HEARTH & SOUL NATUROPATHIC
Joanna Dove, N.D., L. Ac.

Name : ______________________________ Male/Female: ____ Age : _____ Date of Birth : _________

SS# (Last 4) : _____________ Marital Status : ___________ Email Address : ____________________

Address : ______________________________ City : _______________ State : ____ Zip : _____________

Phone: Home: ( ) - _______________ Work: ( ) - _______________ Cell: ( ) - _________________

Occupation : __________________ Employer : ____________________ OK to Call work? : __________

Who referred you to us? : ____

Name of your M.D. : ____________________________________ Phone: ( ) - _________________

In an emergency notify : ___________________ Relationship : ______________ Phone: ( ) - ___________

Main problem you would like us to help you with : ____
: ____

How long ago did this problem begin : ____

Have you been given a diagnosis for this problem? If so, what? _________________________________

What kinds of treatment(s) have you tried? ____

Have they helped alleviate the condition/problem? ____

Are you currently receiving treatment for your problem ? _____ Describe : _______________________

Please rank (scale of 1 to 10): **Pain** : ___ **Fatigue** : ___ **Well-being** : ___ **Overall Energy** : ___

Prescription Meds:(Please provide list) : ____
: ____

Supplements: (Please provide list) : ____
: ____

PAST MEDICAL HISTORY:

Significant Illnesses : ____

Surgeries : ____

Trauma: (i.e. motor vehicle accidents, falls, etc.) : ____
:

Patient Name___________________________

Sleep:
What hours do you sleep?______ Do you feel rested?____ Do you have trouble falling asleep?____
Do you have trouble staying asleep?____ If so, what time do you awaken at night?______________

Physic:
What is your Weight?_______ What is your Height?___' "_____
Do you Exercise?_________ How Often?____________ Describe:_________________________

PERSONAL MEDICAL HISTORY

*Please check if you have **ever** had any of the following*:

Cancer (type):________	Seizures	Diabetes	Heart Disease
Hepatitis	Rheumatic Fever	Herpes	Stroke
HIV (AIDS)	Weight Problems	Venereal disease	High Blood Pressure
Allergies	Tuberculosis	Addictive disorder	Other Major Illness
Asthma (yes / no)	Thyroid disease	Mental Illness	:
**Use Inhaler*?_____	Mononucleosis		

*Please check if you have experienced any of the following in the **last 12 months**:*

General:

Poor appetite	Localized weakness	Peculiar taste/smell	Sweat easily	Warm @ Night
Fevers	Insomnia	Bleeding	Change in Appetite	Bruising easily
Fatigue	Strong thirst	Weight loss	Night Sweats	
Tremors	Poor balance	Weight gain	Depression	
Cravings	Chills	Joint pain	Emotional Changes	
Headaches	Sudden energy drop	Hearing loss	Day time flashes of Heat	

Skin & Hair:

Rashes	Itching	Change in skin texture	Ulcers	Nails Split
Eczema	Hair loss	Dandruff	Acne	Nail White Marks
Recent moles	Change in hair texture	Hives	Psoriasis	

EENT + Head

Dizziness	Eye Pain	Earaches	Migraine	Recurrent Sore
Ringing in Ears	Glasses	Glaucoma	Eye Strain	Throat
Gum Problems	Sinus Problems	Poor Vision	Grinding of Teeth	Sores on Lips
Night Blindness	Headaches	Cataracts	Floaters	Mouth Ulcers
Facial Pain	Blurred Vision	Concussions	Nose Bleeds	Toothache
Color Blindness	Jaw Click	Poor Hearing	Spots in front of Eyes	
Silver Fillings	Dental Implants	Root Canals		

Respiratory:

Cough	Coughing Blood	Phlegm	Shortness of Breath	Painful Breathing
Wheezing	Bronchitis	Asthma	Easily Winded	

Patient Name :___________________________

Cardiovascular:

Blood Clots	Fainting	Cold hands	Low Blood Pressure
Phlebitis	Dizziness	Swelling of Hands	Shortness of Breath
Chest Pain	Swelling of Feet	Irregular Heartbeat	Difficulty Breathing
Cold Sweats	Cold Feet	High Blood Pressure	Palpitations

Gastrointestinal:

Nausea	Bloating	Blood in Stools	Abdominal Pain
Belching	Constipation	Black Stools	Vomiting
Diarrhea	Hemorrhoids	Bad Breath	Gastric Ulcers
Indigestion	Parasites	Intestinal Gas	How often do you have a BM? #____/day

Genito-Urinary:

Painful Urination	Urgent Urination	Scanty Urination	Frequent Urination
Blood in Urine	Impotence	Unable to Hold	Night Urination: #_____
Genital Sores	Kidney Stones	Discolored Urine	How often do you Urinate #____/day

Gynecology & Pregnancy *(females only):*

Irregular period	Duration of Flow :____	# of Pregnancies	Difficult Births
Clots	Date of last Menses : / /	# of Births	Fertility Problems
Heavy Flow	Age of 1st Menses :_____	# of Miscarriages	Breast Lumps
PMS	Breast Tenderness	# of Abortions	Vaginal Discharge
Birth Control Pill **if yes* #_____ *yrs*	Painful Periods	# of Premature Births	Vaginal Sores

Neuro-Psychological:

Seizures	Areas of Numbness	Concussion	Loss of Balance
Dizziness	Lack of Coordination	Depression	Mood Swings
Stress	Poor Memory	Anxiety	Irritability
Disorientation	Migraines	Easily Angered	

Musculo-Skeletal:

Neck Pain	Back Pain	Joint Pain	Muscle Spasms
Scoliosis	Shoulder Pain	Knee Pain	Muscle Cramping
Hip Pain	Arthritis	Muscle Weakness	Muscle Soreness
Recent Sprains	Weak Joints	Foot/Ankle Pain	Injury/Scar Site(s) :________________

TEST HISTORY

***Blood/Urine Tests and Procedures (Colonoscopy, Biopsy,etc:*

Areas of concern :____ (*please provide a copy of latest test*)

Any other problems you would like us to be aware of :_____________________________________

:____

:____

THANK YOU!

HEART & SOUL NATUROPATHIC INC.
910 E. LYNDALE AVENUE
HELENA, MT 59601

Informed Consent to Health Care

I hereby request and consent to the performance of the following diagnostic techniques and treatment modalities on me (or on the patient named below, for whom I am legally responsible): acupuncture; injection and IV therapy; pulse and tongue evaluation; manual palpation on my body; muscle, orthopedic and neurologic testing; physical modalities such as massage, hydrotherapy; electrical or magnetic stimulation; tuning fork resonance; blood draws or finger sticks for laboratory testing; prescriptions of herbal and homeopathic medicines, supplements, food plans, exercise regimens and lifestyle counseling.

I understand that, while unlikely, possible risks may be: bleeding, bruising, puncture pain or other strong sensations at the location of needle insertion, nerve pain, burns, aggravation of symptoms or appearance of new symptoms. I do not expect the practitioner to be able to anticipate and explain all risks and complications; I wish to rely on his/her judgment based on the facts then known.

I understand that, although these procedures have helped millions of people, no guarantee of cure or improvement in my condition is given or implied.

I have read, or have had read to me, the above and I agree to the procedure(s); by signing below; which covers the entire course of treatment for my present condition and any future conditions for which I seek treatment.

Patient:	Patient's Representative:
(Print):______________________	(Print):______________________
Name	Name & Relationship
:______________________	:______________________
Signature	Signature
Date:____________	Date:____________

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our HIPAA booklet for current practices is available in our waiting room.

"I have been give opportunity to see the HIPAA notice and ask for a copy if I so desire."

:______________________	:______________________
Name	***Signature***