	Y N P
		Do you eat refined sugar?	Y N P
		Do you add salt?	Y N P

Do you have a religious or spiritual practice? Y N If yes, what?_____

REVIEW OF SYSTEMS

Mental / Emotional

Treated for emotional problems?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Tension?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P

Immune

Reactions to immunizations?	Y N P	Reactions to vaccinations?	Y N P
Chronic Fatigue Syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

Endocrine

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

Skin

Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P
Color Change?	Y N P	Perpetual Hair Loss?	Y N P
Lumps?	Y N P	Night Sweats?	Y N P

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P

Eyes

Spots in Eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P

Earaches?	Y N P	Dizziness?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness?	Y N P	Hayfever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	" " " lying down?	Y N P
Tuberculosis?	Y N P		

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/Fluttering?	Y N P
Rheumatic Fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? _____	
Gall Bladder disease?	Y N P	Is this a change?_____	
Liver Disease?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P

Urinary

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P

Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

Male Reproduction

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Venereal disease?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N	Chlamydia?	Y N P
Sexual orientation: _____		Gonorrhea?	Y N P
Impotence?	Y N P	Condyloma?	Y N P
Premature ejaculation?	Y N P	Herpes?	Y N P
Birth control? Type? _____		Syphilis?	Y N P

Female Reproduction / Breasts

Age of first menses? _____		Date of last annual exam/ PAP _____	
Age of last menses? (if menopausal) __		Are cycles regular?	Y N
Length of cycle? _____ days		Bleeding between cycles?	Y N P
Duration of menses? _____ days		Pain during intercourse?	Y N P
Painful menses?	Y N P	Clotting?	Y N P
Heavy or excessive flow?	Y N P	Discharge?	Y N P
PMS?	Y N P	Birth control?	Y N P
If yes, what are your symptoms?		What type? _____	
_____		Number of pregnancies: _____	
_____		Number of live births: _____	
Endometriosis?	Y N P	Number of miscarriages: _____	
Ovarian cysts?	Y N P	Number of abortions: _____	
Difficulty conceiving?	Y N P	Menopausal symptoms?	Y N P
Cervical Dysplasia?	Y N P	Abnormal PAP?	Y N P
Sexual difficulties?	Y N P	Chlamydia?	Y N P
Gonorrhea?	Y N P	Condyloma?	Y N P
Herpes?	Y N P	Syphilis?	Y N P
Are you sexually active?	Y N	Sexual orientation: _____	
Do you do breast self exams?	Y N P	Breast lumps?	Y N P
Breast pain/tenderness?	Y N P	Nipple discharge?	Y N P

Is there anything else you would like to add or comment on?

Thank you for your interest in naturopathic medicine. I look forward to meeting you.

WELLSOURCE
Naturopathic Medical Center

8595 E. Bell Rd D101, Scottsdale, AZ 85260 Dr. Wendy Wells 480-607-0299

Dear New Patient,

Welcome to our clinic. We, the health care providers, look forward to providing for your health needs. We encourage your questions and participation in all aspects of your health care.
Please read and initial the following:

_____ **Initials** Payment for all services and dispensary items is due at the time of the visit.

_____ **Initials** You will be charged a Missed Appointment fee of $25.00 for any missed appointments or late cancellations (less then 24 hours notice).

_____ **Initials** I give permission for the staff to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.

As the patient, you are responsible for the total charges incurred for each visit. We accept MasterCard, VISA, Debit cards, checks, and cash. There will be a charge of $20.00 for every returned check(s). We do arrange payment plans.

You recognize, understand and agree that your health care provider is a sole practitioner and is not a partner or otherwise affiliated with any other health care provider who may be providing similar services at Wellsource Naturopathic Medical Center. You further recognize, understand and agree that your health care provider is solely responsible for and shall provide all professional services to you, and you are relying solely on your practitioner's skill for the professional services rendered at Wellsource Naturopathic Medical Center.

Your health care provider may prescribe medication, which may be purchased either at Wellsource Naturopathic Medical Center or elsewhere. Any tests purchased at Wellsource Naturopathic Medical Center are not refundable. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies of Wellsource Naturopathic Medical Center and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

_____
Your Signature (parent signature if minor)

_____ _____
Print your name (parent name if minor & patient name) Date

WELLSOURCE
Naturopathic Medical Center

Consent to Treatment (IN OFFICE)

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Time: _____ am / pm

I, _____ (dated _____), hereby voluntarily consent to outpatient care by Wellsource Naturopathic Medical Center, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.

I understand that the treatment suggestions provided are not all accepted by the United States FDA and therefore should not be taken as such.

I understand that this consent form will be valid and remain in effect as long as I receive medical care by Wellsource Naturopathic Medical Center.

This form has been explained to me and I fully understand this *Consent to Treatment* and agree to its contents.

Signature of Patient or Person Authorized to consent for patient:

X_____ Witness: X_____

****

Patient UNDER 18 or is unable to consent, please complete the following:

- **A.** Patient is a minor and is _____ years of age.
  Name of Father _____ Name of Mother _____
- **B.** Patient is unable to consent because_____

Signature of Closest Relative or Legal Guardian:

_____Relationship: _____

WELLSOURCE NATUROPATHIC MEDICAL CENTER, LLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that **Wellsource Naturopathic** has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact: **Wellsource Naturopathic, Dr. Wendy Wells 480-607-0299**

I also understand that I am entitled to receive updates upon request if **Wellsource Naturopathic** amends or changes its Notice of Privacy Practices in a material way.

Sig: _____ Date:

_____

(Signature Relationship to Patient, if signed by someone other than patient.)

THIS SECTION IS TO BE COMPLETED BY WELLSOURCE, IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (specify):

Name and title of employee: Date:

HIPAA email consent

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website - http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to the Austin Med Clinic to send me personal health information via unencrypted email

Signature (parent or guardian if patient is a minor)	**Date**	**Printed name**	**Please print email address**

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email

Signature (parent or guardian if patient is a minor)	**Date**	**Printed name**

Please bring completed form to your visit