

**Aline Fournier, D.O.**

760.746.1133 – phone

760.746.9880 – fax

drafournier@sbcglobal.net

307 South Ivy Street

Escondido, CA 92025

Dear New Patient:

Thank you for choosing Dr. Fournier as your physician. Dr. Fournier is proud to provide the highest quality care possible for her patients. Dr. Fournier acknowledges and respects the inherent dignity of each person as an individual and strives to provide you with the same special attention to your needs as she expects to receive for herself and her loved ones.

Office Hours:

The office is open Monday through Thursday, 1:30 p.m. to 6:00 p.m. If you are unable to keep an appointment, please give the office 24 hours notice so that another patient may make use of your reserved appointment time. We adhere as closely as possible to scheduled appointments. However, Dr. Fournier's schedule is sometimes unpredictable and we recommend that you call the office to verify the timeliness of your scheduled appointment.

**Note: Please do not wear perfume or scented lotion. Wear loose clothing – no jeans. If you have cold and/or flu symptoms call to reschedule.**

Comprehensive Health History Questionnaire:

Please answer all questions thoroughly and bring any substantiating X-ray, MRI, Ultrasound and/or laboratory reports to your scheduled appointment. We do not recommend that you have your X-ray, MRI and/or Ultrasound films mailed to our office in the event they should get lost in transit.

Directions:

Major freeways and access roads are identified on the enclosed map to guide you to our office without delay.

If you have any questions or wish to reschedule your appointment please contact us by phone at 760.746.1133 or by e-mail at drafournier@sbcglobal.net.

## **ALINE FOURNIER, D.O.**

### **Patient Financial Policy**

- 1. We accept cash, debit cards (with credit card logo), check, Visa, MasterCard, American Express and Discover.**
- 2. We require that any amount due be paid at the time of service. Please contact the Office Manager to discuss any financial questions or concerns.**
- 3. We do NOT accept Medicare, Medical, Worker's Comp, commercial insurance, auto insurance or contingency cases.**
- 4. The fee for a returned check is \$40.00. If you submit a check with insufficient funds, your professional treatment may be suspended until your balance is paid. Checks will no longer be accepted from a patient who has had a returned check.**
- 5. Any patient account balance of 90 days past due, who does not have a financial payment contract, will be turned over to an outside collection agency. This also includes any patient account balances that have defaulted from their financial payment contract.**
- 6. There is a \$50.00 fee to copy records.**
- 7. If you are unable to make your scheduled appointment, you must notify us 24 hours in advance. Failure to do so will result in a \$135.00 fee.**
- 8. Any treatment administered to a patient whose balance exceeds \$400.00 must be paid at time of visit. Said patient must have a written and signed financial payment contract for the outstanding balance.**

*Dr. Aline Fournier*

307 S. Ivy Street  
Escondido, Ca 92025  
760.746.1133

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**Dr. Fournier's Guidelines**

LOW STRESS DIET GUIDELINES

OBJECTIVES: Minimize stress to your system, support detoxification and enhance your overall health.

GENERAL RULES:

1. Eat whole foods as provided by nature: organic vegetables are especially beneficial.
2. Eat raw organic foods with every meal. The best raw foods are salads.
3. Best desserts - fruits except if you're trying to lose weight or reduce inflammation.
4. To improve a poor appetite, normalize excessive appetite or lose weight, eliminate sugar and starches.
5. Drink lots of pure water (free of chlorine and fluorides but not distilled, purified or reverse osmosis): ½ of your body weight in ounces every day. Check with Dr. Fournier to ensure that your specific condition does not preempt you from drinking this much water.
6. No sugar!!! Use only Stevia, Xylitol or Monk Fruit.
7. Eat organic food, grass fed meat (except pork), organic poultry, vegetables, raw nuts, etc. whenever possible.
8. Avoid soy, soy milk, soy products and tofu. Tempe may be used sparingly.
9. Avoid milk and milk products. Use raw organic milk and products (cheese) or unsweetened almond milk or coconut milk.
10. Avoid seafood and fish, except for Alaskan fish, due to mercury toxicity.
11. Eat raw organic nuts for snacks (7-8 nuts eaten slowly).

**IMPORTANT! ELIMINATE FOODS THAT CONTAIN:**

- Hydrogenated or partially hydrogenated fats
- Preservatives, natural flavors, hydrogenated protein
- Artificial sweeteners
- High fructose corn syrup
- **GMO**

# WE WELCOME YOU...

...and thank you for selecting us for your healthcare needs! We are dedicated to providing you with the best possible healthcare. To help us do this, please fill out this form completely in ink. If you have any questions or need help, please ask us - we will be happy to assist you.

## 1. Personal Information

Today's Date \_\_\_\_\_  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Name you prefer to be called \_\_\_\_\_  
Birthdate \_\_\_\_\_  
Male \_\_\_\_\_ Female \_\_\_\_\_ Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Referred by \_\_\_\_\_

## 2. Contact Information

Home Phone (        ) \_\_\_\_\_ Cell Phone (        ) \_\_\_\_\_  
Work Phone (        ) \_\_\_\_\_ Extension \_\_\_\_\_  
E-Mail \_\_\_\_\_  
Where do you prefer to be contacted? Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ E-Mail \_\_\_\_\_  
When is the best time to reach you? (Circle) Mon Tue Wed Thu Fri Sat Sun Time of Day \_\_\_\_\_  
In the event of an emergency, who should we contact? Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Home or Work Phone (        ) \_\_\_\_\_ Cell Phone (        ) \_\_\_\_\_

## 3. Responsible Party

Who is responsible for the account?  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Driver's License Number \_\_\_\_\_ Birthdate \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Phone (        ) \_\_\_\_\_ Ext. \_\_\_\_\_ Home Phone (        ) \_\_\_\_\_  
Cell Phone (        ) \_\_\_\_\_ E-Mail \_\_\_\_\_

#### 4. Insurance Information

##### Primary Insurance

Name of Insured \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insured's Birthdate \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Employer \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Employee/Cert. # \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
\_\_\_\_\_  
Deductible \_\_\_\_\_  
Maximum Annual Benefits \_\_\_\_\_

##### Secondary Insurance

Name of Insured \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insured's Birthdate \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Employer \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Employee/Cert. # \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
\_\_\_\_\_  
Deductible \_\_\_\_\_  
Maximum Annual Benefits \_\_\_\_\_

#### 5. Financial Arrangements

For your convenience, we offer the following methods of payment. Please check which you prefer.

Payment in full is due at time of visit.

Cash

Personal Check

Credit Card – MC  or Visa

I wish to discuss the office's payment policy.

### Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

#### 6. Authorization and Release

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care, to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group, insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_

Signature of patient or parent if minor

Date

**ANDRUS/CLINI-REC® HEALTH HISTORY QUESTIONNAIRE – MALE**

Identification Information

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

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_

**PART A – PRESENT HEALTH HISTORY**

**I. CURRENT MEDICAL PROBLEMS**

Please list the medical problems for which you came to see the doctor. About when did they begin?

Problems	Date Began
_____	_____
_____	_____
_____	_____

What concerns you most about these problems?

\_\_\_\_\_

If you are being treated for any other illnesses or medical problems by another physician, please describe the problems and write the name of the physician or medical facility treating you.

Illness or Medical Problem	Physician or Medical Facility	City
_____	_____	_____
_____	_____	_____

**II. MEDICATIONS**

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets or vitamin supplements)

\_\_\_\_\_

**III. ALLERGIES AND SENSITIVITIES**

List anything that you are allergic to such as certain foods, medications, dust, chemicals, or soaps, household items, pollens, bee stings, etc., and indicate how each affects you.

Allergic To:	Effect	Allergic To:	Effect
_____	_____	_____	_____
_____	_____	_____	_____

**IV. GENERAL HEALTH, ATTITUDE AND HABITS**

How is your overall health now? ..... Health now: Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_ Excellent \_\_\_\_\_

How has it been most of your life? ..... Health has been Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_ Excellent \_\_\_\_\_

In the past year:

Has your appetite changed? ..... Appetite: Decreased \_\_\_\_\_ Increased \_\_\_\_\_ Stayed same \_\_\_\_\_

Has your weight changed? ..... Weight: Lost \_\_\_\_\_ lbs. Gained \_\_\_\_\_ lbs. No change \_\_\_\_\_

Are you thirsty much of the time? ..... Thirsty: No \_\_\_\_\_ Yes \_\_\_\_\_

Has your overall 'pep' changed? ..... Pep: Decreased \_\_\_\_\_ Increased \_\_\_\_\_ Stayed same \_\_\_\_\_

Do you usually have trouble sleeping? ..... Trouble sleeping: No \_\_\_\_\_ Yes \_\_\_\_\_

How much do you exercise? ..... Exercise: Little or none \_\_\_\_\_ Less than I need \_\_\_\_\_ All I need \_\_\_\_\_

Do you smoke? ..... Smokes: No \_\_\_\_\_ Yes \_\_\_\_\_

How many each day? ..... Cigarettes \_\_\_\_\_ Cigars \_\_\_\_\_ Pipesfull \_\_\_\_\_

Have you ever smoked? ..... Smoked: No \_\_\_\_\_ Yes \_\_\_\_\_

How many each day? ..... Cigarettes \_\_\_\_\_ Cigars \_\_\_\_\_ Pipesfull \_\_\_\_\_

Do you drink alcoholic beverages? ..... Alcohol: No \_\_\_\_\_ Yes \_\_\_\_\_

How many each day? ..... I drink \_\_\_\_\_ Beers \_\_\_\_\_ Glasses of Wine \_\_\_\_\_

Do you drink alcoholic beverages? ..... Drinks of hard liquor - per day \_\_\_\_\_

Have you ever had a problem with alcohol? ..... Prior problem: No \_\_\_\_\_ Yes \_\_\_\_\_

How much coffee or tea do you usually drink? ..... Coffee/Tea: \_\_\_\_\_ cups of coffee or tea a day.

Do you regularly wear seatbelts? ..... Seatbelts: No \_\_\_\_\_ Yes \_\_\_\_\_

DO YOU:	Rarely/ Never	Occasionally	Frequently
Feel nervous?	_____	_____	_____
Feel depressed?	_____	_____	_____
Find it hard to make decisions?	_____	_____	_____
Lose your temper?	_____	_____	_____
Worry a lot?	_____	_____	_____
Tire easily?	_____	_____	_____
Have trouble relaxing?	_____	_____	_____
Have any sexual problems?	_____	_____	_____

DO YOU:	Rarely/ Never	Occasionally	Frequently
Ever feel like committing suicide?	_____	_____	_____
Feel bored with your life?	_____	_____	_____
Use marijuana?	_____	_____	_____
Use "hard drugs"?	_____	_____	_____
Do you want to talk to the doctor about a personal matter?	No _____	Yes _____	

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**PART A— PRESENT HEALTH HISTORY (continued)**

**IV. GENERAL HEALTH, ATTITUDE AND HABITS**

Have you recently had any changes in your: If yes, please explain:

Marital status? No  Yes  \_\_\_\_\_

Job or work? No  Yes  \_\_\_\_\_

Residence? No  Yes  \_\_\_\_\_

Financial status? No  Yes  \_\_\_\_\_

Are you having any legal problems or trouble with the law? No  Yes  \_\_\_\_\_

**PART B — PAST HISTORY**

**I. FAMILY HEALTH**

Please give the following information about your immediate family:

Relationship	Age, if Living	Age At Death	State of Health Or Cause of Death
Father .....	_____	_____	_____
Mother .....	_____	_____	_____
Brothers and Sisters } .....	_____	_____	_____
Spouse .....	_____	_____	_____
Children ... }	_____	_____	_____

Have any blood relatives had any of the following illnesses? If so, indicate relationship (mother, brother, etc.)

Illness	Family Members
Asthma .....	_____
Diabetes .....	_____
Cancer .....	_____
Blood Disease .....	_____
Glaucoma .....	_____
Epilepsy .....	_____
Rheumatoid Arthritis .....	_____
Tuberculosis .....	_____
Gout .....	_____
High Blood Pressure .....	_____
Heart Disease .....	_____
Mental Problems .....	_____
Suicide .....	_____
Stroke .....	_____
Alcoholism .....	_____
Rheumatic Fever .....	_____

**II. HOSPITALIZATIONS, SURGERIES, INJURIES**

Please list all times you have been hospitalized, operated on, or seriously injured.

Year	Operation, Illness, Injury	Hospital and City
_____	_____	_____
_____	_____	_____

**III. ILLNESS AND MEDICAL PROBLEMS**

Please mark with an (X) any of the following illnesses and medical problems you have or have had and indicate the year when each started. If you are not certain when an illness started, write down an approximate year.

Illness	(X)	(Year)	Illness	(X)	(Year)
Eye or eye lid infection	___	___	Hernia	___	___
Glaucoma	___	___	Hemorrhoids	___	___
Other eye problems	___	___	Kidney or bladder disease	___	___
Ear Trouble	___	___	Prostate problem	___	___
Deafness or decreased hearing	___	___	Mental problems	___	___
Thyroid trouble	___	___	Headaches	___	___
Strep throat	___	___	Head injury	___	___
Bronchitis	___	___	Stroke	___	___
Emphysema	___	___	Convulsions, seizures	___	___
Pneumonia	___	___	Arthritis	___	___
Allergies, asthma or hay fever	___	___	Gout	___	___
Tuberculosis	___	___	Cancer or tumor	___	___
Other lung problems	___	___	Bleeding tendency	___	___
High blood pressure	___	___	Diabetes	___	___
Heart attack	___	___	Measles/Rubeola	___	___
High cholesterol	___	___	German measles/Rubella	___	___
Arteriosclerosis (Hardening of arteries)	___	___	Polio	___	___
Heart murmur	___	___	Mumps	___	___
Other heart condition	___	___	Scarlet fever	___	___
Stomach/duodenal ulcer	___	___	Chicken pox	___	___
Diverticulosis	___	___	Mononucleosis	___	___
Colitis	___	___	Eczema	___	___
Other bowel problem	___	___	Psoriasis	___	___
Hepatitis	___	___	Venereal disease	___	___
Liver trouble	___	___	Genital Herpes	___	___
Gallbladder trouble	___	___	HIV test	___	___
			AIDS	___	___

**C O N F I D E N T I A L**

Please answer all of the following questions.  
 Circle any questions you find difficult to answer.

**PART C. — MALE BODY SYSTEMS QUESTIONS**

1. How often, if ever:	<b>Rarely/ Never</b>	<b>Occasionally</b>	<b>Frequently</b>
a. Are you nauseated (sick to your stomach)?	_____	_____	_____
b. Do you have stomach pains?	_____	_____	_____
c. Do you burp a lot after eating?	_____	_____	_____
d. Do you have heartburn?	_____	_____	_____
e. Do you have trouble swallowing your food?	_____	_____	_____
f. Have you vomited blood?	_____	_____	_____
g. Are you constipated?	_____	_____	_____
h. Do you have diarrhea? (watery stools)	_____	_____	_____
i. Are your bowel movements painful?	_____	_____	_____
j. Are your bowel movements bloody?	_____	_____	_____
k. Are your bowel movements dark or black?	_____	_____	_____
2. Have you ever had a sigmoidoscopy?	No _____	Yes _____	Date _____
	<b>Rarely/ Never</b>	<b>Occasionally</b>	<b>Frequently</b>
3. Is it sometimes hard to start your urine flow?	_____	_____	_____
4. Is urination ever painful?	_____	_____	_____
5. Do you have to urinate more than 5 times a day?	_____	_____	_____
6. Do you get up at night to urinate?	_____	_____	_____
7. Has your urine ever been bloody or dark colored?	_____	_____	_____
8. Do you ever lose urine when you strain, laugh, cough or sneeze?	_____	_____	_____
9. Do you ever lose urine during sleep?	_____	_____	_____
10. Have you had or do you have prostate trouble?	No _____	Yes _____	
11. Do you have any sexual problems or impotency problems?	No _____	Yes _____	
12. Have you ever had sores or lesions on your penis?	No _____	Yes _____	
13. Have you ever had any discharge from your penis?	No _____	Yes _____	
14. Do you ever have pain, lumps or swelling in your testicles?	No _____	Yes _____	
Check here if you wish to discuss any special problems with the doctor.			
	<b>Rarely/ Never</b>	<input type="checkbox"/>	<b>Frequently</b>
15. In the past year have you had any:		<b>Occasionally</b>	<b>Frequently</b>
a. Severe shoulder pain?	_____	_____	_____
b. Severe back pain?	_____	_____	_____
c. Muscle or joint stiffness or pain due to sports, exercise or injury?	_____	_____	_____
d. Pain or swelling in any joints not due to sports, exercise or injury?	_____	_____	_____
16. Do you have dry skin or brittle fingernails?	No _____	Yes _____	
17. Do you bruise easily?	No _____	Yes _____	
18. Do you have any moles that have changed in color or in size?	No _____	Yes _____	
19. Do you have any other skin problems?	No _____	Yes _____	
20. Have you ever fainted or felt like fainting?	No _____	Yes _____	
21. Does any part of your body get numb?	No _____	Yes _____	
22. Do you ever have fits or convulsions?	No _____	Yes _____	
23. Do you ever shake or tremble?	No _____	Yes _____	
24. Do you ever have any problem with coordination?	No _____	Yes _____	
25. In the last 3 months have you had:			
a. A fever that lasted more than one day?	No _____	Yes _____	
b. Sores or cuts that were hard to heal?	No _____	Yes _____	
c. Any cold sores (fever blisters)?	No _____	Yes _____	
d. Any lumps in your neck, armpits or groin?	No _____	Yes _____	
e. Do you ever have chills or sweat at night?	No _____	Yes _____	

Please Turn Page and Continue

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**GENERAL**

26. Have you traveled out of the country in the last 2 years? No \_\_\_\_\_
27. Write in the dates for the shots you have had: \_\_\_\_\_
28. Have you had a tuberculin (TB) skin test? No \_\_\_\_\_  
 If so, was it negative or positive? Neg \_\_\_\_\_  
 Have you had an HIV test (AIDS)? No \_\_\_\_\_  
 If so, was it negative or positive? Neg \_\_\_\_\_
29. Do you have headaches? Rarely/ Never \_\_\_\_\_
30. Do you have pain in your neck? \_\_\_\_\_
31. Do you have problems with your: \_\_\_\_\_  
 a. Teeth? \_\_\_\_\_  
 b. Gums, jaws or roof of mouth? \_\_\_\_\_  
 c. Tongue, or taste sense? \_\_\_\_\_
32. Do you wear eyeglasses? No \_\_\_\_\_
33. Do you wear contact lenses? No \_\_\_\_\_
34. Has your vision changed in the last year? No \_\_\_\_\_
35. How often do you have: Rarely/ Never \_\_\_\_\_  
 a. Double vision? \_\_\_\_\_  
 b. Blurry vision? \_\_\_\_\_  
 c. Watery or itchy eyes? \_\_\_\_\_
36. Do you ever see colored rings around lights? \_\_\_\_\_
37. Do others tell you you have a hearing problem? \_\_\_\_\_
38. Do you have trouble keeping your balance? \_\_\_\_\_
39. Do you have any discharge from your ears? \_\_\_\_\_
40. Do you ever feel dizzy or have motion sickness? \_\_\_\_\_
41. Do you have any problems with your hearing? No \_\_\_\_\_
42. Do you ever have ringing in your ears? No \_\_\_\_\_
43. How often do you have: Rarely/ Never \_\_\_\_\_  
 a. Head colds? \_\_\_\_\_  
 b. Chest colds? \_\_\_\_\_  
 c. Runny nose? \_\_\_\_\_  
 d. Stuffed up nose? \_\_\_\_\_  
 e. Sore/hoarse throat? \_\_\_\_\_  
 f. Bad coughing spells? \_\_\_\_\_  
 g. Sneezing spells? \_\_\_\_\_  
 h. Trouble breathing? \_\_\_\_\_  
 i. Nose bleeds? \_\_\_\_\_  
 j. Cough blood? \_\_\_\_\_
44. Have you ever worked or spent time: \_\_\_\_\_  
 a. On a farm? No \_\_\_\_\_  
 b. In a mine? No \_\_\_\_\_  
 c. In a laundry or mill? No \_\_\_\_\_  
 d. In very dusty places? No \_\_\_\_\_  
 e. With or near toxic chemicals? No \_\_\_\_\_  
 f. With or near radioactive materials? No \_\_\_\_\_  
 g. With or near asbestos? No \_\_\_\_\_
45. Do you get out of breath easily when you are active (Like climbing stairs)? Rarely/ Never \_\_\_\_\_
46. Do you ever feel light-headed or dizzy? \_\_\_\_\_
47. Have you ever fainted or passed out? \_\_\_\_\_
48. Do you sometimes feel your heart is racing or beating too fast? \_\_\_\_\_
49. When you exercise do you ever get pains in your chest or shoulders? \_\_\_\_\_
50. Do you have any leg cramps or pain in your thighs or legs when walking? \_\_\_\_\_
51. Do you ever have to sit up at night to breathe easier? \_\_\_\_\_
52. Do you use two pillows at night to help you breathe better? \_\_\_\_\_
53. Would you say you are a restless sleeper? \_\_\_\_\_
54. Are you bothered by leg cramps at night? \_\_\_\_\_
55. Do you sometimes have swollen ankles or feet? \_\_\_\_\_

Yes, Traveled in: \_\_\_\_\_  
 Measles \_\_\_\_\_ Tetanus \_\_\_\_\_ Has had  
 Mumps \_\_\_\_\_ Typhoid \_\_\_\_\_ these shots  
 Polio \_\_\_\_\_  
 Yes \_\_\_\_\_ Date \_\_\_\_\_ Date of last TB skin test  
 Pos \_\_\_\_\_ Positive TB test  
 Yes \_\_\_\_\_  
 Pos \_\_\_\_\_ Positive HIV test (AIDS)

Occasionally \_\_\_\_\_ Frequently \_\_\_\_\_  
**HEAD AND NECK**  
 Experiences headaches  
 Experiences neck pain  
**MOUTH**  
 Has teeth problem  
 Gum, jaw or mouth problem  
 Tongue or taste sense problem

**VISION/HEARING**  
 Wears eyeglasses  
 Wears contacts  
 Vision changed in last year

Occasionally \_\_\_\_\_ Frequently \_\_\_\_\_  
 Double vision  
 Blurred vision  
 Watery/itchy eyes  
 Sees halos  
 Hearing problem  
 Loses balance  
 Discharge from ears  
 Dizzy/motion sickness  
 Yes \_\_\_\_\_ Hearing problems  
 Yes \_\_\_\_\_ Ringing in ears

Occasionally \_\_\_\_\_ Frequently \_\_\_\_\_  
**NOSE/THROAT/RESPIRATORY**  
 Head colds  
 Chest colds  
 Runny nose  
 Head congestion  
 Sore/hoarse throat  
 Coughing spells  
 Sneezing spells  
 Trouble breathing  
 Nose bleeds  
 Cough blood

Yes \_\_\_\_\_ Worked on a farm  
 Yes \_\_\_\_\_ Worked in a mine  
 Yes \_\_\_\_\_ Worked in a laundry/mill  
 Yes \_\_\_\_\_ Worked in high dust concentrations  
 Yes \_\_\_\_\_ Exposed to toxic chemicals  
 Yes \_\_\_\_\_ Exposed to radioactive materials  
 Yes \_\_\_\_\_ Exposed to asbestos

Occasionally \_\_\_\_\_ Frequently \_\_\_\_\_  
**CARDIOVASCULAR**  
 Out of breath quickly when exercising  
 Dizziness  
 Fainted

Rapid heartbeat  
 Chest/shoulder pains in exercise  
 Pain in thighs or legs when walking  
 Sits up at night to breathe easier  
 Breathing problems during sleep  
 Restless sleeper  
 Leg cramps at night  
 Swollen ankles/feet

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Please Turn To Page 4 On Back and Complete

**NUTRITION AND DIET**

1. How many meals do you eat each day? \_\_\_\_\_ Meals each day
2. Do you usually eat breakfast? \_\_\_\_\_  No  Yes Breakfast
3. Do you diet frequently and/or are you now dieting? \_\_\_\_\_  No  Yes Diets
4. Do you consider yourself \_\_\_\_\_  Underweight  Overweight  Just right? Weight
5. Do you snack? \_\_\_\_\_  More than once a day  Usually daily  Rarely? Snacks
6. Do you add salt to your food at the table? \_\_\_\_\_  Almost always  Sometimes  Rarely Salts food
7. Check the frequency you eat the following types of foods:

	More than once daily	Daily	3 times weekly	Once weekly	Twice monthly	Less or never
a. Whole grain or enriched bread or cereal						
b. Milk, cheese, or other dairy products						
c. Eggs						
d. Meat, Poultry, Fish						
e. Beans, Peas, or other legumes						
f. Citrus						
g. Dark green or deep yellow vegetables						

List any food supplements or vitamins you take regularly: \_\_\_\_\_

Additional Patient Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thanks for completing this questionnaire. Please review for skipped questions, sign your name on the space to the right and return it to the physician or assistant. If you wish to add any information, please write it on the spaces provided above.

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

Physician's Notes: \_\_\_\_\_

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**C O N F I D E N T I A L**



## CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

(Page 2 of 2)

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“HIPAA”).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):  

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3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected health information to be used or disclosed under this authorization. You do not have the right of access to the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (“CLIA”) prohibits access, or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as “Psychotherapy Notes.” All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client’s medical records to maintain a higher standard of protection. “Psychotherapy Notes” are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual’s medical records. Excluded from the “Psychotherapy Notes” definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release “Psychotherapy Notes” to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.
8. You have a right to an accounting of the disclosures of your protected health information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or health care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual’s health care or payment for health care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.



