

New Patient Registration

Full Legal Name: _____

Date of Birth: _____ Gender & Pronouns preferred: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: () _____ Email: _____

Whom may I thank for referring you? _____

Emergency Contact Information- Please provide name, relationship and phone number

Is this visit **injury related**? Yes No Injury Date: _____

Have you filed a Workman's Compensation claim: Yes No

Have you filed a Motor Vehicle Accident claim: Yes No

Do you currently have a **Primary Care Provider**? Yes No

Name: _____ Phone: _____

Other providers you are receiving healthcare from, please list here:

By signing I agree that all the information provided on this form is complete and correct.

Signature Date

Health History

Name: _____ Date: _____

Main concern or reason(s) for seeing the doctor:

Personal

Major Illnesses (please give types and dates):

Previous hospitalizations and/or surgeries (please provide dates, if possible):

Allergies (food, environmental, medication, etc):

Social

Do you currently use tobacco products (smoke, vape, chew, etc)? **Yes No**

Past tobacco use? **YES NO** Product used? _____ Quit date: _____

What type, how often and for how long? _____

Alcohol Consumption? **YES NO**

If "yes", how often and how much? _____

Occupation/Work Status: _____

Relationship status: **Married/Domestic Partnership Single Widowed/Widower**

Other _____

Living situation: **Alone With family/roommates Assisted Living Facility**

Other _____

Ever been pregnant? **YES NO**

Please provide dates: _____

REVIEW OF SYSTEMS

Y: A symptom you are **currently** experiencing

N: A symptom you have **never** experienced

P: A symptom you have experienced in the **past**

GENERAL	Y	N	P	Explain:
Fever/chills				
Change in weight				
SKIN	Y	N	P	Explain:
Rashes/itching				
Acne				
HEENT	Y	N	P	Explain:
Headaches				
Vertigo				
Impaired vision/hearing				
Ringing in ears				
Sinus congestion/pain				
RESPIRATORY	Y	N	P	Explain:
Cough				
Phlegm/Sputum				
Shortness of breath				
Wheezing				
CARDIOVASCULAR	Y	N	P	Explain:
Chest pain				
Palpitations				
Edema/swelling				
Murmurs				
GASTROINTESTINAL	Y	N	P	Explain:
Heartburn				
Nausea/vomiting				
Abdominal pain				
Gas/bloating				
Diarrhea/ Constipation				
MUSCULOSKELETAL	Y	N	P	Explain:
Numbness				
Weakness				
Muscle spasms/cramps				

NEUROLOGICAL	Y	N	P	Explain:
Memory loss				
Tremors/Involuntary movements				
Seizures				
ENDOCRINE	Y	N	P	Explain:
Excessive thirst				
Excessive sweating				
MENTAL/EMOTIONAL	Y	N	P	Explain:
Depression/ Anxiety				
Addiction/OCD				
URINARY	Y	N	P	Explain:
Pain with urination				
Incontinence				
Blood in urine				
MALE REPRODUCTIVE	Y	N	P	Explain:
Testicular swelling				
Sexual/erectile dysfunction				
Weak urine stream				
FEMALE REPRODUCTIVE	Y	N	P	Explain:
Breast tenderness/lumps				
Vaginal irritation/discharge				
Pain with intercourse				
Sexual dysfunction				
Abnormal menses				
Pain with menses				

SCREENING EXAMS: If applicable, please provide date of most recent exam and results.

-Routine Physical Exam _____

-Well Women Exam (pap test, HPV screening) _____

-Mammogram (>45 years old) _____

-Colonoscopy (>50 years old) _____

-Bone Density Screening (DXA, >65 years old) _____

Holistic Health Clinic
Patient Responsibility and Policy Agreement

We ask that every patient read and sign their agreement to the following. You can request a copy for your records.

- Please be prepared to provide identification and insurance card (if applicable) at the time of each visit.
- A **minimum of 24 hours notice of appointment cancellations is required** except in legitimate emergencies. Cancellations made less than 24 hours from the appointment may be charged a \$50 fee for the first absence and the full amount of the visit for all missed appointments thereafter.
- Each patient is **responsible for knowing the terms and coverage of your insurance plan**. If you have insurance that the practitioner “accepts,” it does not guarantee payment will be made from your insurance company. You will then be personally responsible for the bill. *Please note; Medicare and any supplemental plans will not cover any acupuncture or naturopathic care unless you also have a secondary plan.*
- Patients are seen by appointment only. In the case of an urgent medical need patients can call the office to be scheduled for an emergency visit. In the case of an after-hours, urgent medical need, established patients can call 760-938-6453.
- Payments for dispensary items are due at the time of service; cash, check, credit or debit cards are accepted.
- Though advice or recommendations may be declined, neither Dr. Michelle Young, nor Holistic Health Clinic will be held accountable for anything that may happen as a result of your refusal.
- You may authorize that medical information including, but not limited to, lab results, be communicated via voicemail or email by indicating and initialing here:

Phone for voicemail: _____ Initials: _____

Email: _____ Initials: _____

By signing below you acknowledge your understanding of the terms and conditions listed above and agree to adhere to the policies of the clinic and physician.

Patient Signature or Signature of Legal Guardian

Printed Name

Date

Informed Consent for Treatment

I, _____ the undersigned, hereby authorize Dr. Michelle Young to perform the following specific procedures necessary to facilitate my diagnosis and treatment. Medical treatments and procedures not within the scope of our licensed practice will be referred to an appropriate provider.

- Common Medical Procedures: physical exams, orthopedic testing, gynecological and well women visits, venipuncture, laboratory testing, etc.
- Botanical Medicine: granulation and bulk herb infusions, alcohol and or glycerin-based tinctures, capsules, creams, compresses, suppositories, etc.
- Nutritional Supplements: vitamins, minerals, amino acids recommended in therapeutic and/or maintenance doses.
- Bio-identical hormone replacement therapy: clinical and laboratory evaluations and prescribe creams, troches, pills from compounded pharmacy
- Lifestyle and Hygiene Counseling: nutrition therapy and promotion of wellness, including recommendations for exercise, diet, sleep, stress reduction.
- Acupuncture: insertion of specialized sterile needles through the skin into the underlying tissues at specific points on the body.
- Cupping: a technique to myofascial tension by applying glass cups to the skin, using heat to create a vacuum seal.
- Moxa: an indirect warming technique on an acupuncture point using an herbal stick.
- Injection therapies, including Trigger Point Injections, Prolotherapy, and Neural Therapy: a combination of dextrose, lidocaine and/or procaine is injected into muscles, tendons and/or joints to promote regeneration of tissue, improve mobility and alleviate pain.

Potential Risks: unsuspected reaction at the site of procedure, an aggravation of symptoms existing prior to treatment, allergic reactions to recommended treatments, side effects of natural medications, inconvenience of lifestyle changes, injury from needle insertion, injections, or venipuncture.

Notice to **Pregnant Women**: All female patients must alert the doctor **immediately** if they know or suspect that they are pregnant, as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that Dr. Michelle Young has given me no guarantees regarding cure or improvement of my condition. I hereby release Holistic Health Clinic from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I acknowledge that Holistic Health Clinic is not responsible for patient compliance and will not be held responsible for outcomes due to patient non-compliance. I understand that I am free to withdraw my consent and to discontinue participation in the above procedures at any time.

By signing I agree that I have read and understand the above and consent to treatment.

Signature

Date

HIPPA COMPLIANCE

The Health Insurance Portability and Accountability Act, also known as HIPAA, was created in 1996 by the US Congress to protect the privacy of your health information. The act prohibits your health care providers from releasing your health care information unless you have provided your health care provider with a HIPAA release form.

Unless you have provided a signed release form, your health care providers are prohibited from discussing any aspect of your medical information with anyone who is not directly involved in your care.

I understand that a record will be kept of all health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless required by law. I understand that I may look at my medical record and request a copy of it. I understand that my medical record will be kept no longer than ten years after the date of my last treatment. I understand that my practitioner will answer any questions I have.

PRIVACY POLICY: Due to HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take in protecting your health information. Please ask the front office staff if you would like a copy.

Do **not** want a copy

Received a copy

By signing I agree that I have read and understand the above

Signature

Date