SHEA WELLNESS GROUP

Name: Date:

Date of birth: / / Age: Sex: M ☐ F ☐ SS#:

Address:

City: State: Zip:

Phone: Home Work: Mobile:

Fax: Email Address:

Occupation: Name of Employer

Name of (check one): Spouse ☐ Legal Guardian ☐ Name:

Are you: Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐

Emergency Contact Person

Name Relationship to you:

Phone number Alternative number:

Please choose *Yes or No* to the following and initial:
I authorize employees or agents of Shea Wellness Group to leave a detailed message for me on a voice message device associated with the phone number listed below regarding my:

1. **Laboratory reports** ☑ **YES (initials :____)** ☐ **NO (initials: _____)**
2. **Protected health information** ☑ **YES (initials :____)** ☐ **NO (initials: _____)**

If you answered **YES** to either of the above on which phone number is it acceptable to leave this information?

If you answered **NO** to either of the above, the physicians and/or staff members at Shea Wellness Group will, as necessary, leave a message indicating your need to call the clinic to retrieve any of your health information.

☐ DO NOT speak to family members.

I authorize the following individuals to inquire and receive verbal information regarding my care.

1. _____
2. _____
3. _____

Whom may we thank for referring you? _____

**********ALLERGIES** (please describe your response to allergen):**********

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

SHEA WELLNESS GROUP

Patient Name (on each page): DOB:

List, in order of importance, your goals for working with your physician:

1) _____
2) _____
3) _____
4) _____
5) _____

Which of your physicians would you consider in charge of your care?

Name: Phone:

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:	_____	_____	_____	_____	_____	_____
Age when died:	_____	_____	_____	_____	_____	_____
Reason for death:	_____	_____	_____	_____	_____	_____
Cancer type:	_____	_____	_____	_____	_____	_____
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Please note when and why you have had each of the following:

X-Rays: _____ MRI/CAT Scan: _____
Ultrasounds: _____ Accidents: _____
TB Test: _____ HCV: _____
HIV: _____ Flu Shot: _____
Last Dental Visit: _____ Last eye exam: _____

Did you have the following **D**isease **(D),** Get **I**mmunized **(I),** or **N**either **(N):**

Measles:	**D I N**	**Chicken Pox**	**D I N**	**Rubella**	**D I N**	**Hemophilia (HIB)**	**D I N**
Mumps:	**D I N**	**Whooping Cough:**	**D I N**	**Tetanus**	**D I N**	**Hep B**	**D I N**
German Measles:	**D I N**						

Any vaccination reactions?

SHEA WELLNESS GROUP

Patient Name (on each page): _____ DOB: _____

List **Y**es **(Y)**, **N**o **(N),** or **P**ast **(P)** regarding use of the following:

Antacids:	**Y N P**	**Steroids:**	**Y N P**	**Smoking:**	**Y N P**	**Packs per day & number of years:**	
Analgesics:	**Y N P**	**Laxatives:**	**Y N P**	**Coffee:**	**Y N P**	**Cups per day if Yes:**	

Soda Pop:	**Y N P**	**Ounces per day if Yes**
Alcohol:	**Y N P**	**How often & how much if Yes**

Any Alcohol Addiction:	**Y N P**	**Any Alcohol Treatment:**	**Y N P**
Recreational Drugs:	**Y N P**	**Any Drug Addictions:**	**Y N P**
Any Drug Treatment:	**Y N P**		

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and include dosage if known:

_____

_____

_____

Review of Systems:

Present Weight: _____ Weight one year ago: _____ Height: _____
Maximum weight and when: _____ Minimum weight as adult & when: _____
Ideal Weight: _____

REGARDING THE NEXT LONG SECTION: Please circle **(Y)** if you have the problem **NOW**, **(N)** if you've **NEVER** had the problem, **(P)** if you had the problem in the **PAST.**

Good Energy: Y N P
Fatigue: Y N P
If you have fatigue when in morning, afternoon, evening is it the worst? _____
If you have fatigue, can you do what you need to during the day? Y N

SKIN

Rash:	**Y N P**	Color Change:	**Y N P**
Hives:	**Y N P**	Lump:	**Y N P**
Psoriasis/eczema:	**Y N P**	Itchy:	**Y N P**
Dry:	**Y N P**	Warts/moles:	**Y N P**
Cancer:	**Y N P**	Perspiration:	**Y N P**

HEAD

Headache:	**Y N P**	Migraine:	**Y N P**
Dandruff:	**Y N P**	Head Injury:	**Y N P**
Oil/Dry Hair:	**Y N P**	Hair Loss:	**Y N P**

SHEA WELLNESS GROUP

Patient Name (on each page): DOB:

NOSE

Frequent Colds:	Y N P	Nosebleeds:	Y N P
Congestion:	Y N P	Post Nasal Drip:	Y N P
Polyps:	Y N P	Seasonal Allergies:	Y N P

EYES

Dry/Watery:	Y N P	Blurry Vision:	Y N P
Double Vision:	Y N P	Cataracts:	Y N P
Glaucoma:	Y N P	Styes:	Y N P
Strain:	Y N P	Discharge:	Y N P
Itchy:	Y N P	Dark Under Eyelid:	Y N P

MOUTH/THROAT

Canker Sores:	Y N P	Cold Sores:	Y N P
Sore Throat:	Y N P	Gum Disease:	Y N P
Dentures:	Y N P	Cavities:	Y N P
Loss of Taste:	Y N P	Hoarseness:	Y N P

NECK

Stiffness:	Y N P	Swollen Glands:	Y N P
Full Movement:	Y N P	Tension:	Y N P

RESPIRATORY

Cough:	Y N P	TB:	Y N P
Shortness of breath w/exertion:	Y N P	Bronchitis:	Y N P
Shortness of breath sitting:	Y N P	Pneumonia:	Y N P
Shortness of breath lying:	Y N P	Asthma:	Y N P
Wheezing:	Y N P	Painful breathing:	Y N P

CARDIOVASCULAR

High Blood Pressure:	Y N P	Rheumatic Fever:	Y N P
Low Blood Pressure:	Y N P	Murmurs:	Y N P
Arrhythmias:	Y N P	Palpitations:	Y N P
Edema:	Y N P	Chest Pain:	Y N P

URINARY TRACT

Incontinence:	Y N P	Pain w/Urination:	Y N P
Frequent Infections:	Y N P	Kidney Stones:	Y N P
Urgency:	Y N P	Discharge/Blood:	Y N P

SHEA WELLNESS GROUP

Patient Name (on each page): DOB:

GASTROINTESTINAL

Heartburn:	Y N P	Bowel Movement Freq:	
Indigestion:	Y N P	Recent BM Change:	Y N P
Bloating:	Y N P	Diarrhea/Constipation:	Y N P
Nausea:	Y N P	Hemorrhoids:	Y N P
Vomiting:	Y N P	Gall Bladder Disease:	Y N P
Change In Appetite:	Y N P	Liver Disease:	Y N P
Pancreatitis:	Y N P	Ulcer:	Y N P

MALE GENITALIA

Testicular pain/swelling:	Y N P	Sexually Active:	Y N P
Hernia:	Y N P	S.T.D.:	Y N P
Discharge:	Y N P	Prostate Disease/Symptoms:	Y N P
Impotency:	Y N P	Sexual Orientation:	Hetero Homo Bi

FEMALE GENITALIA

Age Period Began:		How Often Period Occurs:	
How long period lasts:		Heavy menstrual bleeding:	Y N P
Menstrual cramping:	Y N P	Menstrual Pain:	Y N P
PMS:	Y N P	Food cravings:	Y N P
Times Pregnant:		How many births:	
Miscarriages:		Abortions:	
Last Pap Smear:		Diagnosis:	
Any abnormal paps:	Y N P	When was abnormal:	
Menopausal since what age:		Use of hormones:	Y N P
Type of hormones used:		Healthy libido:	Y N P
Dry vagina:	Y N P	Sexually Active:	Y N P
Pain w/intercourse:	Y N P	Vaginitis:	Y N P
S.T.D.:	Y N P	Mammography:	Y N P
Dexa Scan:	Y N P	If Yes, what were results:	

Please list any birth control used and ages used: _____
_____

SHEA WELLNESS GROUP

Patient Name (on each page): DOB:

MUSCULOSKELETAL

Weakness:	**Y**	**N**	**P**		Arthritis:	**Y**	**N**	**P**	
Stiffness:	**Y**	**N**	**P**		Leg Cramps:	**Y**	**N**	**P**	
Tremors:	**Y**	**N**	**P**		Pain:	**Y**	**N**	**P**	

NERVOUS

Paralysis:	**Y**	**N**	**P**		Sciatica:	**Y**	**N**	**P**	
Tingling/numbness:	**Y**	**N**	**P**		Carpal tunnel syndrome:	**Y**	**N**	**P**	
Seizures:	**Y**	**N**	**P**		Fainting:	**Y**	**N**	**P**	

MENTAL/EMOTIONAL

Depression:	**Y**	**N**	**P**		Anger/irritability:	**Y**	**N**	**P**	
Suicidal:	**Y**	**N**	**P**		High-strung/tense:	**Y**	**N**	**P**	
Anxiety:	**Y**	**N**	**P**		Fear/Panic:	**Y**	**N**	**P**	
Eating disorder:	**Y**	**N**	**P**		Psych Hospitalization:	**Y**	**N**	**P**	

EXERCISE

How often do you exercise? _____

What type of exercise? _____

For how long? _____

Hobbies: _____

SLEEP

How long per night? _____

If you wake up frequently, what is the reason? _____

Nightmares:	**Y**	**N**	**P**		Wake Refreshed:	**Y**	**N**	**P**	
Sleep Walk:	**Y**	**N**	**P**		Grind teeth:	**Y**	**N**	**P**	
Must nap during the day:	**Y**	**N**	**P**		Snore:	**Y**	**N**	**P**	

SHEA WELLNESS GROUP

Patient Name (on each page): DOB:

TOXIN EXPOSURE

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____
_____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____
_____

SOCIAL LIFE

Enjoy job: **Y** **N** **P** Hours worked per week: _____

Highest Level of Education: _____ Active spiritual practice: **Y** **N** **P**

Quality of significant relationship: _____

History of sexual, mental/emotional, physical abuse: **Y** **N** **P**

If so, at what age and by whom: _____

What is your greatest health concern: _____

How does it limit you the most: _____

How committed are you towards making valuable changes: ☐ Little ☐ Moderately ☐ Very

SHEA WELLNESS GROUP

NATUROPATHIC INFORMED CONSENT TO TREATMENT AND CARE

Patient Name (on each page): DOB:

Office Name: Shea Wellness Group Naturopathic Doctor: Dr. Jacqueline Poulos

Consent: I hereby request and consent to the performance of naturopathic treatments and / or other naturopathic procedures, including various modes of physical therapy and diagnostic procedures, on me (or the patient named above, for whom I am legally responsible) by the doctor of naturopathy named above and/or other licensed doctors of naturopathy who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of naturopathy named above, including those working at the clinic or office listed above or any other office or clinic whether signatories to this form or not.

Type of Care: I have had an opportunity to discuss with the doctor of naturopathy named above and/or with other office clinic personnel the nature and purpose of naturopathic care and procedures. A description of the specific care which is currently contemplated follows: Naturopathic Assessments and Diagnostic Techniques including but not limited to obtaining a thorough medical history to the best of the doctors ability, physical screening exam, complaint oriented physical exam, breast exam, gynecological exam and pap smear, prostate exam, and various laboratory procedures. Naturopathic treatments including but not limited to herbal medicine, nutritional counseling and supplementation, lifestyle counseling, naturopathic physical therapy, hydrotherapy, homeopathics, and hormone therapy/replacement.

No Guarantee: I understand that results are not guaranteed.

Recital of Risks: I understand and am informed that, as in the practice of medicine, in the practice of naturopathic medicine, there are some risks to treatment, including, but not limited to: side effects of medication, side effects of natural supplementation, herbs and hormones, allergic reactions, anaphylaxis, fractures, disc injuries, strokes, dislocation and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely on the Doctor's judgment based upon the facts then known, to provide me with any care and procedures considered to be in my best interest during the course of my treatment.

Agreement and Continuous Effect: I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE: _____
(Or Patient Representative) (Indicate relationship is signing for patient)
Date: _____

SHEA WELLNESS GROUP

Dear Patient:

E-mail and/or text messaging offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember: there are important differences. E-mail and/or text messaging is not the same as calling us; there is no person at the other end of the call – just a computer or a cell phone. You can't tell for certain when your message will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail and/or text messaging affords are a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us using e-mail and/or text messaging. Please check the box after reading each rule.

☐ E-mail and/or text messaging are never, ever, appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Department for emergencies.

☐ E-mail and/or text messaging are great for asking those little questions that don't require a lot of discussion. Appropriate uses of e-mail and/or text messaging also include prescription refill requests, referral and appointment scheduling requests and billing/insurance questions.

☐ E-mails and/or text messages should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

☐ E-mail and/or text messages are not confidential. It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.

☐ E-mail and/or text messages may become a part of the medical record when we use it; a copy may be printed and put in your chart

☐ E-mail and/or text messages are not a substitute for seeing us. If you think that you might need to be seen, please call and book an appointment!

☐ E-mails and/or text messages may be forwarded to my staff for handling, if appropriate.

Finally, either one of us can revoke permission to use the e-mail system at any time.

☐ I DO want to communicate with my doctor electronically. I have read the above information and understand the limitations of security on information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed.

Patient Name: _____

Patient Signature: _____

E-mail Address: _____

Date: _____

State of Residence: _____

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated but **we must provide you with the following important information:**

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative leave order
3. If we are required to do so by a law enforcement official
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat
5. If you are a member of U.S. foreign military forces (including veterans) and if required by the appropriate authorities
6. To federal officials for intelligence and national security activities authorized by law
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official
8. For Workers Compensation and similar programs

Your rights regarding your health information

1. You can request that our practice communicates with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decision about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Shea Wellness Group, 10401 N 32nd Street, Suite A, Phoenix, AZ 85028
   Note: We must respond to this request within 30 days

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Shea Wellness Group, 10401 N 32nd Street, Suite A, Phoenix, AZ 85028

   Note: We must respond within 60 days. The Privacy Officer or the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact the front desk receptionist.

6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Rose Strickland at Shea Wellness Group. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Our practice will obtain your written authorization for used and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Rose Strickland at Shea Wellness Group.

SHEA WELLNESS GROUP

ACKNOWLEDGEMENT 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 Shea Wellness Group 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:

Rose Strickland
602-569-0223

I also understand that I am entitled to receive updates upon request if Shea Wellness Group amends or changes it Notice of Privacy Practices in a material way.

_____ _____

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

_____

Date

THIS SECTION IS TO BE COMPLETED BY SHEA WELLNESS GROUP IF UNABLE TO OBTAIN WRITEEN ACKNOWLEDGEMENT FROM THE PATIENT

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

Patient declined to sign this Written Acknowledgement
Other (specify): _____

_____ _____

Name and Title of Employee | Date: