CONFIDENTIAL CONTACT FORM

Full Legal Name:_____

Last Name, First Name Middle Initial

Preferred Name:_____Age_____ Date of Birth:_____

S.S. # _____

Address: _____

Street #/P0 Box City State Zip code_____

Telephone: (H) _____ (W) _____ (M)_____

E-mail Address: _____

Gender: Female_____ Male _____

Occupation: _____

(circle) Full Time / Part Time / Student /Retired

Emergency Contact: _____

Name Relationship_____

Emergency Contact Number: (H) _____ (W)_____(M) _____

How did you hear about us?_____

COMMUNICATION

What is the best way to communicate with you between office visits? E-mail / Home ph. / Work ph. / Cell ph.

Is there any place you do NOT want us to leave a message? _____

May our practitioner(s) discuss your private medical information with you via e-mail? Yes No

May we send you educational/promotional materials such as newsletters via e-mail? Yes No

Primary Care Information:
Physician's Name: ..... Phone: .....
Address: .....

Do you have a gynecologist?
Physician's Name: ..... Phone: .....
Address: .....

Date of last Well Woman exam: ..... Any abnormal findings? Y N .If yes, please explain: .....

Are you under the care of a physician for a chronic illness? If yes, please explain .....

MEDICATIONS

List all pharmaceutical medication(s) and dosage(s)that you are currently taking

1. .....
2. .....
3. .....
4. .....
5. ....
6. ....
7. ....
8. ....

Are you allergic to any medications? Y N
If Yes, please list: .....

What is your reaction to these medications? .....
Do you have any other allergies to foods, drugs or other allergens in your environment
(e.g. cats, mold, dust)? .....

SUPPLEMENTS

List all homeopathic remedies, herbs, vitamins and minerals with dosage that you are currently taking.

1. .....
2 .....
3 .....
4 .....
5. ..
6. ..
7. ..
8. ..

SUPPLEMENTS

List all homeopathic remedies, herbs, vitamins and minerals with dosage that you are currently taking.

1. .....
2.....
3 .....
4.....
5. ..
6. ..
7. ..
8. ..

SOCIAL HISTORY

Occupation ..... (circle) Full Time /Part Time /Student /Retired/Disability
Employer / School .....
Are you currently: (circle) Single / Married / Long - term relationship / Widowed / Divorced / Other .....
Number of children and ages? .....

Have you traveled outside the US? Y N If yes, where? ..... When? .....
Decsribe your support network: .....

Health Habits	Yes	No	If Yes, for how long and/or how often per week?
Do you exercise?			
Do you smoke tobacco? Past or present use?			
Do you drink alcohol?			
Do you use recreational drugs?			
Have you ever been treated for drug/alcohol dependence?			Explain:
Do you drink coffee, soda or black tea?			
Do you drink "diet" sodas or eat "diet" foods?			
Do you follow any dietary modifications?			Describe:
Do you follow a spiritual practice?			
Do you have any hobbies/ interests?			Describe:

.....

General Review

	Yes	No		
Do you..... Sleep well?			Current weight	
Wake feeling rested?			Weight one year ago	
Eat three meals daily?			Max adult weight, date	
Enjoy your work?			Min adult weight, date	
Spend time outside?			Max adult height	
Take vacations?			Best energy level? (time of day)	
Watch television? Hours/week			Lowest energy level? (time of day)	
Read? Hours per week			Subjectively, do you feel your temperature runs warm or cool?	
Use a computer? Hours per day?			Are you a morning, afternoon or night person?	

FOOD DIET

Please describe your typical food intake

Breakfast	Lunch	Dinner	Snacks Beverages
			Water /day Filtered? Y N

Favorite Foods: .....
List the 3 healthiest foods you eat during an average week .....
List the 3 worst foods you eat during an average week .....
Do you consider yourself a picky or an adventurous eater? .....
What flavors do you like? (circle) sweet / salty / bitter / sour / aromatic / spicy / bland
Do you follow a certain type of diet? Y N Please explain .....
Have you or do you regularly fast? Y N Please explain. .....
Do you or have you ever had an eating disorder? Y N If 'yes', please explain. .....
.....
.....

PAST MEDICAL HISTORY

Please mark P (past) or C (current) for any of the following that you or your family members have had:

Condition	Self	Father	Mother	Sibling(s)	Aunt/Uncle	Grandparent	Child
ADD/ADHD							
Alcoholism							
Allergies							
Anemia/ Blood Disorder							
Anxiety/Depression							
Arthritis							
Asthma							
Autoimmune Disease							
Blood Vessel Disorder							
Cancer (type)							
Chemical Sensitivities							
Diabetes							
Drug/Other Addiction							
Eating Disorder							
Epilepsy/Seizures							
Food Poisoning (type)							
Gallbladder Disease							
Gastrointestinal Disorder							
Glaucoma/Cataracts							
Gum Disease							
Headaches/Migraines							
Heart Disease							
Heart Murmur							
High Blood Pressure							
Hypoglycemia							
Infertility							
Kidney Disease							
Liver Disease							
Lung Disease							
Menstrual Disorder							
Mental Illness							
Mouth, Throat Disease							
Muscular Disorder							
Neurological Disorder							
Pain, Chronic							
Skeletal Disorder							
Skin Disorder							
Stroke							
Thyroid Disorder							
Tuberculosis							
Ulcer							
Urinary Disorder							
Vision Problems							
Yeast Infections							


AZNA WOMEN'S
WELLNESS CENTER

REVIEW OF SYSTEMS

Please check(V) the box for any conditions that you currently experience - ❑ for Current, 0 for Past

Blood/ Peripheral Vascular
CP
- ❑ O Anemia
- ❑ O Cold hands/feet
- ❑ O Deep leg pain
- ❑ O Easy bleeding/ bruising
- ▪ Thrombophlebitis
- ❑ O Varicose veins

Cardiovascular
- ❑ O Chest pain/pressure
- ❑ O Fainting/ Light-headed
- ❑ O Heat Disease
- ❑ O High blood pressure
- ❑ O High cholesterol
- ❑ O Heart beat, irregular
- ❑ O Heart murmur
- ❑ O Palpitations, fluttering
- ❑ O Rheumatic fever
- ❑ O Swelling in ankles

Endocrine
- ❑ O Fatigue
- ❑ O Heat or cold intolerance
- ❑ O Hypo/hyperglycemia
- ❑ O Hypo/hyperthyroid
- ❑ O Increasing hunger
- ❑ O Increasing thirst
- ❑ O Seasonal depression

Neck
- ❑ 0 Goiter
- ❑ 0 Lumps
- ❑ 0 Pain or stiffness
- ❑ 0 Whiplash injury

Respiratory
CP
- ❑ **O Asthma**
- ❑ **O Bronchitis**
- ❑ **O Cough, chronic**
- ❑ **O Difficulty breathing E0**

Emphysema
- ❑ **O Pain on breathing**

Neurologic
CP
- ❑ O Loss of memory
- ❑ O Numbness or tingling
- ❑ O Paralysis
- ❑ O Seizures
- ❑ O Tremor

Mental/Emotional
- ❑ O Anxiety, nervousness
- ❑ O Poor memory
- ❑ O Depression
- ❑ O Concentration, difficult
- ❑ O Contemplate suicide
- ❑ O Critical of others
- ❑ O Critical of self
- ❑ O Experience loneliness
- ❑ O Mood swings
- ❑ O Tension, stress
- ❑ O Treatment for mental/ emotional concerns

Head
- ❑ O Headaches
- ❑ O Head injury
- ❑ O Jaw; TMJ problems
- ❑ O Migraines

Nose and Sinuses
- ❑ O Hay fever
- ❑ O Nose bleeds
- ❑ O Red nose
- ❑ O Runny nose
- ❑ O Sinus problems
- ❑ O Stuffiness, congestion

Eyes
CP
- ▪ Blurriness
- ❑ O Cataracts
- ❑ O Color blindness
- ❑ O Diminished night vision
- ❑ O Dryness, excessive
- ❑ O Itchy eyes
- ❑ O Eye pain
- ❑ O Glasses or contacts
- ❑ O Glaucoma
- ❑ O Retinal detachment
- ❑ O Spots in eyes
- ❑ O Tearing, excessive

Ears
- ❑ O Dizziness/Vertigo
- ❑ O Earache
- ❑ O Ear infections
- ❑ O Ears, itchy
- ❑ O Hearing, impaired
- ❑ O Ringing, tinnitus
- ❑ O Wax, excessive

Mouth and Throat
- ❑ O Bad breath
- ❑ O Dental cavities/fillings
- ❑ O Dentures
- ❑ O Frequent sore throat
- ❑ O Frequently clearing throat
- ❑ O Gum problems
- ❑ O Hoarseness
- ❑ O Metallic taste in mouth
- ❑ O Mouth sores
- ❑ O Saliva, excess
- ❑ O Sore tongue, lips
- ❑ O Teeth grinding

❑ O Pneumonia
❑ O Pleurisy
❑ O Shortness of breath
❑ O At night
❑ O Lying down
❑ O With exercise/exertion
❑ O Spitting up blood
❑ O Sputum
❑ O Wheezing

Urinary
❑ O Bed wetting
▪ BPH
❑ O Frequency at night
❑ O Frequent infections
❑ O Increased frequency
❑ O Inability to hold urine
❑ O Kidney stones
❑ O Kidney, back pain
❑ O Low force of urine
❑ O Pain with urination
❑ O Urine retention
❑ O Urgency with urination

Gastrointestinal
CP
❑ O Abdominal pain, cramps
❑ 0 Alternating diarrhea/constipation E0
Belching
❑ 0 Blood in stool
❑ O Change in stool
❑ O Bowel movements, how often?
... per day/ 2days/ 3 days/ week
❑ 0 Bulimia
❑ O Change in appetite
❑ O Change in thirst
❑ O Constipation
❑ 0 Diarrhea
❑ 0 Fatigue after eating
❑ 0 Flatulence/gas
❑ O Gallbladder disease
❑ O Heartburn
❑ O Hemorrhoids
❑ O Hepatitis
❑ O Jaundice
❑ 0 Liver disease
❑ 0 Nausea
❑ O Pain in rectum
❑ O Painful stool
❑ O Parasites, diagnosed
❑ 0 Reflux
❑ O Stomach pain
❑ O Trouble swallowing
❑ O Vomiting

Musculoskeletal
CP
❑ O Arch supports/heel lifts
❑ O Arthritis
❑ O Back pain
❑ O Broken bones
❑ O Joint pain or stiffness
❑ O Joint swelling
❑ O Muscle pain
❑ O Muscle spasms/cramps
❑ O Muscle weakness,

Skin
❑ O Acne
❑ O Boils
❑ O Cancer
❑ O Color change
❑ O Eczema
❑ O Flushing/hot flashes
❑ O Hair loss
❑ O Hives
❑ O Itching
❑ O Lumps
❑ O Night sweats
❑ O Moles
❑ O Psoriasis
❑ O Rashes
▪ Rosacea

REPRODUCTIVE, MALE

Please check (V)the box for any which apply to you:

❑ Birth control, type?
❑ BPH
❑ Ejaculation concerns
❑ Fertility concerns
❑ Impotence
❑ Penile discharge
❑ Penile sores
❑ Prostate disease
❑ Sexually active
❑ Sexual difficulties
❑ Sexually transmitted
❑ infection(s) .....
❑ Testicular masses
❑ Testicular pain

Date of last prostate exam?
Sexual orientation (circle): Men / Women / Bisexual Transgender: Y N

Please complete Health Goals on next page.

REPRODUCTIVE, FEMALE

Age of first menses ..... Avg. length of blood flow ..... (days)
Number of days between menstrual cycles ..... (days) Date of last menstrual period .....
Are cycles regular? Y N Are you pregnant? Y N Age of last period (if menopausal) .....
Mother's age at menopause .....
Do you do self-breast exam? Y ..... N How often?
Please specify number of: Pregnancies ..... Live Births ..... Miscarriages ..... Abortions .....
Sexual orientation (circle): Men / Women / Bisexual Transgender: Y

Please check (V) the box for any which apply to you:

- ❑ Abnormal PAP
- ❑ Birth control, type?
- ❑ Bleeding between cycles
- ❑ Breast lumps, fibrocystic changes
- ❑ Cervical dysplasia
- ❑ Clotting
- ❑ Cramping with menses
- ❑ DES exposure
- ❑ Difficulty getting pregnant
- ❑ Endometriosis
- ❑ Genital warts
- ❑ Heavy menstrual flow
- ❑ Hormone replacement therapy
- ❑ Hysterectomy, oophorectomy
- ❑ Hysterectomy, ovaries intact
- ❑ Increased or decreased libido
- ❑ Irregular cycles
- ❑ Menopausal symptoms
- ❑ Nipple discharge
- ❑ Other
- ❑ Ovarian cysts/PCOS
- ❑ Painful intercourse
- ❑ Painful periods
- ❑ Premenstrual Syndrome (PMS)
- ❑ Scanty menstrual flow
- ❑ Spotting between periods
- ❑ Sexual difficulties
- ❑ Sexually active
- ❑ Sexually transmitted infection _____
- ❑ Uterine fibroids
- ❑ Vaginal discharge

HEALTH GOALS

What are your health goals? .....

What is your level of motivation regarding your healing? .....

What do you expect from your practitioner? .....

Financial Agreement

Treatment Authorization: I authorize medical and health care treatment of myself to Dr. Faith Whittier.

Privacy Statement: Dr. Whittier does respect your privacy and will only release information required to further your treatment, assist you in obtaining payment, managing her own internal operations, or as specifically authorized by you.

Medical Records Release Authorization: I authorize Dr. Whittier to release my medical information to any physician or health practitioner to whom I am being referred for care

Financial/Insurance Responsibility: I understand that Dr. Whittier does not participate in any insurance plans. I understand and agree that Dr. Whittier does not take assignment, which means that payment will be required at each visit. I understand that while Dr. Whittier's office will provide me with a receipt, I am ultimately responsible for submitting these claims to the insurer if I am interested in requesting reimbursement for my visit fee. I understand and agree that I am responsible for all charges incurred for all treatment rendered, including procedures and laboratory tests, even if my insurance company determines that any services are non-covered or excluded, or, in their opinion, are unreasonable or not medically necessary.

Cancellation Fee: A cancellation fee of $50 will be assessed for missed appointments not cancelled with more than 48 hours notice. A cancellation fee of half the cost of the appointment will be assessed for no-show appointments without any prior notice.

No Guarantees: I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive.

Patient Signature

What to Expect

Thank you for making the decision to focus on your health. We look forward to partnering with you. Our goal is to help you solve your health problems and promote a healthy lifestyle.

In order to give you the extended time and attention necessary to treat you in an integrative manner, you can expect that each new patient visit with the physician will take one hour. The time scheduled for established well-woman visits and follow-up is thirty minutes. During your visit we will listen carefully to your health concerns, review your medical history, and perform a physical examination as deemed necessary. We will work as a team to develop an individualized plan for you to reach your specific health goals. The labs required to uncover underlying issues and medical conditions varies per patient and are separate from the initial consultation. Dr. Whittier is extremely conscious of these expenses and only recommends the most necessary for your care.

Our plan is for you to be seen at your scheduled time (just like the schedule at a spa). This will allow you to maintain your own schedule on the day of the appointment. In order to achieve this goal, we request that you complete your new patient forms prior to arrival. However, if this is not possible, please arrive thirty minutes prior to the appointment time.

Payment is due at the time of service. We currently accept cash, check, or credit card. We do not accept insurance but will be happy to help you submit your insurance claim before you leave our office.

We look forward to your journey with us at Azna Women's Wellness Center!

_____

Initials