Living Health
Holistic Health Care

ART New Patient Packet

Date: _____

Name: _____ Date of Birth: _____
Address: _____ City:_____ State:_____ Zip:_____
Best Telephone # to reach you at: _____ Email: _____
Age: ____ Male ___ Female___ Marital Status: _____
# of Children: _____ Occupation: _____
Any known environmental allergies: _____
Any known medication allergies? Reaction? _____
How were you referred to us? _____
What is your main concern today? _____
_____
When did you first notice it? _____
What brought it on? _____
What aggravates it? _____
Was there an event or illness that seemed to bring on or trigger your symptoms? _____
Does it interfere with activities such as work, sleep or recreation? _____
What have you done to get relief? _____
Have you been diagnosed with any medical conditions? If so please list: _____
_____
Are there any other areas of concern? _____
Any Previous Surgeries? If so, at what age did the surgery occur? _____
_____
Any Previous Accidents or Injuries? If so, at what age did this occur? _____
_____
Major Psychological Trauma: _____
Serious Infectious Diseases – Past or Present (pneumonia, mono, TB, cancer, heart attack, chronic bronchitis, colitis, mumps, measles, chicken pox, etc.): _____
Toxic Profession – Past or Present (artist, graphic designer, dental assistant, gas station, computer cleaning, industry, painter, etc.): _____
Dental concerns: _____
Typical Childhood Vaccinations: ( ) Yes ( ) No
Long Visits or residence in foreign country: India, Mexico, Africa, etc. _____
Are you taking any: ( ) Laxatives ( ) Sleeping Pills ( ) Blood Thinners ( ) Birth Control Pills
( ) Sedatives ( ) Insulin ( ) Aspirin
( ) Medications _____
_____
( ) Vitamins/Minerals/Herbs _____
_____

Indicate the following habits with: **H – Heavy, M – Moderate, L- Light, N – None**

_____ Cola _____ Coffee _____ Sugared Products _____ Tobacco _____ Exercise

_____ Artificial Sweeteners _____ White Flour Products _____ Alcohol

Please **CIRCLE** any of the following that you are *currently* having difficulty with.
UNDERLINE any you have had as a *past* problem.

Anemia	Arthritis	Asthma
Bladder trouble	Blood clots	Cancer
Chest Pains	Cold feet	Cold hands
Cold sweats	Constipation	Depression
Diabetes	Dizziness pressure	Epilepsy
Excessive perspiration	Face flushed	Fainting
Fatigue	Gall bladder trouble	Grating in neck
Hay fever	Headaches	Head feels too heavy
Heart attack	Heart pain	Heart Palpitations
Herniated disc	High blood pressure	Indigestion
Inflammation of throat	Inner tension	Intestinal gas
Kidney trouble	Liver trouble	Loss of balance
Loss of memory	Loss of smell	Loss of taste
Low blood pressure	Muscle spasms in neck	Nervousness
Nervous stomach	Neuritis in shoulders & arms	Numbness in hands/feet
Pain in legs/feet	Painful joints	Phlebitis
Pinched nerves in back	Pins & needles in arms & hands	Pins & needles in legs/feet
Rheumatic fever	Ringing in ears	Sciatica
Shooting pains in head	Shortness of breath	Skin Disorders
Sinus trouble	Sleeping troubles	Stomach troubles
Swollen ankles	Swollen joints	Thyroid trouble
Tightness in shoulder muscles	Tightness in throat	Twitching of face
Ulcers	Varicose veins	

Male only	**Female only**	
Burning during urination	Are you pregnant? _____	
History of prostate trouble	Premenstrual tension	
Urination difficulty	Vaginal Inflammation or itch	
Frequent night urination	Painful menstruation – cramps	
Pain in groin area	Menses excessive or prolonged	How many pregnancies? _____
Diminished sex drive	Menses scanty or missing	Date of last menstrual cycle:_____
Burning/pain during orgasm	Form of birth control: _____	

Hormone Symptoms Questionnaire

Please circle a number from each category below to let us know how you are **CURRENTLY** feeling.

	Low-------Moderate-------Severe											Comments, if any
Sleep Disturbances	0	1	2	3	4	5	6	7	8	9	10	_____
Depression	0	1	2	3	4	5	6	7	8	9	10	_____
Irritability	0	1	2	3	4	5	6	7	8	9	10	_____
Anxiety	0	1	2	3	4	5	6	7	8	9	10	_____
Mood Swings	0	1	2	3	4	5	6	7	8	9	10	_____
Migraine Headaches	0	1	2	3	4	5	6	7	8	9	10	_____
Palpitations	0	1	2	3	4	5	6	7	8	9	10	_____
Painful Intercourse	0	1	2	3	4	5	6	7	8	9	10	_____
Night Sweats	0	1	2	3	4	5	6	7	8	9	10	_____
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10	_____
Breast Tenderness	0	1	2	3	4	5	6	7	8	9	10	_____
Restless Leg Syndrome	0	1	2	3	4	5	6	7	8	9	10	_____
Hair Loss (Women)	0	1	2	3	4	5	6	7	8	9	10	_____
Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	10	_____
Fatigue	0	1	2	3	4	5	6	7	8	9	10	_____
Weight Gain	0	1	2	3	4	5	6	7	8	9	10	_____
Low Sex Drive	0	1	2	3	4	5	6	7	8	9	10	_____
Erectile Dysfunction	0	1	2	3	4	5	6	7	8	9	10	_____
Poor Focus	0	1	2	3	4	5	6	7	8	9	10	_____
Body Joint Pains	0	1	2	3	4	5	6	7	8	9	10	_____
Memory Lapses	0	1	2	3	4	5	6	7	8	9	10	_____
Exercise Tolerance	0	1	2	3	4	5	6	7	8	9	10	_____
Loss of Muscle Tone	0	1	2	3	4	5	6	7	8	9	10	_____
Acne	0	1	2	3	4	5	6	7	8	9	10	_____
Facial/Body Hair	0	1	2	3	4	5	6	7	8	9	10	_____

General Consent for Care and Treatment Consent

TO THE PATIENT:

You have the right, as a patient, to be informed about your condition and the recommended Diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary examinations, testing and treatment. By signing below, you are indicating that:

(1) You intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended

(2) You consent to treatment at this office or any other satellite office under common ownership.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your practitioner about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request the health care providers or the designees as deemed necessary, to perform reasonable and necessary examination, testing and treatment for the condition which has brought me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative _____

Printed Name of Patient or Personal Representative _____

Relationship to Patient_____

Date _____

Cancellation Policy

If you need to cancel or reschedule an appointment, please give 24 hours advance notice to ensure you will not be charged for the appointment. If less than 24 hours notice is given and we are unable to fill your time slot, you will be charged for the appointment. (Remember, our confirmation texts do not receive replies. You must call or email to change or cancel an appointment.)

Return Policy

All supplement sales are final.

I have read and understand the Cancellation and Return Policies.

Signature of Patient or Personal Representative _____

NOTICE OF PRIVACY PRACTICES

Effective January 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

Your Health Information & Rights

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care or treatment. This information is referred to as your health or medical record. This Notice of Privacy Practices describes how we use or disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

Although your health records are the property of the practice, this information belongs to you. You have the right to:

1. Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
2. Obtain a paper copy of this notice of privacy practices
3. Inspect and request a copy of your medical record as provided for in 45 CFR 164.524
4. Amend your health record as provided in 45 CFR 164.526
5. Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
6. Request communications of your health information by alternative means and locations

Living Health's Responsibilities:

1. Maintain the privacy of your health information
2. Provide you with this notice as to our legal duties and privacy practices with respect to your health information
3. Abide by the terms of this notice
4. Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. The current Notice of Privacy Practices can be reviewed by contacting us and requesting that a revised copy be sent to you in the mail. We will not use or disclose your health information without your authorization, except as described in this notice.

For more information or to report a problem:

If you have questions and would like additional information, you may contact the office at (830) 632-5906. If you believe that your privacy rights have been violated, you can file a complaint with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Care Operations:

Living Health will use your health information for treatment. Your health information may be released to other healthcare professionals with the hospital and the community for the purpose of providing you with quality healthcare. For example: information obtained by one of our staff including providers, nurses and administrative staff will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or a subsequent healthcare provider, such as a nursing home, home health care agency or physical therapy office, with copies of various reports that will assist them in treating outside of this office as necessary.

We will use your health information for payment. For example: a bill may be sent to your insurance company or other third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, tests and supplies used in the course of your care in our office.

If you understand the above notice and information contained within, we ask that you sign and date that you acknowledge receipt of this information from our office. We will keep a copy of this signed notice in your medical record and provide you a copy for your own records if requested.

Disclosures

Business Associates: There are some services provided in our clinic through contracts with business associates. Examples include physician services in the emergency department and radiology, certain lab tests, transcription services and billing companies. Through a signed agreements, we require all business associates to comply with HIPPA laws and requirements to safeguard your health information.

Notification: We may use or disclose information to notify a family member, personal representative, or other person responsible for your car, your location and general condition.

Communication with Family: Our staff, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Food & Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized to comply with Texas laws relating to the workers compensation program.

Public Health: As required by Texas law we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
Communicable Disease: We may disclose health information as required by Texas law to a person who may have been exposed to communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Abuse or Neglect: We may disclose health information to a health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the government agent authorized to receive such information.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing & Patient Satisfaction Surveys: We may contact you to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. We may also contact you to obtain your opinion about our services.

Law Enforcement: We may disclose health information for law enforcement purposes as required by Texas law or in response to a valid subpoena or court order.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Military & Veterans: If you are a member of the armed services, we may disclose health information as required by military command authorities.

Signature of Patient (or legal representative) Date