Health History

Name _____ Date of Birth: _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Email _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Reason for office visit | Date began

_____ _____

_____ _____

List current health problems for which you are being treated: _____

_____

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health:

☐ Diet modification ☐ Fasting ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs

☐ Other _____

Do you experience any of these general symptoms on a regular basis?

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation	☐ Chronic pain/inflammation
☐ Depression	☐ Panic attacks	☐ Nausea	☐ Fecal incontinence	☐ Bleeding
☐ Disinterest in sex	☐ Headaches	☐ Vomiting	☐ Urinary incontinence	☐ Discharge
☐ Disinterest in eating	☐ Dizziness	☐ Diarrhea	☐ Low grade fever	☐ Itching/rash

Current medications (prescription or over-the-counter): _____

_____

_____

Allergies: (Medication/Drug; Food; Environmental)

_____

_____

Outcome: _____

_____

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

Year	Surgery, illness, or injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence or finances): _____

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Healthy weight Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., firefighter, police officer, etc.)?

_____

What are your current health goals: _____

_____

Health History

Medical History
- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Sleep Concerns
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other _____

Medical (Men)
- ☐ Benign prostatic hyperplasia
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other _____

_____

Medical (Women)
- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other _____

Date of last GYN exam _____

Mammogram ☐ + ☐ –

PAP ☐ + ☐ –

Form of birth control _____

# of children _____

# of pregnancies _____

☐ C-section _____

Age of first period _____

Date of last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _

- ☐ Surgical menopause
- ☐ Menopause

Family Health History (Parents and Siblings)
- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction Eating
- ☐ disorder Genetic
- ☐ disorder Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Neurological disorders
- ☐ (Parkinson's, paralysis)
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide
- ☐
- ☐
- ☐

Other _____

_____

Health Habits
- ☐ Tobacco:

Cigarettes: # /day _____

Cigars: # /day _____
- ☐ Alcohol:

Wine: # glasses/d or wk _____

Liquor: # ounces/d or wk _____

Beer: # glasses/d or wk _____
- ☐ Caffeine:

Coffee: # 6 oz cups/d _____

Tea: # 6 oz cups/d _____

Soda w/caffeine: # cans/d _____

Other sources _____
- ☐ Water: # glasses/d _____

Exercise
- ☐ 5-7 days/wk
- ☐ 3-4 days/wk
- ☐ 1-2 days/wkk
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk: #days/wk _____
- ☐ Run, jog, other aerobic -#days/wk _____
- ☐ Weight lift: #days/wk _____
- ☐ Stretch: #days/wk _____

Other _____

Nutrition & Diet
- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ wheat ☐ eggs

☐ soy ☐ corn ☐ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits
- ☐ Skip meals (which ones) _____
- ☐ One meal/day
- ☐ Two meals/day
- ☐ Three meals/day
- ☐ Graze (small frequent meals)
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not

Current Supplements

Multivitamin/mineral
- ☐ Vitamin C
- ☐
- Vitamin E
- ☐ EPA/DHA
- ☐ Evening primrose/GLA
- ☐ Calcium, source _____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals (describe) _____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol)
- ☐ Herbs
- ☐ Homeopathy
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals

Other _____

Well-Natured PLLC

INFORMED CONSENT FOR TREATMENT

I, _____ voluntarily consent to outpatient care at Well-Natured PLLC, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), and administration of medications prescribed by the doctor.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Well-Natured PLLC.

I understand that not ALL of the treatment suggestions provided are accepted and/or regulated by the United States FDA and therefore should not be taken as such. The following treatment modalities may be utilized in my care:

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Nutritional counseling: therapeutic nutrition & nutritional supplementation.
Botanical medicine: botanical substances may be recommended as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.
Physical medicine: including therapeutic exercise recommendations and at-home hydrotherapy treatments as indicated.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
Pharmaceuticals: prescription medications when medically necessary/appropriate and as allowable per the Naturopathic physician's formulary as outlined by the Vermont Office of Professional Regulation.

Acupuncture/Moxibustion: performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological function

I recognize the potential risks of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, interaction between natural herbs and nutritional supplements and pharmaceutical medications, inconvenience of lifestyle changes.

Acupuncture risks: These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment.

Notice to Pregnant Women: All female patients must alert their physicians at Well-Natured PLLC if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above services/procedures, realizing that no guarantees have been given to me by Dr. Melanie Meyer or Dr. Lauren Mandych or any of their agents regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Your signature below acknowledges that you have read and understand the above statements.

Date: _____ Patient or Legal Guardian Signature: _____

Printed Name: _____

Patient Name: _____

Well-Natured PLLC

NOTICE OF PRIVACY PRACTICE

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have a right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the address listed below.

   Note: We must respond to this request within 30 days.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, you request must be made in writing and submitted to Well-Natured PLLC. You must provide us with a reason that supports your request for amendment.

   Note: We must respond within 60 days. The Privacy Officer or the patient's doctor will usually do this. If the doctor believes the information is complete and accurate, the doctor can refuse to make any changes.

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact Dr. Melanie Meyer. This notice contains a summary of our privacy practices. If you would like to receive the detailed version of our policies, please feel free to request this.

6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact your physician or the office manager at Well-Natured. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Well-Natured PLLC

PRIVACY PRACTICES ACKNOWLEDGEMENT & ASSIGNMENT OF INSURANCE BENEFITS AUTHORIZATION

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to view it.

Name: _____ Birthdate:_____

Signature: _____ Date: _____
(Patient/Legal Guardian/Legal Representative)

AUTHORIZATION FOR ASSIGNMENT OF INSURANCE BENEFITS

I request that payment of authorized medical benefits is made on my behalf directly to Well-Natured PLLC or the provider of all service(s) furnished to me. I authorize Well-Natured PLLC to release any medical information directly to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to determine plan benefits in accordance with HIPAA release of protected health information standards. Further, I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to Well-Natured PLLC or the provider of service(s). I hereby authorize the photocopies of this form to be valid as the original.

Name: _____ Birthdate:_____

Signature: _____ Date: _____
(Patient/Legal Guardian/Legal Representative)

TELEMEDICINE INFORMED CONSENT

Patient Name: _____

Date of Birth: _____

LOCATION OF PATIENT (State): _____

Practitioner/Practice:
Melanie Meyer, ND MS or Lauren Mandych, ND at Well-Natured PLLC

Physical Office Location: 250 Main Street Suite 301 Montpelier VT 05602

I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to the provider(s) of Well-Natured, PLLC providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, my insurance carrier will have access to my medical records for quality review/audit.

I understand that I will be responsible for any copayments or co-insurances that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Well-Natured, PLLC at 802-522-4597.

For as long as this consent is in force, and has not been revoked, the providers of Well-Natured PLLC may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign on behalf of patient):

Signature: _____

Date: _____

If authorized signer, relationship to patient:

Please keep a copy of this consent form.

Well-Natured PLLC

Insurance and Financial Policy

Office Visits and Reimbursement Guidelines

1. **Accepted Forms of Payment:**
   Cash, personal checks, and most major credit cards are accepted at our office.
2. **Insurance Policy:**
   Our office accepts some insurance plans and VT Medicaid. Patients are responsible for knowing their health care plan. If our office has verified your coverage, we will gladly submit claims for you. If you would like us to do this, we require that you sign an Assignment of Benefits form that authorizes the insurance company to pay directly to this office.

   You will be required to pay your deductible and/or co-payment at the time of service. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Cancellation Fees:**
   Kindly alert us within 24 hours of your scheduled appointment if you must cancel the visit. Missed appointments will result in a fee of $75.00.

Non-Covered Services

Occasionally we may recommend or offer a service, treatment, or diagnostic option that may not be covered by insurance. If you choose to utilize these non-covered services, you are responsible for payment at the time the service is rendered. You will be informed in advance of the fee schedule for each non-covered service or option.

WE DO NOT BILL INSURANCE FOR THE FOLLOWING:

- Nutritional and botanical supplements
- Acupuncture treatments
- Hydrotherapy
- Massage therapy
- Constitutional homeopathic intake and remedy prescription
- Some functional or specialty laboratory services

By my signature below, I acknowledge that I have read and understand the above policies.

Signature: _____

Printed Name: _____

Date: _____