Utah Natural Medicine

242 S 400 East, Suite A; Salt Lake City, UT 84111 • Tel. 801-363-UTAH (8824)

PATIENT INFORMATION

Today's Date:________________ Patient Name: ____

Date of Birth: _____________ Sex: ____ Patient Social Security Number: ____________________

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

Fax: (   )   -   Email:

Can we send general information such as a newsletter to you by email? ____Yes____No

---

Residential Address   Mailing Address (if different)

______________________________   ______________________________

______________________________   ______________________________

Check One: ___Minor___Single ___Married ___Divorced___Widowed___Separated

---

How Did You Hear about the Clinic: ___ Yellow Pages ___Advertisement
___Publication/Book ___Acquaintance ___Internet

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name:______________________ Relationship:______________________

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

---

Complete if Patient is a Minor

Father:___________________   Home Phone: (   )   -   Work Phone: (   )   -

Mother:__________________   Home Phone: (   )   -   Work Phone: (   )   -

---

FINANCIALLY RESPONSIBLE PERSON

Name:________________________   Relationship:_______________________

Employer:_____________________   Occupation:_______________________

Retired?:_________

Utah Natural Medicine

242 S 400 East, Suite A; Salt Lake City, UT 84111 • Tel. 801-363-UTAH (8824)

PATIENT INTAKE

Patient Name: _____________________Date of Birth______________ Today's Date:____________

Please list in order of importance your chief medical complaints or problems:

1.____

2.____

3.____

Current Prescription Medications with dose:

______________________________ ________________________________

______________________________ ________________________________

______________________________ ________________________________

Recent [within past 6 months] Prescription Medications no longer taking:

______________________________ ________________________________

______________________________ ________________________________

______________________________ ________________________________

Current Non-Prescription Substances [Nutritional, herbal, over-the-counter meds.] with dose:

______________________________ ________________________________

______________________________ ________________________________

______________________________ ________________________________

If additional space is needed, please use the end of this form or backside.

Diet: Circle the foods you eat on a regular basis.

Tofu	Luncheon meats	Eggs	Fresh vegetables	Coffee/Tea
Beef	Milk: cow's, soy,	Frozen foods	Dark leafy	Herbal tea
Chicken	rice, almond	Fast foods	greens	Alcohol
Turkey	Cheese	Organic foods	Pasta	Sodas
Fish	Butter	Nuts & Seeds	Rice	Filtered water
Tuna fish	Margarine	Flax/Fish oil	Whole grains	Diet foods/plans
Pork		Fresh fruit	White flour	Artificial
			Refined sugar	sweetener

What describes your diet best? ____Omnivore (animal and plant based) ____ Vegetarian ____ Vegan _____ Low Fat _____ Low Salt ____ Low Carbohydrate

Specific restrictions: ____ Wheat or gluten ___ Dairy ___Soy ___Gluten __other ? ___________

Servings of fruits per day? ____________ Servings of vegetables per day? ____________

Family Medical History: Have any family members had any of the following (please indicate mother, father, brother, aunt, grandfather, etc. and whether on paternal or maternal side):

Diabetes ____________	High blood pressure ____________	Heart disease ____________
Cancer ____________	Bleeding disorder ____________	Epilepsy ____________
Asthma ____________	Thyroid disorder ____________	Gout ____________
Birth defects ____________	Kidney disease ____________	Mental illness ____________
Heart attack ____________	Stroke ____________	Tuberculosis ____________
Emphysema ____________	Alcoholism ____________	Substance abuse ____________
Osteoporosis ____________	Auto-Immune disease___________	Arthritis ____________

Patient Name: Date of Birth:

Your Medical History

Current Weight:______ Max. Weight:_______ Significant weight change in past six months?:_____

Please list major illnesses you have ever had: ____

____

Please list any major surgeries and/or hospitalizations you have ever had, include date:

____

____

Do you have any allergies to Medications? __No __Yes, please list: ________________________

____

Do you have any food allergies? __No __Yes, please list: ________________________________

Do you have Seasonal/Environmental allergies? __No __Yes, please list:

____

Have you ever been diagnosed/treated for psychological or emotional conditions? __No __Yes please specify with dates: ____

____

How would you rate your General Health? Excellent Good Fair Poor

Review of Systems: Please circle any of the following conditions/symptoms you have had in the past year:

- **Skin:**
  - Rashes
  - Itching
  - Burning
  - Warts
  - Hair Loss
  - Skin cancer
  - Dry skin
  - Brittle nails
  - Discoloration
  - Eczema
  - Psoriasis
  - Swellings or bumps
- **Head, Eyes, Ears, Nose, Throat:**
  - Headaches
  - Blurred vision
  - Partial/full loss vision
  - Eye pain
  - Chronic sinusitis
  - Mouth sores
  - Change/loss of taste
  - Thrush
  - Chronic cough
  - Chronic sore throat
- **Cardiovascular:**
  - Angina
  - Heart attack
  - Stroke
  - Valve disease
  - Chest pain
  - Palpitations
  - Fainting
  - Swollen Feet/ankles
  - Varicose veins
- **Pulmonary:**
  - Breathing difficulty
  - Shortness of breath
  - Asthma
  - Coughing up blood
- **Gastrointestinal:**
  - Abdominal pain
  - Chronic constipation
  - Chronic diarrhea
  - Nausea
  - Vomiting
  - Jaundice
  - Dark/bloody stools
  - Abnormal colonoscopy
- **Genitourinary:**
  - Pain/burning urination
  - Blood in urine
  - Frequent urination
  - Urgent need to urinate
  - Kidney stones
  - Flank or kidney pain
  - Sexually transmitted diseases
  - Problems with sexual function
- **Musculoskeletal:**
  - Loss of muscle strength
  - Joint/muscle pain
  - Chronic back pain
  - Sciatica
  - Stiff joints
  - Fingers blue when cold
- **Endocrine:**
  - Heat/cold intolerance
  - Excessive thirst
- **CNS:**
  - Changes in memory
  - Inability to concentrate
  - Loss of coordination
  - Tingling/numbness
  - Sleep disturbance
  - Strong emotion change
  - Mood swings
- **Women:**
  - Hot flashes
  - Vaginal itching/ dryness
  - Unusual pelvic exam
  - Unusual breast exam
  - Do self breast exam
- **Men:**
  - Prostate enlarged or infected
  - Penile Pus/drainage
  - Swelling in groin
  - Nodule in testicle
  - Painful/tender groin
  - Do self testicular exam

For Women Only:

Age onset of menses: ____ History of irregular menses? ___ History of contraceptive use? ___

# of pregnancies ___ # of miscarriage ___ # of children ___

Age onset of menopause ___

Patient Name: Date of Birth:

Chemical Exposure:
Did your mother take any drugs, alcohol, medications, or tobacco during her pregnancy with you? ___ Are you exposed to second hand smoke? ___ Do you use tobacco products? ____ If so, how many cigarettes/day? ______ Past smoker? ____ Yes ____ No If so, dates? ______________ Do you take antacids regularly?___Do you use recreational drugs?___ Any current or past addictions: ____Yes ____No If so, please explain ____________________________ Are you exposed to chemicals/fumes at work/home/hobby?___ Are you sensitive to strong odors? ___ Past exposure to pesticides?____ solvents?____ heavy metals? ____ radioactivity? other known chemicals? ____ If so, please explain: ____ Do you use any of the following? ____natural cleaning products____air fresheners ___organic lawn care ____ scented candles Do you use any of the following? ____ acrylic nails ____ perfumes/cologne ___ artificially scented products Do you have silver fillings/ amalgams?___ How many? ___

Health Maintenance:

Please indicate the date of your last:	Abnormal?
Full general checkup/ physical ________________________	Y / N
Skin/dermatologic checkup__________________________	Y / N
Colonoscopy____	Y / N
DEXA Bone scan______________________________________	Y / N
Vision/ophthalmologic exam__________________________	Y / N
Dental exam____	Y / N
For *men*: PSA and Prostate exam_____________________	Y / N
For *women*: Mammogram _____________________________	Y / N
PAP/Pelvic exam__________________________	Y / N

Safety:
Do you wear a seat belt? ____ Yes _____ No
Do you use a cell phone while driving? ___ Yes __No Do you text while driving? ___Yes ___No
Do you have a smoke detector in your home? ____ Yes ____ No
Do you have a carbon monoxide detector in your home? ____ Yes ____ No
Do you have a fire extinguisher in your home? ____ Yes ___ No
Stress:
Circle your usual level of stress. (1 = lowest) 1 2 3 4 5 6 7 8 9 10 For how long?_____

Health goals: Please circle all that apply.

Have more energy/vitality
Have more endurance
Sleep better
Eat better
Have less pain
Get sick less often
Have more libido/sex drive
Have less dependency on certain medication
Lose weight
Improve posture
Increase activity level
Have stronger bones
Have stronger muscles
Improve flexibility
Reduce stress
Have less brain fog
Balance moods
Gain motivation
Reduce risk of disease and cancer
Have better relationships
Have a healthier life longer

Willingness to change: Please circle: (0 = not willing, 10 = I'll do almost anything!
0 1 2 3 4 5 6 7 8 9 10

Patient Name: Date of Birth:

U T A H N A T U R A L M E D I C I N E DIET AND LIFESTYLE DIARY							
Date	**Time**	**Food & Liquids consumed**	**Any Symptoms (1 to 10) 1 = least 10 = most problematic**	**Feelings: emotion, energy, and stress level**	**Bowel movement, urination, gas, bloating**	**Exercise/ Activity level**	**Sleep – include naps**

Please follow these guidelines as best as possible:

1. **Make 6 copies of this page and fill it out for 4 weekdays and 2 weekend days and bring completed diary to first appointment.**
2. **Be honest! Try not to change your diet and lifestyle habits during this time so we can make a fair assessment of what you're doing currently.**
3. **Include the amount of food you eat and brand name as applicable. Also include ingredients of the food as best you can (e.g. instead of salad, please write 1 ½ cups romaine lettuce, 1 medium tomato, ½ carrot, ½ ounce turkey, 2 Tbsp ranch dressing).**
4. **Include symptoms, if any, that you experience (e.g. headache, pain, joint stiffness, rash, cramping).**
5. **Note when you have a bowel movement and if it was difficult to pass or loose. Note any changes (e.g. color) or abnormalities (e.g. blood).**
6. **Note under the exercise column your activity level (e.g. if you sit in the office all day or gardened for 7 hours, please list this).**
7. **List your naps, if any, and the time you fall asleep and awaken. If you're up in the night, other than briefly to urinate or otherwise, please specify time and reason, if known (e.g. mind racing, stress, hot flashes, restless legs, pain).**

Utah Natural Medicine

242 S 400 East, Suite A; Salt Lake City, UT 84111 • Tel. 801-363-UTAH (8824)

Financial Agreement

Insurance Information

Many insurance companies, flex plans, and health savings accounts will cover visits with us as Out of Network Providers. For all patients with health insurance and those without insurance, we ask that you pay for your visit at the time of service. We can provide a receipt/ "superbill", including necessary codes and information for reimbursement for those who wish to submit for having seen an Out of Network Provider.

Most insurance companies cover the standard lab tests, blood work, or imaging tests that we order, but we cannot guarantee coverage for them. For patients who choose to pay out of pocket, we offer onsite blood draws at reduced rates. Some specialized testing we offer such as food allergy tests or heavy metal testing is typically not covered by insurance.

Medicare and Medicaid are not contracted with Utah Natural Medicine and visits for patients with these insurance plans will NOT be covered.

Rates

Please call our office for specific rates for services we offer. The doctor fee schedule is posted on our website under Patient Information for your reference. We do not accept checks, but do accept Visa and Mastercard. Visits with the doctors include physician consult, physical exam, and a comprehensive treatment plan. New patient visits are usually 90 minutes and return visits are usually 15-45 minutes long. If you would like to book a specific amount of time, please let the receptionist know when you make the appointment.

Cancellation/Re-scheduling and No-Show Policy

We have a less than 2 business day cancellation/rescheduling fee policy for new patients and a less than 1 business day cancellation/re-scheduling fee policy for return patients. Please be aware that the doctors do not overbook or double book their appointments and their time is reserved exclusively for you. In order to accommodate those on the waiting list, we appreciate ample notification when rescheduling and for cancellations. **We will hold your first appointment with a $150 deposit by credit card. This deposit is non-refundable in the event you cancel or reschedule less than 2 business days before your scheduled appointment or do not appear for your appointment. Return patients are charged a fee of $60 for either a less than 1 business day cancellation or not appearing for their appointment.**

FINANCIAL TERMS: I, the undersigned, certify that I have read the above and agree to follow the parameters of this agreement. I understand that I am financially responsible for all charges whether or not they are paid for by insurance and will pay at the time of service. *For Medicare and Medicaid patients only*: I have been informed that the services I am requesting are not covered by Medicaid, Medicare, or Medicare Supplemental insurance. I am aware that I cannot submit these bills to Medicare/Medicaid for reimbursement and I will be financially responsible for these services, including but not limited to: nutritional counseling, treatments for wellness, and any labwork associated with these services.

______________________	______________________	______________________
Patient's Signature	Printed Name of Patient	Date
______________________	______________________	______________________
Guardian/Representative's Signature	Relationship to Patient	Date

Utah Natural Medicine

242 S 400 E, Suite A; Salt Lake City, UT 84111 • Tel. 801-363-UTAH(8824)

INFORMED CONSENT FOR MEDICAL TREATMENT AND PROCEDURES

This document is a binding agreement (the "Agreement") between Utah Natural Medicine ("the Doctor" "UNM") and the individual whose name and signature appears below ("I" "the Patient") or the legal guardian thereof. In consideration of the health care services provided to the Patient by Utah Natural Medicine at the present and at all times in the future, I agree as follows (agreement is indicated by placing Patient initials on the lines following each section and by signing in the space provided at the bottom of the page):

1. **Consent For Treatment:** I, ____________________________, the undersigned, do hereby authorize and give consent to UNM to provide health care, medical treatment and procedures to the Patient which may include but is not limited to the following:

a) General Diagnostic Procedures: Including, but not limited to, venipuncture (phlebotomy), x-rays, ultra sound, blood & urine lab work, pap smears, and physical exams.
b) Prescriptions: Including, but not limited to, pharmaceutical drugs, nutritional supplements, homeopathic remedies, plant, mineral, and animal materials/products for internal or external use. These products may contain diluents, solvents, or carrier mediums such as alcohol in tinctures.
c) Lifestyle & Dietary Counseling: Including, but not limited to diet regimens, exercise plans, nutritional supplements, psychological and emotional counseling, and advice concerning sleep hygiene, stress reduction, and balance of life activities.
d) Office Procedures and Treatments: Including, but not limited to, intramuscular injections (e.g. nutritional substances, vaccines, local anesthetics, homeopathic medicines, dextrose and other prescriptive medicines), intradermals and subcutaneous injections, intravenous therapy, mesotherapy, prolotherapy, scar infiltration, acupuncture, trigger point injections, nerve blocks, joint injections, dressing of wounds, ear cleansing (lavage), cryotherapy, escharotic treatment, and minor surgery.
e) Physical Therapies: Including, but not limited to, massage, neuro-muscular technique, muscle energy stretching, craniosacral therapy, visceral manipulation, cupping & Gua Sha (Chinese techniques involving manual instruments for scraping & suction to increase circulation), as well as manipulation of extremities and spine.
f) Thermal and Electrical Therapies: Including, but not limited to, ultrasound, high & low volt muscle stimulation, interferential, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, infrared and ultraviolet therapies, hydrotherapies (hydrocolators, hyperthermia, contrast baths) and moxabustion.

I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. I acknowledge that UNM has not made any guarantees or promises as to the outcome, the safety or the efficacy of the Treatments. (Initial)_____________

2. **Experimental Nature of Treatment.** I acknowledge and agree that the Treatments may consist in whole or in part of experimental procedures and methods, on which no governmental (including the U.S. Food and Drug Administration [FDA]), scientific or medical authority has issued any guidelines or statements as to the safety or efficacy thereof. I acknowledge that I am choosing an alternative treatment instead of the conventional standard of care. I acknowledge that the safety record of the Treatments may be based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe. I have been informed that the treatments MAY alter, address or decrease my symptoms or complaints, but also may have NO effect. (Initial)_____________

3. **Potential Risks, Side Effects, Complications.** I agree and acknowledge that there are certain unavoidable risks, side effects, and complications to the Treatments including, but not limited to infection, swelling, allergic reaction, increased pain, aggravation of existing conditions, bleeding, scarring, scar or wound enlargement, keloid formation, blistering, burns, itching, discoloration, temporary or permanent alteration in sensation, permanent skin contour irregularities at the site of Treatments, need for additional surgery or treatment, internal or external leaking of fluids,

pneumothorax (air on the outside of lung), paralysis, dizziness, loss of consciousness, serious or debilitating injury, and death. (Initial)______________

4. **Information I Have Provided to UNM.** I hereby verify that I have provided UNM with a complete list of all prescription and non-prescription medications and substances I am currently or have recently been taking; and I agree to update such list whenever a change is made. I have also provided a list of all known allergies including medications, dietary/nutritional substances, and plant and animal substances. I have also provided a list of all medical, surgical and/or psychological conditions I currently have, and any such major conditions I have had in the past. I covenant that all the information I have provided including but not limited to the information required by this Section 4, is true, accurate, complete and up-to-date to the best of my, the Patient's, knowledge. (Initial)_________

5. **Assumption of Risk**. I hereby verify that I have not been legally adjudged as incompetent. Furthermore, I attest that I am fully capable of understanding the risks and benefits of the above mentioned procedures and treatments, that I have carefully read and understand fully the terms of the Agreement, and after having adequate time to ask any questions about this Agreement or the Treatments that I have, I am willing to assume any and all risks associated with the Treatments including without limitation those described in this Agreement. I also acknowledge that no explanation or description of Treatment can ever fully explain every possible risk, side effect or complication that may or could arise from Treatment, but that by initialing and signing this Agreement, I nevertheless, acknowledge my, the Patient's, willingness to assume such risks and that my, the Patient's, consent to Treatment is willing, voluntary and informed. I furthermore acknowledge and understand that IT IS MY RIGHT TO DETERMINE THE EXTENT OF THE TREATMENT AND THAT I MAY DECLINE TREATMENT AT ANY TIME BEFORE OR DURING TREATMENT. (Initial) ________

6. **Miscellaneous.** I agree that this Agreement constitutes the entire agreement between UNM and the Patient regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by the Patient. This Agreement shall be binding on the Patient, their successors, heirs, legal representatives and assigns. This Agreement shall be governed by the laws of the state of Utah without regard to any choice of law principal. (Initial)_______

BY SIGNING THIS AGREEMENT, I INDICATE THAT I HAVE READ, UNDERSTAND AND AGREE TO ITS TERMS, THAT I AM THE PATIENT, GUARANTOR, THE PATIENT'S LEGAL REPRESENTATIVE OR GUARDIAN, OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS.

Patient/Legal Guardian	**Witness**	**Interpreter** (If necessary)
____________________ Signature	____________________ Signature	____________________ Signature
____________________ Print Name	____________________ Print Name/Title of Witness	____________________ Print Name/Title of Interpreter
____________________ Relation, if signed by other than patient	____________________ Date	
____________________ Date		

UTAH NATURAL MEDICINE
989 E. 900 South, Suite A-1; Salt Lake City, UT 84105 • Tel. 801-363-UTAH (8824)

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

Utah Natural Medicine (UNM) respects your privacy and understands that your medical information is personal and sensitive; and we are required by law to keep medical information that identifies you private. This notice explains how we use and disclose your personal information, the choices and rights you have about how your information may be used and disclosed, and our obligations to protect the privacy of your personal health information. When you receive care at UNM we may use your health information for treating you, billing for services, and conducting normal business ("health care operations"). We reserve the right to change our privacy practices and to make such changes apply to all protected health information we maintain.

HOW WE USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Your personal health information may be used in the following ways:

•To the extent that we are required to by law.

•For Treatment: to plan, provide, and coordinate you health care services within UNM and with other health care providers.

•To obtain payment for health care services we have provided to you from insurance companies, yourself, or other third-party. We may contact your insurance company to verify your coverage.

•For health care operations.

•To our business associates to provide the service we have contracted them to do in your behalf. We require all business associates to also safeguard your information in accordance with the law.

•For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases or injuries permitted by law; reporting births and deaths; and reporting reactions to drugs and products under the jurisdiction of the U.S. FDA; and problems with medical devices.

•To protect victims of abuse, neglect, or domestic violence.

•To a health oversight agency charged with overseeing the health care system as authorized by law.

•For law enforcement purposes to law enforcement officials in compliance with and as limited by applicable law.

•To organ procurement organizations for organ, eye, or tissue donation purposes.

•For research purposes when such research has been approved by an institutional review board that has reviewed the research to ensure the privacy of your personal health information, or as otherwise allowed by law.

•To certain government agencies charged with special government functions as limited by applicable law.
•To prevent or lessen a serious threat to any person's or the public's health or safety. In all cases, disclosers will only be made in accordance with applicable law.
•For workman's compensation.
•Unless you object, we may contact you to provide appointment reminders or information about treatment, health benefits or services that may interest you.
•We may also use your information to notify a family member, close friend, or another person responsible for your care, provided that you have the opportunity to object. If you are unable to object, we may disclose this information as necessary if we determine it is in your best interest base upon our professional judgment.

YOUR INDIVIDUAL RIGHTS

You have the following rights with regard to your personal health information:
•Upon request, to access and obtain a copy of your health information maintained by UNM (a processing fee may apply).
•Request, in writing, restrictions on how we use and share your health information. We will consider all requests of restrictions carefully but are NOT required to agree to any restrictions.
•Request that we use a specific contact information to communicate with you.
•Request, in writing, an accounting of certain disclosures of your health information made by UNM. The accounting may include the date, a brief description of the information disclosed, and the person or entity that received the disclosure, and a brief statement of the reason for the disclosure. Your request must state the period of time desired for the accounting, which must be within six years prior to your request and exclude dates prior to April 14, 2003.
•If you feel your rights have been violated, you may file a formal complaint with UNM and/or a written complaint with the Office of Civil Rights of the U.S. Dept. of Health and Human Services. We will investigate all complaints and will not penalize or treat you any differently for filing a complaint.

I hereby acknowledge that I have read and understand Utah Natural Medicine's "Notice of Privacy Practices" and have received and/or been offered a signed copy of them.

Name of Patient or Guardian: ____
(Printed)

Signature of above Person: _________________________________ ____________
(Date)

Witness: ______________________________ ____________
(Signature) (Date)

UTAH NATURAL MEDICINE

242 S. 400 East, Suite A; Salt Lake City, UT 84111 • Tel. 801-363-UTAH (8824)

PATIENT AUTHORIZATION OF
MEDICAL RECORDS REQUISITION

Name of Patient: ___________________________ Date of Authorization/Request: ____/___/_______

Date of Birth: ___/___/______ Patient Social Security #: _____-____-__________

Phone #: (____)_____-___________ Patient Address: ____________________________

____

I, ______________________, authorize Utah Natural Medicine to receive patient's medical records from:

(Medical Facility) ______________________________

Dr. _________________________________

Address:_____________________________

____

Phone: (   ) _______-________________

Fax: (   ) _______-__________________

Please release records for the period beginning ____/____/_______ to ____/____/_______
Please Release/Disclose the following information: (Circle to indicate selection)

History & Physical	Treatment Plans
Educational Reports	Consultation Reports
Radiology and Lab Reports	Discharge Summary
Outpatient Clinical Records	ALL Available Records

Other: (please list):___________________________________

Please Fax/Send my records to Utah Natural Medicine at:

Address: 242 S. 400 East, Suite A
Salt Lake City, UT 84111

Fax: (801) 363-8821

I understand that I may revoke this authorization at any time by sending written notice to records holding facility listed above.

________________________________ ________________________________
Patient's Name (Print) Patient's Signature