Name: Date:

NEW PATIENT INFORMATION FORM

NOTE: Naturopathic care is only possible when the doctor has a complete picture of the patient physically, mentally, and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire.

Patient Name_____ Age____ Date of Birth ___/___/_____ Sex: F M

Address_____ City _____ State_____ Zip_____

Daytime Phone_____ Ok to leave message? ____
Evening Phone _____ Ok to leave message? ____
Cell Phone_____ Ok to leave message ?____

Occupation_____ Employer_____

SSN _____/____/_____ Email Address:_____

Emergency Contact:_____ Phone:_____

How did you hear about us?_____

Reason for Visit today?_____

Primary Health Concerns: (In order of importance)
1. _____
2. _____
3. _____
4. _____

Medical History

Allergies: (Medications, Food, Environmental)

Please list Past Surgeries and/or Hospitalizations:

1) Date:

2) Date:

3) Date:

Name: Date:

Please List the Medications you are currently taking: (with dosage)

1)

2)

3)

4)

5)

Please attach additional sheet if you are taking more than 5 medications

Please list the supplements you are taking: (with dosage)

1)

2)

3)

4)

5)

Family History

Please list any significant health concerns for the following relatives.

Are you adopted?_____

	Age (if alive)	Age (at death)	Health Problems
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Maternal			
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Aunts/Uncles	_____	_____	_____
Paternal			
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Aunts/Uncles	_____	_____	_____

Name: Date:

Social History

Do you work? Y/N If yes, how many hours per week?_____ Please indicate level of job satisfaction on a scale of 1 to 10:____

Are you married or in a long term relationship? Y/N If yes, please indicate level of satisfaction on a scale of 1 to 10:____

How many marriages have you had:_____ How many divorces have you had:_____

Do you have children?_____ If so, how many and what ages:_____

Drug/Alcohol/Tobacco history

Please indicate substances currently used (over the past 6 months), How much at one time, how many times per day/week, age of first use, past use history, length of time used.

Substance	Current	Past	Age	Amount	Frequency	Length
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Pain Killers						
Tranquilizers						
Sleeping pills						
Diet pills						
Steroids						
Methamphetamines						
PCP/LSD/Mushrooms						
Ecstasy						
Cocaine/Crack						
Heroin						

Mental Health Information

Have you ever been in counseling/therapy before:_____ If yes, did you find it helpful or effective?
_____

Have you ever sought alternative treatment for mental health:_____ If yes, what type of treatment and did you find it helpful or effective?
_____

Are you currently receiving mental health services:_____ If yes, please list name of practitioner and type of service you are receiving:
_____

Have you ever been hospitalized for mental health concerns:_____ If yes, list date(s), length of stay, and reason for hospitalization:
_____

Have you ever been diagnosed with a mental illness? If yes, please list illness(es) and date(s) first diagnosed:
_____

Has anyone in your family ever been diagnosed with a mental illness? If yes, please list relationship(s) and diagnosis:
_____

Have you ever or are you currently engaging in self harm? Current:_____ Past:_____
Have you ever or are you currently contemplating suicide? Current:_____Past:_____
Have you ever, or are you currently contemplating harming another person? Current:____ Past:____

Have you ever attempted suicide:_____ If yes, please list date(s), method(s), and your age at time of attempt:_____

Name: Date:

Has anyone else in your life ever attempted_____ or completed suicide: _____
Relationship_____

Have you ever been the victim of abuse (verbal, physical, sexual):_____If yes, at what age:_____

Please indicate if you are currently experiencing or have recently experienced any of the following symptoms:

	Depressed mood		Hearing voices		Loneliness
	Suicidal thoughts		Hallucinations		Scary dreams
	Angered easily		Delusions		Sleep paralysis
	Anxiousness		Racing thoughts		Mental confusion
	Restlessness		Decreased need for sleep		Rapid mood swings
	Excessive worry		Excessive energy		Frequent crying
	Shy/timid		Elated mood		Suspicious/jealous
	Delusions of grandeur		Over confidence		Paranoia

Review of Systems

Please mark "now" or "past" next to all areas that apply to your past and present health.

NOW	PAST	**GENERAL SYMPTOMS**
		Tired, weak, lack of energy
		Irritability/moodiness
		Worry, anxiety, nervousness
		Sleeplessness, or too much sleep
		Frequent colds
		Dizziness, fainting, black out
		Night sweats/excess sweat
		Anemia
		Headaches
		>10lb Weight Loss/Gain in the last year

NOW	PAST	**EARS**
		Earaches
		Noises or ringing in ears
		Discharge
		Loss of hearing
		Excess earwax
		Difficulty hearing

NOW	PAST	**SKIN & HAIR**
		Acne
		Hives or rashes
		Itching skin
		Skin ulcers
		Dryness, roughness, or scaling
		Hair loss or thinning
		Dry, course hair
		Easy bruising
		Nails weak or ridged
		Hangnails
		Warts, moles, skin tags
		Poor wound healing

NOW	PAST	**EYES**
		Glasses/contacts
		Blurry vision
		Dry, burning, itchy eyes
		Watery eyes
		Night blindness
		Red or puffy eyes
		Mucus or discharge in eyes
		Pain in eyes

NOW	PAST	**CHEST**
		Persistent cough
		Spitting up blood or mucous
		Difficulty breathing
		Chest pain
		Wheezing
		Palpitations

NOW	PAST	**NOSE & THROAT**
		Allergies, sinusitis, runny nose
		Nosebleeds
		Dry or chapped lips
		Swollen lymph nodes
		Sore, red, cracked tongue
		Cold sores or Canker sores
		Loss of smell or taste
		Bleeding gums
		Hoarseness or sore throat
		Grinding teeth
		Dental problems
		Difficulty swallowing

Name: Date:

NOW	PAST	**GASTROINTESTINAL**
		Loss of appetite
		Nausea or vomiting
		Bad breath
		Metallic or bad taste in mouth
		Heartburn
		Indigestion
		Fatigue after eating
		Bloating
		Gas
		Constipation
		Diarrhea
		Light colored stool
		Undigested food in stool
		Floating stool
		Blood or mucous in stool
		Hemorrhoids
		Rectal pain/itching

NOW	PAST	**FEMALE**
		Irregular periods
		Pain with period
		Mood swings around period
		Painful or swollen breasts
		Lumps in breast
		Nipple discharge
		Vaginal discharge
		Vaginal pain or itching
		Heavy periods
		Hot flashes
		Decreased sex drive
		Difficulty reaching orgasm
		Miscarriages (how many?___)
		Abortions (how many?___)
		Pain with intercourse
		Pelvic pain
		Inability to conceive

NOW	PAST	**MALE**
		Prostate enlargement/pain
		Erectile dysfunction
		Premature ejaculation
		Decreased libido
		Genital discharge
		Rashes or sores
		Pain in genitals
		Pain in testicles
		Prostate cancer

NOW	PAST	**CARDIOVASCULAR**
		Heart beats fast or irregular
		Tightness in chest
		Dizziness or weak on standing
		Swollen feet, ankles, or legs
		Cold hands or feet
		Discoloration of hands or feet
		Leg pain walking
		High blood pressure
		Low blood pressure

NOW	PAST	**MUSCULOSKELETAL**
		Muscle pain
		Muscle weakness
		Joint pain
		Joint swelling
		Back pain
		Neck pain
		Joint stiffness
		Numbness or tingling
		Restless legs

NOW	PAST	**URINARY**
		Difficulty urinating
		Frequent urination at night
		Bed wetting
		Incomplete urination
		Incontinence (urine leakage)
		Pain with urination
		Urinary tract infections
		Kidney stones
		Blood in urine

Name: Date:

Please Initial and Sign

____ I understand that Dr. Brooke McNeal is a licensed Naturopathic Doctor and I consent to treatment.

____ I understand that Naturopathic medical treatments and therapies may be different from those offered by other licensed health care providers and that I am at liberty to seek other care.

_____ I understand that payment is expected at the time of service and rates are listed below.

____I understand that Dr. Brooke McNeal, N.D. does not accept insurance, but she may provide an invoice which I can submit to my insurance provider for possible reimbursement.

____ I understand the privacy practices of this office, required by HIPAA, and have had the opportunity to read them if I wish.

Patient or Responsible Party Signature _____ Date_____

Fees for Service

A La carte services

New client consult - $500

Follow up consultation - $100

Wellness packages

Package 1: New client consultation +5 follow up consultations - $900 (10% discount)

Package 2: New client consultation + 10 follow up consultations - $1,275 (15% discount)

Package 3: New client consultation + 15 follow up consultations - $1,600 (20% discount)

Package 4: New client consultation + 20 follow up consultations - $1,875 (25% discount)

Package 5: New client consultation + 25 follow up consultations - $2,100 (30% discount)

Follow up packages

10 follow ups - $850 (15% discount)

20 follow ups - $1,500 (25% discount)

30 follow ups - $1,950 (35% discount)

Payment Agreement

Please read the following agreement. It explains your financial obligations while under our care.

Payment is always due at the time of service. We accept the following forms of payment:

- Cash
- Check
- Credit/Debit Card

Long distance patients who prefer to pay with check may arrange for invoicing with their doctor, however we do require a credit card to be kept on file. All unpaid invoices over 30-days old will be billed to your credit card.

We do not submit insurance

- Because most insurance in California will not cover our services, we will not submit insurance for you. You are welcome to submit our invoice to your insurance company to see if they will reimburse any portion of the visit.
- If you would like to check with your insurance provider prior to scheduling an appointment to find out if they will cover our services, here is a guide of questions to ask.
    - Does my plan only cover services determined to be "medically necessary"?
    - Does naturopathic/complimentary/alternative care need to be pre-approved?
    - Does my plan have a limit on the conditions it will cover?
    - Do I need to see an in network provider? Is coverage available for out of network providers?

Phone Consultations:

- We do bill for phone consultations. We manage many patients by phone for convenience to long distance patients. They require the same time and expertise by the doctor as office visits and will be billed accordingly. Long distance patients are required to have a valid credit card on file at all times.
- Long distance patients may elect to receive invoices after each visit, in which case payment is expected within 30 days of receipt of invoice.

Wellness Packages:

- All wellness packages include a comprehensive new client homeopathic consultation, individualized wellness plan, and all homeopathic remedies (including shipping).
- Follow up credits must be used within one year from date of purchase. Unused consultations within the year may be transferred to family members or friends who are already established clients. Transferred credits will be good for one year from date of transfer.
- Wellness package must be paid for in full at time of elected package.
- Brooke McNeal, ND will alert you when your package is about to expire, or when all your follow up credits have been used. At that time, you may elect to purchase a new follow up package, or begin a la carte follow ups.

By signing this payment agreement, you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you have given your permission to Dr. Brooke McNeal, N.D. to charge your credit card for services rendered or if any of the fees explained above apply to you.

Name of Patient or Legal Guardian:_____

Type of Card: Visa MC Card Number:_____

Expiration:_____ Security Code:_____ Billing Zip Code:_____

Signature:_____ Date:_____

If you are a long-distance patient please indicate your preferred method of payment for follow ups:

__ bill credit card after each visit

__ mail invoices so I may send payment and charge any unpaid invoices greater than 30 days old to the above credit card

Confidentiality Statement

Your privacy is important to us. All medical records and interactions between doctor and patient are entirely confidential.

Outlined below is a brief summary of your rights and protections under the Health Insurance Portability and Accountability Act (HIPAA). You can learn more about your rights from the website at http://www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

You have the right to:

- Ask to see and get a hard copy or e-copy of your health records, if readily producible.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used or shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Request where you would like to be contacted.
- Ask that your information not be shared. For example, you could ask your doctor not to share your medical record with other doctors in the office.
- Receive breach notifications in a timely manner should any breach of protected health information occur.
- Request restriction of information to a health plan when you pay out of pocket, in full for health care services.

We will**:**

- **Not** sell your protected health information for marketing, and other purposes requiring authorization.
- Obtain authorization prior to disclosing protected health information for any use or disclosure that is not for treatment, payment, or health care operations, or otherwise permitted or required by the Privacy Rule. Including:
    - Psychotherapy notes
    - Research and Marketing
    - Disclosure of immunization information (can be oral consent)

- For disclosure to a third party: attorney, medical representative or a stand alone electronic patient health record, or family member who is not participating in or paying for treatment.

If you believe your rights are being denied or your health information isn't being protected, you can:

- File a complaint with your doctor.
- File a complaint with the U.S. Government.

If it is necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public, your doctor has the obligation to disclose any relevant information.

Name of Patient or Legal Guardian:_____

Signature:_____Date:_____

Electronic Communications:
Dr. Brooke McNeal, N.D. takes every precaution to protect your information and communication with us. Unfortunately, text messaging and email are not 100% secure. We are unable to communicate with you via email or text without signed consent. Please initial next to the forms of communication you consent to, and sign at the bottom to authorize communication. If you do not wish to use text messaging or email, no signature is required.

___ I understand that text messaging is not a secure method of communication, and I am authorizing communication by this method.

___ I understand that email is not a secure method of communication, and I am authorizing communication by this method.

Name of Patient or Legal Guardian:_____

Signature:_____Date:_____

*In order to reduce our carbon foot-print and expedite the flow of service, our preferred method of delivery for invoices and receipts is via Intuit Quickbooks Online. This information is delivered to you via email over Intuits secure servers that use industry best practices to protect your information. The only information contained in these communications will be your name, address, and service (i.e. new patient intake – brief). However, you have a right to request that your billing communications not be delivered in this manner.

Case Study Release

Occasionally, Dr. Brooke McNeal, N.D. likes to share patient stories via blog post, articles, presentations, etc. to illustrate the amazing power of homeopathy. We would be very grateful if you would allow us to share your case story for these purposes. All identifying information will be removed for your protection.

I, _____ hereby give Dr. Brooke McNeal, N.D. permission to use my (or my dependent's) case for the following purposes (please mark all that you are giving permission for):

____ Research cases

____ Grant proposal writing/presentations; funding purposes

____ General Media (ie. articles in professional and layperson magazines, television/radio interviews, etc)

____ Professional Presentations

____ I would like to be informed any time my story is used

_____ _____
(Signature) (Date)

Name: Date:

HOMEOPATHIC GENERALS FORM

Please circle the answers to the corresponding statements as honestly and accurately as possible. Some of these questions may not seem directly related to your health concerns, however they will help us find the best homeopathic remedy for you. Feel free to add explanations to your answers if you so choose.

WEATHER

Cold weather affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Rainy or humid weather affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Hot weather affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Change of weather affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Wind or thunderstorms affect me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I can tolerate exposure to warm sun (around 85 degrees) for a duration of
10 min. or less 10-30 min. 30-60 min. 1-2 hours 2-4 hours 4 hours or more

I generally feel better in the following atmosphere/weather
Mountains Seashore Dry weather Rainy/Stormy weather Sunny weather Cloudy weather

My symptoms get worse during the following seasons:
No season affects my symptoms Spring Summer Fall Winter
If so, which symptoms worsen? _____

ENVIRONMENT

Bright light affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Warm rooms affect me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Cold open air affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Loud noise affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Cold drafts affect me negatively (fans, A/C, wind)
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Strong odors affect me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

TIME OF DAY

The time of day that I generally feel the best or the most energetic is _____ AM/PM until _____ AM/PM

The time of day that I generally feel the worst or have the lowest energy is _____ AM/PM until _____ AM/PM

Name: Date:

GENERAL PHYSICAL CHARACTERISTICS

I tend to become uncomfortable faster in a room that is
Warmer than usual (80 degrees) Cooler than usual (60 degrees) (Circle the one that tends to bother you more)

Tight clothing affects me negatively (If so, around what part of the body? _____)
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

During sleep, I experience the following
Restlessness Sleep walking Teeth grinding Uncovering Perspiration Heat Coldness Snoring
Strange dreams Talking in sleep Frequent urination Frequent waking (at a specific hour?_____)

My usual sleep position is
On back On abdomen On side (right or left?) Feet/arms uncovered Fully covered Head also covered

In general, I tend to perspire
Never Only with exertion When heated When cold When nervous Easily, all the time

The part of my body where I tend to perspire the most is _____

FOOD & DRINKS

I crave the following flavors strongly on a daily basis (you may circle more than one)
Sweet Salty Sour Spicy Bitter Smoked Pungent

I crave the following types of food or drinks strongly on regular basis (you may circle more than one)
Apples Bacon Beer Bread Butter Cake/Cookies Cheese Chocolate Coffee Eggs Fish Fresh fruit Fried food Frozen food Garlic Ham Ice Ice cream Indigestible things (clay, chalk, etc.)
Lemons/Lemonade Liquor Meat Milk Nuts/Nut butters Onions Olives Oranges Pastries Pickles Potatoes Salsa Sausage Shellfish Tea Vegetables Wine Other: _____

If all food were healthy, I would enjoy the following foods/drinks multiple times per day:
_____

I tend to dislike the following foods, drinks, or flavors:
_____

With regard to thirst, on an average temperature day without physical exertion, I feel the need to drink water or another beverage to quench my thirst
Almost never Several times per day Several times per hour Every few minutes

I prefer my water
Hot Room temperature Cold Ice cold

I prefer my food
Hot Cold No strong preference

Name: Date:

FEARS

I have a strong fear of:

Darkness	Becoming seriously ill	Knives or needles
Thunderstorms	Loved one becoming ill or injured	Blood
Heights or falling	Ghosts	Spiders or insects
Small or narrow places	Evil	Snakes
Strangers	Failure	Animals (what kind? _____)
Robbers/intruders	Poverty	Being alone
Water, lakes, or the ocean	Death	Being in public or in a crowd
Contagious disease/germs	Insanity	That something terrible will happen

Other fears or phobias:_____

MENTAL & EMOTIONAL CHARACTERISTICS

In general, I tend to feel restless
Almost never Less than once a week Once a week Once a day More than once a day

If so, is there a part of your body that tends to be the most restless_____?

In general, I feel the need to keep things clean or organized
Almost never Less than once a week Once a week Once a day More than once a day

In general, I tend to feel impatient or hurried
Almost never Less than once a week Once a week Once a day More than once a day

In general, I tend to feel suspicious
Almost never Less than once a week Once a week Once a day More than once a day

In general, I tend to feel jealous or envious
Almost never Less than once a week Once a week Once a day More than once a day

In general, I tend to feel irritable or angry (whether you express it or not)
Almost never Less than once a week Once a week Once a day More than once a day

In general, I tend to criticize myself
Almost never Less than once a week Once a week Once a day More than once a day

In general, I tend to criticize others (either verbally or in my thoughts)
Almost never Less than once a week Once a week Once a day More than once a day

I think about disagreeable or troubling events from the past
Almost never Less than once a week Once a week Once a day More than once a day

I have urges to throw things, hit people/things, or break things (whether you act on this desire or not)
Never/Almost never Less than once a week Once a week Once a day More than once a day

Name: Date:

I have urges to hurt myself (whether you act on this urge or not)
Never/Almost never Less than once a week Once a week Once a day More than once a day

I cry easily or often
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

If someone upsets or offends me, I feel nervous confronting that person about it
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree Only with authority figures

I am offended easily by rudeness or injustice
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I am overly sensitive to hearing sad or cruel stories about children, adults, or animals
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Being scolded, reprimanded, or criticized affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I am frightened or startled easily
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I often worry about social status and success
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I often feel impulsive, or have sudden changes in mood or behavior
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I have difficulty making decisions
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I have a strong desire to travel or to be outdoors in nature
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I have a strong affinity for and love of animals
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I have a strong religious or spiritual faith
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I am often forgetful of the following
Dates Names Numbers Words Places Faces Recent events Distant past events
What I was about to say What someone just told me What I was about to do What I just did What I just said

I have had dreams or daydreams that have come true (clairvoyant or prophetic dreams)
Less than twice Less than 4 times Less than 10 times More than 10 times

Name: Date:

Regarding any past emotionally traumatic events, I feel
Grief Guilt Anger Fear Sadness Shame Indifference Peace Empowerment
Other: _____

Regarding my health condition, and the possibility of recovery, I feel
Very optimistic Hopeful Somewhat doubtful Discouraged Fearful Severe despair

In general, my overall outlook on life at this time is
Very optimistic Generally positive Indifferent Pessimistic

Loathing life Desire death Suicidal thoughts Suicidal plans

When I am feeling sad or upset, at the very worst point, I need
To be completely alone To have someone nearby To be distracted from my feelings

To vent about what I am feeling To have someone talk to me about what I'm feeling, and console me

If I am feeling at my worst, the following makes me feel much better (circle any that apply)
Rest/Sleep Massage/Pressure Crying Yelling Music Dancing
Company Being alone Talking Quiet Darkness
Sunshine Eating Gentle exercise
Vigorous exercise Exposure to heat
Exposure to cold

Anything else that consistently makes you feel better: _____

Anything that consistently makes you feel worse: _____

(If you have a partner/spouse) My general feeling toward my partner/spouse is
Loving Affectionate Indifferent Dissatisfied Disappointed Irritated Resentment
Disgust Hatred

The frequency of my sexual desire or interest is (whether you act on this desire or not)
Never/Less than 1x/year 1-6 x/year Every 1-2 months Every 1-2 weeks 2-4x/week
Once/day More than once/day

(If sexually active) Approximate frequency of intercourse
Never/Less than 1x/year 1-6 x/year Every 1-2 months Every 1-2 weeks 2-4x/week
Once/day More than once/day

Approximate frequency of masturbation
Never/Less than 1x/year 1-6 x/year Every 1-2 months Every 1-2 weeks 2-4x/week
Once/day More than once/day

I experience the following (circle any that apply):
Lack of sexual enjoyment Difficulty reaching orgasm
Troubling sexual thoughts Impotence