



Natural Healthcare Center

Integrated Health & Wellness Programs

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www.Naturalhealthcarecenter.com

New Patient Questionnaire

General Information

Please print clearly

Today's Date: _____

Name (First) _____ (Last) _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Gender Male Female

Marital Status Single Married Widowed Divorced Separated Spouse Name _____

Language preference: English Spanish Other: _____

Race Caucasian African American Hispanic Asian Middle-Eastern Pacific Islander Native American

Ethnicity (Italian, Polish, etc.): _____ Date of Birth: _____

Home Phone# _____ Work/Cell Phone# (please circle one) _____

Email Address: _____ Contact Preference (email, cell etc.) _____

How were you referred to our office? _____

Your Occupation _____ Employer _____

Address _____

City _____ State _____ Zip _____

Person who holds primary health insurance, if other than yourself:

Name _____ Date of Birth _____

Person who holds secondary health insurance, if other than yourself:

Name _____ Date of Birth _____

Insurance Carrier _____

Primary Care Provider: Do you have a primary care physician? Yes No

Doctor's name: _____ Office Address: _____

Phone #: _____ Fax #: _____

Do we have your permission to contact your PCP? Yes No

Physical Medicine

DO YOU HAVE A PACEMAKER: Yes No

PLEASE FILL OUT EACH SECTION IN ITS ENTIRETY. IF IT DOES NOT APPLY, WRITE NONE

Problem List Please list your symptoms below in order of importance and give date symptoms began.

_____ Date _____

_____ Date _____

_____ Date _____

Name: _____

Date: _____

Is your pain or discomfort:

- Sharp Burning Aching Cramping
- Dull Fixed Moving Tight

What helps the pain?

- Cold Heat Exercise Rest
- None of the Above

What makes the pain worse?

- Cold Heat Exercise Pressure Humidity Rest

Medications

<u>Date Started</u>	<u>Medication</u>	<u>Dosage</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medication

<u>Medicine</u>	<u>Reaction</u>
_____	_____
_____	_____

Surgeries

<u>Date</u>	<u>Surgery</u>
_____	_____
_____	_____

Hospitalization

<u>Date</u>	<u>Reason</u>
_____	_____
_____	_____

Family History

<u>Relationship</u>	<u>Medical History</u>
_____	_____
_____	_____

Height: _____ft. _____ inches Weight: _____lbs.

Have you ever had the same or similar symptoms? ____ Yes ____ No. If yes, when? _____

Have you had treatment by another doctor for these symptoms? ____ Yes ____ No

If yes, name of doctor _____.

Do you smoke? Yes No If no, have you quit within the past 24 months (2 years)? Yes No

If you are 65 years of age or older, have you received a Pneumonia Vaccination? Yes No If yes, when? _____

If you are between the ages of 50-75, have you received appropriate screening for Colorectal Cancer, such as colonoscopy, fecal blood testing or sigmoidoscopy? Yes No If yes, when? _____

Females: If you are between the ages of 40-69, have you received a mammogram to screen for Breast Cancer?

Yes No If yes, when? _____

Have you noticed any recent changes in bowel or bladder habits? ____ Yes ____ No. If yes, please describe

Do you do aerobic exercise? ____ Yes ____ No Times/Week _____ Minutes/Session _____

Do you do strengthening exercise? ____ Yes ____ No Times/Week _____ Minutes/Session _____

HIPAA Notice of Privacy Practices

HIPAA (the Health Insurance Portability & Accountability Act of 1996) was passed to provide rules for how medical care providers might use your Protected Health Information (PHI). It also provides you with certain rights pertaining to that information. As a provider of healthcare services, Natural Healthcare Center (NHC) fully complies with all HIPAA regulations. These regulations require that we provide you with the **HIPAA Notice of Privacy Practices**, which is reproduced below.

Please sign below to acknowledge receipt of this information, and return this form to us at the time of your first visit. Thank you.

I have received the HIPAA Notice of Privacy Practices information from Natural Healthcare Center.

Print Name: _____

Signature: _____ Date: _____

This notice describes how medical information about you may be used and disclosed as per HIPAA regulations, and describes your rights regarding access to this information. Please review it carefully.

This Notice of Privacy Practices describes how Natural Healthcare Center may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 of HIPAA.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

1. **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
2. **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

3. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**
4. **You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically.)**
5. **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
6. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections please ask to speak with our HIPAA Compliance Officer in person or by phone at 732-222-2219.

I have received the HIPAA Notice of Privacy Practices information from Natural Healthcare Center.

Print Name: _____

Signature: _____ Date: _____