**SANTA CRUZ NATUROPATHIC MEDICAL CENTER**
**BIOGRAPHICAL INFORMATION FORM - ADULT**

# *Santa Cruz Naturopathic Medical Center*

*Dr. Tonya Fleck*

Hello and welcome to the Santa Cruz Naturopathic Medical Center!
You can read more about us and our Center at **www.scnmc.com**.

Attached are forms to complete before your appointment. Please bring these completed forms with you at the time of your appointment, and also bring any medications, herbs, and/or supplements you are currently taking. **Please also bring copies of any recent laboratory test results**. If you have had labs but do not have the results, we will have you sign a release of record and we can obtain those for you.

Your new patient exam is two hours, and includes an extensive intake and treatment plan. The cost is $365. **Follow-up appointments are charged according to the time spent with the doctor, and phone appointments are available at the same rates.**

You may also receive supplements on your first visit (i.e. vitamins, herbs, homeopathics, etc.) for an additional charge. **The Center does not accept returns or give refunds on any supplements or medications provided.** Payment is due in full at the time of the visit.

We look forward to seeing you at your appointment and partnering with you in your health.

**Please be sure to read our Cancellation policy on the following page.**

Appointment Date:_____Time:_____

Our clinic is located at 736 Chestnut Street in Santa Cruz, CA 95060. If you need further directions, or if you have any questions, please don't hesitate to call us at 831-477-1377.

## Cancellation Policy

SCNMC works diligently to provide suitable and convenient appointment times for all of our patients to assist them in receiving excellent care. Patients are encouraged to schedule their appointments well ahead of time, with the understanding that last minute appointments are very difficult for us to accommodate. We request that patients please try to commit to the appointment times they schedule, and we understand that sometimes things come up. The following is our cancellation policy:

If you need to cancel or reschedule, we require **a 48 hour notice** (2 business days) for a new patient exam. For example, if your appointment is on a Thursday, you would need to cancel by Tuesday morning at the latest. You will be charged a **$150 cancellation fee** for a missed appointment or canceling with less than 48 hour notice.

For all other appointments we require a **24 hour notice** (one business day) for both canceling and rescheduling. The cancellation fee for less than a 24 hours notice is **the cost of the scheduled appointment time.**

Patients who arrive late may or may not be seen depending on the schedule; this is at the discretion of the doctor. Patients who are scheduled to receive an IV will be responsible for the cost of their IV if the appointment is missed.

SCNMC makes reminder calls 3 business days before your new patient intake and 2 days before your follow-up appointment, however, each patient is responsible for keeping their scheduled appointment. Waiting until the reminder call is unadvisable as that call sometimes falls after the cancellation window has closed.

Should you have any questions regarding these policies, please contact us at 831-477-1377.

## Insurance

**Naturopathic Clinic care is covered under many policies by medical insurance providers.** Please call the number on the back of your insurance card and ask if your specific policy covers **Naturopathic** care. If you have insurance coverage for naturopathic care, we will be happy to provide a superbill to you so you can submit for reimbursement. We require payment in full at the time of service. We accept Visa, MasterCard, American Express, check or cash.

**Here's how to increase your chances of getting coverage for alternative treatments:**

### 1) Check Your Policy

If you're seeking coverage for complementary and alternative medicine, start by carefully studying your health insurance plan. Since many plans have considerable limits to their coverage, you should also call your insurance company and ask the following questions before you begin treatment:

- Does my plan only cover services determined to be medically necessary?
- Does complementary care need to be pre-authorized or pre-approved?
- Does my plan limit the conditions it will cover?
- Will I need to see a practitioner in your network?
- Is coverage available for care provided by out-of-network practitioners?
- Is there a co-payment?

### 2) Know Your Visit Limits

Many insurance companies restrict the number of visits that will be covered within a certain period of time. Because alternative therapies often require a series of sessions in order to complete treatment, it's important to be aware of your visit limits prior to pursuing complementary care.

### 3) Make a Case for Your Coverage

If your insurance company is unwilling to cover the complementary care you're seeking, consider asking your primary-care physician to give you a prescription (including your diagnosis and the suggested frequency of treatment). You can also attempt to convince your insurer that your desired complementary care is more cost-effective than such standard medical treatments as surgery and medication.

If you have any questions please feel free to contact us.

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**Date: _____**

## Personal History:

Name: _____ Age: _____ Gender: __ M __ F

Address: _____
Street and Number City State Zip

Weight: _____ Height: _____ Race: _____

Date of Birth: _____ Highest Level of Education: _____

Cell Phone: _____ Home Phone: _____ Business: _____

E-Mail:_____

Emergency Contact _____ Phone _____

*As patient at SCNMC, you will receive our monthly email newsletter informing you of upcoming specials and events. You may choose not to receive this email newsletter by checking here _____.*

Insurance Carrier: _____

Present Marital Status: S___ M ___ D___ W___ Domestic Partnership___Other:_____

If married, years married to present spouse? _____

Current Occupation: _____ How long? _____ Hrs/Wk _____

On a scale of 1 to 10, how much do you enjoy your job? _____

Do you have any known allergies to drugs or medications? _____

**List Yes (Y), No (N), or Past (P) regarding the 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 / Past: _____

Soda: Y N P Ounces per day if Yes / Past: _____

Alcohol: Y N P How often & how much if Yes / Past: _____

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

**Exercise**

How often do you exercise? _____

What type of exercise?_____ For How Long? _____

Hobbies: _____

Who referred you? _____

What do you expect from this visit? _____

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**Health Concerns:**

List in order of importance your primary health concerns: How long have these problems persisted?

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

Under what conditions do your problems usually get worse? Under what conditions do they improve?

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

**Medical History**

Your primary physician:

Physician's Name: _____

Address: _____ Phone # _____

Please list any other conventional specialists that you're currently seeing: _____

_____

List any major illnesses, hospitalizations and/or operations you have had (include year).

_____

_____

_____

Have you had any recent vaccinations? _____ If so, did you have any reactions? _____

When was your most recent physical exam? _____

Have you ever had a DEXA (bone) scan? If so, when? _____

Have you ever had a colonoscopy? If so, when? _____

When was your most recent blood work and by what doctor? _____

Do you currently see other healthcare practitioners such as an Acupuncturist, Nutritionist, Chiropractor, etc? _____

If so, whom? _____

**For Women ------**

Date of last Pap Smear _____

Have you ever had an abnormal Pap? _____ If so, when? _____

When was the first day of your last menses? _____

Are you menstrual cycles regular? _____

Do you experience PMS symptoms? _____ If so, please list them. _____

Date of last your last Mammogram_____

How many Mammograms have you had? _____

Have you ever had a Breast Thermography? _____ If so, where and when? _____

Any family history of breast cancer? _____ If yes, whom? _____

**For Men ----**

Have you ever had a prostate exam? If so, when? _____

**Sleep**

How many hours per night? _____ If you wake, how often & why? _____

Do you have a difficult time falling or staying asleep? _____

Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P

**Diet**

Have you gained or lost over ten pounds in the past year? Yes ____ No ____ Gained ____ Lost ____

If yes, was the gain/loss on purpose? Yes ____ No _____

Do you have any known food allergies/sensitivities to foods? _____

**Medications**

What medications are you currently taking?

| Medications | Dosage | For What | How Long |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Who prescribes your medications? _____

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List any supplements & dosages that you are currently taking:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

*(*Please bring the supplements you are **currently** taking to your first appointment.)*

**Counseling History**

Are you currently receiving counseling? Yes ____ No ____

If yes, please briefly descried:_____

Have you received counseling in the past? Yes ____ No ____

If yes, please briefly describe: _____

Please list what are the major stresses in your life:

_____

**Family History**

| | **Father** | **Mother** | **Siblings** | **Grandparents** | **Spouse** | **Children** |
|---|---|---|---|---|---|---|
| **Age If Living:** | _____ | _____ | _____ | _____ | _____ | _____ |
| **Age when Died:** | _____ | _____ | _____ | _____ | _____ | _____ |
| **Cause of Death** | _____ | _____ | _____ | _____ | _____ | _____ |

| | **Father** | **Mother** | **Siblings** | **Grandparents** | **Spouse** | **Children** |
|---|---|---|---|---|---|---|
| **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** |
| **Auto-Immune Dz:** | **Y N** | **Y N** | **Y N** | **Y N** | **Y N** | **Y N** |
| **Diabetes:** | **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** |
| **Cancer** | **Y N** | **Y N** | **Y N** | **Y N** | **Y N** | **Y N** |

**Thoughts and Behaviors**

Please check how often the following thoughts occur to you:

| | | | | |
|---|---|---|---|---|
| 1) Life is hopeless. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 2) I am lonely. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 3) No one cares about me. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 4) I am a failure. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 5) People don't like me. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 6) I want to die. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 7) I want to hurt someone. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 8) I am so stupid. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 9) I am going crazy. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 10) I can't concentrate. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 11) I am so depressed. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 12) God is disappointed in me. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 13) I can't be forgiven. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 14) Why am I so different? | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 15) I can't do anything right. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 16) People hear my thoughts. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 17) I have no emotions. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 18) I hear voices in my head. | Never____ | Rarely____ | Sometimes____ | Frequently____ |
| 19) I am out of control. | Never____ | Rarely____ | Sometimes____ | Frequently____ |

## Symptoms

Circle the behaviors and symptoms that occur to you more often than you would like them to:

| | | | | |
|---|---|---|---|---|
| aggression | fatigue | sexual difficulties | alcohol dependence | hallucinations |
| sick often | anger | antisocial behavior | anxiety | avoiding people |
| chest pain | depression | disorientation | distractibility | worrying |
| drug dependence | eating disorder | mood elevated | heart palpitations | high blood pressure |
| hopelessness | impulsivity | irritability | judgment errors | loneliness |
| memory impairment | mood shifts | panic attacks | phobias/fears | recurring thoughts |
| sleeping problems | dizziness | suicidal thoughts | thoughts disorganized | trembling |

Other (specify): _____

_____

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**Informed Consent Form**

I, (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed Naturopathic Doctor.

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act, which may include but are not limited to nutritional counseling, western herbs, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections, and IV therapy.

I have had the opportunity to discuss with the Naturopathic Doctor the nature and purpose of Naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including Naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a Naturopathic Doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that you follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily 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 diagnosis and treatment.

**PATIENT NAME, (printed)**_____

I agree to the terms of the cancellation policy. I agree to provide a 24 hour notice of cancellation for all follow-up appointments or pay the cost of the visit. $150 will be charged for new patient exams if cancellations are made with less than a 48-hour notice.

**PATIENT SIGNATURE** _____ **Date:** _____
**(or Patient Representative)**
**Indicate relationship if signing on behalf of patient** _____