THE herban ALCHEMIST

PATIENT INTRODUCTION

Date:___________________ Social Security Number______-____-________

Patient's Name: ____

Gender: ☐ male ☐ female Age:___________ Birth date:_______________

Marital Status: ☐ single ☐ married Race or ethnic background:
☐ separated ☐ divorced _________________________
☐ widowed ☐ significant other _________________________

Home Address:____

City:____________________________________ State:____________ Zip code:___________

Home Phone:___________________________ Cell Phone: ___________________________

Personal e-mail Address: ____

Employment Information

Employer:______________________________ Occupation: ____________________________

Business Address: ____

City:____________________________________ State:____________ Zip code:___________

Business Phone:__________________________ Email Address:__________________________

Website: ____

Nearest relative not living with you:

____ Phone Number _________________________

Who can we contact in case of an emergency?

____ Phone Number _________________________

Who can we thank for referring you? ____

_____ I understand that Dr. Francis does not accept insurance assignment and that I am responsible for all fees incurred under her care. If I wish to have insurance payment, I will submit my receipts for reimbursement myself.

_____ I understand that due to the extended length of visits under the care of Dr.Francis, that it is necessary to cancel my appointment 24 hours in advance or I will be charged full price for the visit at the descretion of Dr.Francis. However,if my appointment is able to be filled by Dr.Francis or me, I will not be charged.

_____ I wish to recieve Dr. Francis' e-newsletter.

____

Please sign your name

PRIVACY POLICIES

Our office is dedicated to providing service with respect to human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in the law. This notice provides an explanation as to how we may collect information about you and what we will do with the "Protected Information" (personal information, financial information and health information). This protected information is received from you, your healthcare provider or any other source in the normal course of health care operations. We are concerned about protecting the privacy of our patients and will use our best efforts to safeguard your protected information.

We gather personal information and health information in several ways:

- Information we receive from you.
- Information we receive from other healthcare providers.
- Information we receive from third party payors.

This information is used for treatment , payment and other healthcare operations.
You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment and healthcare operations.
You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any personal representation you choose to have your protected health information.

Marketing

This office WILL NOT use your health information for marketing communication without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, or mail.

Disclosure

This office may use or disclose your Protected Health Information when required to by law.

Patient Rights

- Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee of $15 and allow 10 working days to process it.
- Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
- You have the right to request that this office place additional restrictions on the disclosure of your Protected Health Information.
- You have the right to request that we amend your Protected Health Information; the request must be in writing.
- You have a right to receive all notices in writing.

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RECEIPT OF NOTICE OF PRIVACY POLICIES

I ____, have read, reviewed, and understand and agree to the statement of the Privacy Policy for healthcare services in this Office.

This practice has attempted to provide each patient with a statement of Privacy Policies.

Patient Signature ____

Date ____

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PATIENT HEALTH HISTORY AND ASSESSMENT

Patient Name: ______________________________ Date: ______________

Purpose of this appointment ______________________________

Have you been seen by other physicians for this problem? ______________________________

If yes, what physicians? ______________________________

Have you ever tried or do you currently use (name technique or practicioner):

- Chiropractic ______________________________
- Massage Therapy ______________________________
- Acupuncture and Oriental Medicine ______________________________
- Naturopathic medicine ______________________________
- Other Wholistic therapies ______________________________
- Psychotherapy ______________________________
- Other ______________________________

How does this problem affect your life? ______________________________

Please list up to 8 major health concerns in order of importance:

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

FAMILY HISTORY

Please state if anyone in your family has or has had any of these diseases:

☐ Cancer	☐ Asthma/Hayfever	☐ Epilepsy	☐ Alzheimers
☐ Diabetes	☐ Anemia	☐ Mental Illness	☐ Alcoholism
☐ High Blood Pressure	☐ Kidney	☐ Heart Disease	☐ Obesity
☐ High Cholesterol	☐ Tuberculosis	☐ Neurological	☐ Osteoporosis
☐ Stroke	☐ Glaucoma	☐ Allergies	

CURRENT MEDICATIONS Please include the dosages if available

	For Doctor Use Only
1. ____________	____________
2. ____________	____________
3. ____________	____________
4. ____________	____________
5. ____________	____________
6. ____________	____________
7. ____________	____________
8. ____________	____________

CURRENT VITAMINS AND SUPPLEMENTS

For Doctor Use Only

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

Please check if you have now or have had in the past, any of these symptoms.

ALLERGIES

Please list any known allergies next to the item

For Doctor Use Only

- ☐ Drugs ____________
- ☐ Chemicals ____________
- ☐ Foods ____________
- ☐ Animals ____________
- ☐ Environmental ____________
- ☐ Other ____________

What happens when you have an attack? ____________

Have you ever had allergy testing? ____________

When? ____________

By Whom? ____________

What kind of test? ____________

RESPIRATORY

- ☐ Frequent colds and flus
- ☐ Swollen glands
- ☐ Sore throats
- ☐ Chest congestion
- ☐ Fevers

- ☐ Sinusitis
- ☐ Itchy eyes
- ☐ Nasal drip
- ☐ Ear aches
- ☐ Nose bleeds frequent
- ☐ Laryngitis

- ☐ Bronchitis
- ☐ Wheezing
- ☐ Asthma
- ☐ Difficulty breathing
- ☐ Cough
  - Color of sputum ____________
  - Thin or thick mucous ____________
- ☐ Pain on breathing
- ☐ Emphysema
- ☐ Positive TB test ever?

- ☐ Shortness of breath
- ☐ Shortness of breath when exercizing
- ☐ Shortness of breath lying down
- ☐ Air hunger
- ☐ Shortness of breath in cold
- ☐ Sigh frequently

SKIN, HAIR, NAILS

For Doctor Use Only

- ☐ Rashes
- ☐ Hives
- ☐ Eczema
- ☐ Dry, flaky skin
- ☐ Itching
- ☐ Swollen skin
- ☐ Psoriasis

- ☐ Acne
- ☐ Oily skin
- ☐ Little pimples on upper arms
- ☐ Cysts

- ☐ Infection of skin
- ☐ Warts
- ☐ Burning of feet
- ☐ Athletes foot
- ☐ Peeling of skin of feet
- ☐ Herpes or Shingles

- ☐ Growths
- ☐ Brown spots or bronzing of skin
- ☐ Discolorations
- ☐ Moles
- ☐ Cuts heal slowly
- ☐ Scars easily
- ☐ Bruise easily

- ☐ Dry Hair
- ☐ Hair growth on face or body (females only)
- ☐ Hair loss
- ☐ Thinning of outside portion of eyebrow
- ☐ Nails weak or brittle
- ☐ White spots in nails

HEAD, EYES, EARS

- ☐ Head injury
- ☐ Headaches
  - ☐ Tension Headaches
  - ☐ Sinus Headaches
- ☐ Migranes

Triggered by what? ______________

Prodrome ______________

How long do they last? ______________

What part of head hurts? ______________

- ☐ Impaired vision
- ☐ Dark circles under eyes
- ☐ Glasses
- ☐ Strong light irritates eyes
- ☐ Tearing of eyes
- ☐ Blurred vision
- ☐ Dryness of eye
- ☐ Eyelids twitch
- ☐ Double vision
- ☐ Yellow in whites of eyes
- ☐ Glaucoma
- ☐ Blue in whites of eyes
- ☐ Eyes blink often
- ☐ Spots of floaters in vision
- ☐ Eyes swollen or puffy
- ☐ Eyes bulging

HEAD, EYES, EARS continued

For Doctor Use Only

- ☐ Hearing loss
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Ear infections
- ☐ Dizziness

- ☐ Jaw pain
- ☐ Dental work
- ☐ Jaw clicks
- ☐ Braces
- ☐ Grinds teeth at night
- ☐ Retainer
- ☐ Wearing down of teeth
- ☐ Bite guard for teeth
- ☐ Tooth pain

- ☐ Sores on Mouth
- ☐ Bleeding gums
- ☐ Gum problems
- ☐ Sore tongue

- ☐ Reduced sense of taste or smell

THROAT

- ☐ Sore throat
- ☐ Laryngitis
- ☐ Lump in throat
- ☐ Difficulty swallowing
- ☐ Lump in neck
- ☐ Gags easily
- ☐ Swollen lymph glands

CIRCULATORY SYSTEM

- ☐ Heart disease
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Chest pain with exertion
- ☐ Heart palpitations
- ☐ Pain in left arm
- ☐ Racing heart
- ☐ High altitude discomfort
- ☐ Chest tightness

- ☐ Strokes
- ☐ Heaviness in arms and legs
- ☐ High Blood pressure
- ☐ Anemia
- ☐ Low Blood pressure
- ☐ Leg cramps at night
- ☐ Swelling in ankles
- ☐ Muscle cramps during exercise
- ☐ High cholesterol
- ☐ Cold hands and feet
- ☐ Hands and feet go to sleep
- ☐ Poor circulation
- ☐ Afternoon yawner

- ☐ Varicose veins
- ☐ Deep leg pain

Take a deep breath...
...in...out...
...Relax...
Now you're ready to continue on...

GASTROINTESTINAL/DIGESTION

For Doctor Use Only

- ☐ Stomach aches
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Belching
- ☐ Halitosis/bad breath
- ☐ Ulcers
- ☐ Loss of taste for meat
- ☐ Gas after eating
- ☐ Burning in stomach, better after eating
- ☐ Coated tongue

- ☐ Gas
- ☐ Bloating
- ☐ Indigestion

- ☐ Number of Bowel Movements per day _____
  - ☐ Mucous in stool
  - ☐ Blood in stool
  - ☐ Undigested food in stool
  - ☐ Black/ tarry stool
  - ☐ Light colored stools
- ☐ Diarrhea
- ☐ Constipation
- ☐ Alternating Constipation/ Diarrhea

- ☐ Hemorrhoids
- ☐ Bitter metallic taste in mouth
- ☐ Greasy foods upset
- ☐ Pain on right side of abdomen
- ☐ Gallbladder stones/attacks
- ☐ Liver problems

- ☐ Parasites
- ☐ Sickness after foreign travel
- ☐ Itchiness in the anus/ rectum

- ☐ What foods do you crave? ____________________
- ☐ What tastes do you crave?
  - ☐ Sweet
  - ☐ Salt
  - ☐ Sour
  - ☐ Pungent
  - ☐ Bitter
- ☐ What foods cause indigestion? ____________________
- ☐ What foods are you allergic to? ____________________

BLOOD SUGAR

- ☐ Eat when nervous
- ☐ Excessive appetite
- ☐ Loss of appetite
- ☐ Hungry between meals
- ☐ Irritable if meals skipped
- ☐ Get Shaky if meal missed
- ☐ Fatigue relieved by eating
- ☐ If meals delayed or missed
  - ☐ Lightheaded
  - ☐ Heart palpitates

BLOOD SUGAR continued

For Doctor Use Only

- ☐ Overeating sweets upsets
- ☐ Fatigue after eating
  - ☐ Immediately
  - ☐ 2 hours after eating
- ☐ Crave sweets/coffee
- ☐ Awaken a few hours after sleeping
- ☐ Difficult to get back to sleep
- ☐ Low Blood Sugar
- ☐ Diabetes

URINARY TRACT

- ☐ Pain on urination
- ☐ Bladder infections
- ☐ Urinary tract infections
- ☐ Kidney stones
- ☐ Burning when urinating
- ☐ Blood in urine

- ☐ Increase frequency of urination
- ☐ Frequency of urination at night
- ☐ Inability to hold urine
- ☐ Difficulty in the stream of urine
- ☐ Prostate Problems

MUSCULOSKELETAL

- ☐ Joint pain or stiffness
- ☐ Arthritis
- ☐ Joint swelling
- ☐ Stiff in morning

- ☐ Broken bones
- ☐ Sprains or strains
- ☐ Bone pain
- ☐ Tendonitis
- ☐ Injuries
- ☐ Bone loss/Osteoporosis

- ☐ Muscle spasms or cramps
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Muscle atrophy

- ☐ Numbness/Tingling
- ☐ Sciatica
- ☐ Referred pain down legs or arms

- ☐ Heel spurs
- ☐ Foot pain
- ☐ Bunions
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle pain
- ☐ Shoulder pain
- ☐ Elbow pain
- ☐ Wrist pain
- ☐ Hand pain

- ☐ Neck pain
- ☐ Low back pain
- ☐ Midback pain
- ☐ Scoliosis
- ☐ Herniated disc
- ☐ Jaw pain

NEUROLIGICAL

- ☐ Seizures
- ☐ Loss of memory
- ☐ Lack of mental alertness
- ☐ Fainting
- ☐ Insomnia
- ☐ Paralysis

NEUROLIGICAL continued

For Doctor Use Only

- ☐ Dizziness
- ☐ Shaking
- ☐ Tremors
- ☐ Motion sickness
- ☐ Numbness or tingling
- ☐ Weakness
- ☐ Neurological disease

EMOTIONAL

- ☐ Nervousness
- ☐ Irritable and restless
- ☐ Anxiety
- ☐ Can't work under pressure
- ☐ Easily stressed
- ☐ Fears/Phobias
- ☐ Insecure
- ☐ Highly emotional
- ☐ Obsessive thoughts
- ☐ Worrier
- ☐ Anger feelings
- ☐ Depression
- ☐ Mood swings
- ☐ Suicidal
- ☐ Claustrophobia
- ☐ Post traumatic stress
- ☐ Addictive personality ____________
- ☐ Substances you feel you may be addicted to: ____________

FEMALE REPRODUCTIVE (females only)

Age menses began ____________

Menstrual flow is ☐ light, ☐ medium or ☐ heavy

# of days of menstrual flow ____________

Length of complete menstrual cycle ____________

☐ Are cycles regular? ______

- ☐ Bleeding between cycles? ____________
- ☐ Clumps/clots in blood flow
- ☐ Painful menses
- ☐ Excessive blood flow
- ☐ Menses scanty or missed
- ☐ PMS
- ☐ Mood swings before menses
- ☐ Depressed feeling before menses
- ☐ Cramps
- ☐ Painful breasts
- ☐ Do you do the Breast self exam?
- ☐ Fibrocysitic breasts
- ☐ Breast Cancer
- ☐ Date of last Mammogram ____________

FEMALE REPRODUCTIVE continued

For Doctor Use Only

- ☐ Abnormal vaginal discharge
- ☐ Date of last PAP smear ______________
- ☐ Abnormal PAP findings
- ☐ Yeast infections
- ☐ Venereal diseases

- ☐ Are you pregnant? ________
- ☐ Method of birth control ______________
- ☐ # of pregnancies ________
- ☐ # of miscarriages/ abortions ________
- ☐ # of live births ________
- ☐ Difficulty in conceiving

- ☐ Are you sexually active? ______________
- ☐ Sexual difficulties
- ☐ Reduced sex drive
- ☐ Increased sex drive
- ☐ Sexual preference (optional) ________

- ☐ Vaginal dryness
- ☐ Menopause
- ☐ Hotflashes
- ☐ Hysterectomy

- ☐ Headaches which seem cyclical
- ☐ Pain during intercourse
- ☐ Endometriosis
- ☐ Fibroids/cysts
- ☐ Hair growth on face and body

MALE REPRODUCTIVE (males only)

- ☐ Prostate problems
- ☐ Hernias

- ☐ Reduced sex drive
- ☐ Excessive sex drive
- ☐ Impotence
- ☐ Premature ejaculation

- ☐ Are you sexually active? ______________
- ☐ Birth control methods ______________
- ☐ Sexual preference (optional) ________

- ☐ Do you Testicular self exam?
- ☐ Testicular masses
- ☐ Testicular pain

- ☐ Venereal disease
- ☐ Discharge or sores on penis
- ☐ Bed wetting

CHILDREN

- ☐ Colic
- ☐ Teething problems
- ☐ Behavioral problems
- ☐ Ear infections
- ☐ Allergies
- ☐ Skin problems
- ☐ Learning disabilities
- ☐ Hyperactivity

GENERAL WEIGHT

For Doctor Use Only

- ☐ Overweight
- ☐ Underweight
- ☐ Weight gain
- ☐ Weight loss
  - ☐ Height ______
  - ☐ Weight ______
- ☐ Where do you tend to gain weight? ______
- ☐ Is it difficult to loose or gain weight? ______
- ☐ Diets you have tried ______
- ☐ Desire to loose or gain weight ______

ENERGY

- ☐ What is you energy level on a scale of 1-10? 10 being the highest. ______
- ☐ Fatigue
- ☐ What time of day does energy drop? ______
- ☐ Insomnia
- ☐ Chronic fatigue

- ☐ Tired after eating
- ☐ More energy in the evening
- ☐ Morning person
- ☐ Night person
- ☐ Reduced initiative/ motivation
- ☐ Desires naps in the middle of the day

- ☐ How many hours of sleep do you get per night? ____
- ☐ Difficult to fall asleep
- ☐ Remembers dreams
- ☐ Nightmares
- ☐ Wakes at night to urinate

- ☐ Wakes at night and can't fall back to sleep
- ☐ Slow starter in the AM
- ☐ Wakes rested
- ☐ Wakes tired

TEMPERATURE

Body temperature is
- ☐ Warm
- ☐ Cold
- ☐ Alternating

Prefers
- ☐ Warm weather
- ☐ Cool weather
- ☐ Warm drinks
- ☐ Cold drinks

- ☐ Cold hands and feet

Aversion or Intolerance to
- ☐ Heat
- ☐ Cold
- ☐ Wind
- ☐ Damp

- ☐ Flush easily
- ☐ Night sweats
- ☐ Sweats easily
- ☐ Hotflashes
- ☐ Slight fever sensation in body
- ☐ Afternoon fevers
- ☐ Abnormal thirst

PAST MEDICAL HISTORY Please List

For Doctor Use Only

List any disease you have had or have now

Immunizations and vaccines

Surgeries and dates

Hospitalizations and dates

Fractures and dates

Accidents and dates

Traumas

LIFESTYLE

For Doctor Use Only

Date of last physical

What type of exercise do you do

How often do you exercise

☐ Do you smoke?

How many packs per day?

How many years?

How many alcoholic drinks do you drink per week?

What recreational drugs do you do?

What hobbies and activities do you do in your free time

Relaxation activities

DIET Please List

For Doctor Use Only

Do you have any special diet or eating restrictions?

____

- ☐ How much coffee/caffeine do you drink daily? _____
- ☐ Do you drink or eat products with nutrasweet in them? ____________
- ☐ How much water do you drink daily ____________
- ☐ Skip meals
- ☐ How many meals do you eat per day
- ☐ Diet frequently

Please fill out the Diet Diary for 3-7 days

PERSONAL (Optional)

- ☐ Are you happy in your job or career?

____

- ☐ What personal goals do you have

____

- ☐ What makes you happy

____

- ☐ What are you grateful for

____

- ☐ Religious/spiritual affiliation ______________________
- ☐ What would you like to change about your life

____

- ☐ What behaviors, habits or thoughts would you like to eliminate ______________________________

TREATMENT INTERESTS

What types of treatments are you interested in trying?

- ☐ Chiropractic
- ☐ Massage
- ☐ Physical therapy
- ☐ Nutrition
- ☐ Herbs
- ☐ Homeopathy
- ☐ Acupuncture
- ☐ Counselling
- ☐ Aromatherapy

What forms of supplements would you prefer?

- ☐ Pills
- ☐ Powders
- ☐ Liquids
- ☐ Teas

Are you willing to make some lifestyle changes to get better?

____

Do you want to take an active part in your healthcare plan?

____

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Supplement And Medication List

Patient Name: ____ Date of Birth: ______________________

Date Started	Date Discontinued	Prescription Medication	Dosage	Doctor
Date Started	**Date Discontinued**	**Supplement**	**Dosage**	**Doctor**

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INSTRUCTIONS FOR COMPLETING A DIET DIARY

DATE

Write in the date of the diary entries.

TIME

Write down, as accurately as possible, the time you eat.

FOODS EATEN

Be sure to include fluids, vitamins, and medications, as well as foods.

Write in the amount of food you eat, like "bowl of Cheerios, with a cup of milk and banana." Among the measurements you may use are fluid ounce, ounce-weight, cup, gram, teaspoon (jam, butter), slice (bread), tablespoon, gallon, liter, or milliliters. If you list something as a "cup" (as in coffee or tea), a "glass" (milk, beer, water, etc.), or a "bottle" or "can," estimate the size of the container. You may also write in just the quantity of the food when the amount is obvious, like "1 hamburger, 2 apples, 3 cookies", or a "serving of McDonald's fries" (but write in whether it was a small or large order).

It is also important that you write in brand names of foods that you eat, as nutrient content will vary by manufacturer.

And finally, write in the contents of foods where appropriate. For example, instead of writing "vegetable soup", write in "soup with carrots, vegetable broth, onion, garlic, etc."

FEELINGS

Write in your emotions, as well as energy and physical stress levels. This is the place to chart your ups and downs during the day. Typical entries might include: "sad, depressed, high energy, low energy, very happy, tired, poor sleep last night, sleepy, runny nose, caught a cold, feeling very irritable, fighting with partner." Do not limit yourself to just these entries. What is important is that you depict a picture of the ebbs and flows of your day. Try to correlate the entries as closely as possible with the times listed to the left on the diet diary form.

BOWEL, URINE HABITS, GAS

List your bowel movements, urine voids and any flatulence. Again, try to correlate these entries with the times. As well, note any changes or abnormalities in bowel movements or urine, such as constipation, diarrhea, excessive quantity of urination, color changes, etc.

MAJOR ACTIVITIES

List your activity level (i.e., whether you are sedentary or active). Typical listings might include, "short walk, worked in the garden, ran three miles, sat in the office all day."

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Please Use Both Sides

Diet Diary

Name: ______________________________

Date	Time	**Foods Eaten:** Include fluids, vitamins and medications	**Feelings:** Emotions, Physical Stress Levels	**Bowel/Urine Habits, Gas**	**Major Activities**

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Please Use Both Sides

Diet Diary *continued*

Name: ______________________

Date	Time	**Foods Eaten:** Include fluids, vitamins and medications	**Feelings:** Emotions, Physical Stress Levels	**Bowel/Urine Habits, Gas**	**Major Activities**

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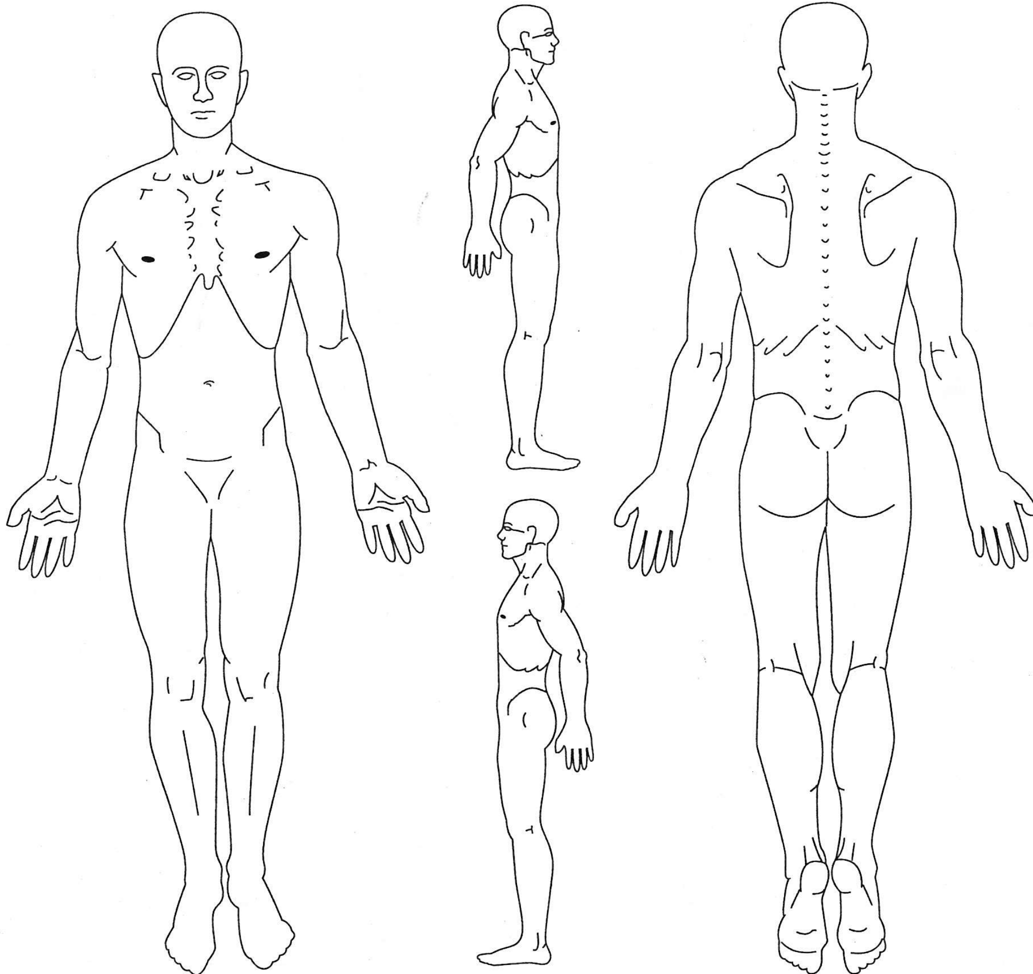
Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull	**S** = Stabbing/Cutting	**B** = Burning
T = Tingling (Pins & Needles)	**N** = Numb	**C** = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now**:

No Pain — Unbearable Pain

Rate your pain at it's **best** in the past week:

No Pain — Unbearable Pain

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain

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