New Patient Registration

Full Legal Name: ____

Address: ____

City: ________________________________ State: __________ Zip Code: ______________

Home Phone: (   ) ___________________ Cell Phone: (   ) ___________________

Email: ____ Gender: M F

Date of Birth: ____________________________ SSN: _______________________________

Whom may I thank for referring you? ____

Is this visit **injury related**? Yes No

Injury Date: __________________________

If yes, is the injury work related? Yes No

Employer: ____________________________

If yes, is the injury from a motor vehicle accident? Yes No

State: ______________

Do you currently have a **Primary Care Provider**? Yes No

Name: __________________________________ Phone: ________________________________

Are you looking to establish a relationship with a PCP today? Yes No

By signing I agree that all the information provided above is complete and correct.

____

Signature Date

Health History

Name: ____ Date: ________________________

Main concern or reason(s) for seeing the doctor:

____

____

____

Personal

Major Illnesses (please give types and dates):

____

____

____

Previous hospitalizations and/or surgeries:

____

____

Allergies:

____

Social

Current Smoker? NO YES Past Smoker? NO YES Quit date: ________________

If "yes" for either, how often and for how long?_______________________________________

Alcohol Consumption? YES NO

If "yes", how often and how much? ____

Occupation: ____

Family

Please list any major illnesses for the following BLOOD relatives:

Father: ____

Mother: ____

Siblings: ____

Other: ____

Wellbeing

Name: ____ Date: _______________________

What are your expectations of your health care provider?

____

____

What type of treatment do you wish to receive?

____

____

What therapies have you tried in the past and how did you feel about the results?

____

____

Current Medications and Supplements

Please list all prescription and over the counter medications, vitamins and supplements.

Medication/Supplement Name	Dosage and Frequency

REVIEW OF SYSTEMS

Y: A symptom you are ***currently*** experiencing
N: A symptom you have ***never*** experienced
P: A symptom you have experienced in the ***past***

GENERAL	**Y**	**N**	**P**	**Explain**:
Fever/chills				
Fatigue				
Change in weight				
SKIN	**Y**	**N**	**P**	**Explain:**
Rashes/itching				
Acne				
HEENT	**Y**	**N**	**P**	**Explain:**
Headaches				
Vertigo				
Impaired vision/hearing				
Ringing in ears				
Sinus congestion/pain				
RESPIRATORY	**Y**	**N**	**P**	**Explain:**
Cough				
Phlegm/Sputum				
Shortness of breath				
Wheezing				
CARDIOVASCULAR	**Y**	**N**	**P**	**Explain:**
Chest pain				
Palpitations				
Edema/swelling				
Murmurs				
GASTROINTESTINAL	**Y**	**N**	**P**	**Explain:**
Heartburn				
Nausea/vomiting				
Abdominal pain				
Gas/bloating				
Diarrhea/ Constipation				
MUSCULOSKELETAL	**Y**	**N**	**P**	**Explain:**
Aches/Pains				
Numbness				
Weakness				
Muscle spasms/cramps				

NEUROLOGICAL	Y	N	P	Explain:
Memory loss				
Tremors/Involuntary movements				
Seizures				
ENDOCRINE	**Y**	**N**	**P**	**Explain:**
Excessive thirst				
Excessive sweating				
Blood sugar dysregulation				
MENTAL/EMOTIONAL	**Y**	**N**	**P**	**Explain:**
Depression				
Anxiety				
Stress/tension				
URINARY	**Y**	**N**	**P**	**Explain:**
Pain with urination				
Incontinence				
Blood in urine				
MALE REPRODUCTIVE	**Y**	**N**	**P**	**Explain:**
Testicular swelling				
Sexual/erectile dysfunction				
Weak urine stream				
FEMALE REPRODUCTIVE	**Y**	**N**	**P**	**Explain:**
Breast tenderness/lumps				
Vaginal irritation/discharge				
Pain with intercourse				
Sexual dysfunction				
Abnormal menses				
Pain with menses				

-Date of last mammogram: _______________ Results: _______________________________________

-Date of last Pap/Annual Women's Health exam: ____

Results: ____

-Pregnancy(s): __________ Dates: ____

Holistic Health Clinic

Patient Responsibility and Policy Agreement

We ask that every patient read and sign their agreement to the following. You can request a copy for your records.

- Please be prepared to provide insurance card (if applicable) at the time of each visit.
- A **minimum of 24 hours notice of appointment cancellations is required** except in legitimate emergencies. Cancellations made less than 24 hours from the appointment may be charged a $50 fee for the first absence and the full amount of the visit for all missed appointments thereafter.
- Each patient is **responsible for knowing the terms and coverage of your insurance plan**. If you have insurance that the practitioner "accepts," it does not guarantee payment will be made from your insurance company. You will then be personally responsible for the bill. *Please note; Medicare and any supplemental plans will not cover any acupuncture or naturopathic care unless you also have a secondary plan.*
- Patients are seen by appointment only. In the case of an urgent medical need patients can call the office to be scheduled an emergency visit. In the case of an after-hours, urgent medical need, established patients can call 972-571-6275.
- Payments for dispensary items and/or copays are due at the time of service; cash, check, credit or debit cards are accepted.
- Though advice or recommendations may be declined, neither Dr. Michelle Young, nor Holistic Health Clinic will be held accountable for anything that may happen as a result of your refusal.
- You may authorize that medical information including, but not limited to, lab results, be communicated via voicemail or email by indicating and initialing here:

  Phone for voicemail: ______________________________ Initials: ___________

  Email: ____ Initials:___________

By signing below you acknowledge your understanding of the terms and conditions listed above and agree to adhere to the policies of the clinic and physician.

____

Patient Signature or Signature of Legal Guardian

____

Printed Name   Date

Informed Consent for Treatment

I, ________________________________ the undersigned, hereby authorize Dr. Michelle Young to perform the following specific procedures necessary to facilitate my diagnosis and treatment. Medical treatments and procedures not within the scope of our licensed practice will be referred to an appropriate provider.

Diagnosis and Treatment

- Common Diagnostic Procedures: venipuncture, pap smears, laboratory services, and physical exams, etc.
- Botanical Medicine: granulation teas, alcohol-based tinctures, capsules, tablets, creams, poultices, compresses, suppositories, etc.
- Homeopathic Medicine: the use of high quality dilute quantities of naturally occurring substances to gently stimulate the body's healing responses.
- Nutritional Supplements: vitamins, minerals, amino acids in combination with botanical extracts prescribed as therapeutic and/or maintenance doses.
- Lifestyle and Hygiene Counseling: nutrition therapy and promotion of wellness, including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
- Acupuncture: insertion of specialized sterilized needles through the skin into the underlying tissues at specific points on the surface of the body.
- Cupping: a technique to relieve pain by applying glass cups to the skin, using heat to create a vacuum seal.
- Gua Sha: a rubbing technique on areas of the body with a round instrument.
- Moxa: an indirect warming technique on an acupuncture point using an herbal stick.

Potential Risks: discomfort, pain, infection, blistering, and temporary discoloration of the skin at the site of procedure, an aggravation of symptoms existing prior to treatment, allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from needle insertion, injections, venipuncture, or other procedures.

Notice to Pregnant Women: All female patients must alert the doctor immediately 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 procedures, realizing that Dr. Michelle Young has given me no guarantees regarding cure or improvement of my condition. I hereby release Holistic Health Clinic from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I acknowledge that Holistic Health Clinic is not responsible for patient compliance and will not be held responsible for outcomes due to patient non-compliance. I understand that I am free to withdraw my consent and to discontinue participation in the above procedures at any time.

I understand that a record will be kept of all health services provided to me. This record will be kept confidential and will not be released to others unless so

directed by my representative or myself, or unless required by law. I understand that I may look at my medical record and request a copy of it. I understand that my medical record will be kept no longer than ten years after the date of my last treatment. I understand that my practitioner will answer any questions I have.

PRIVACY POLICY: Due to HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take in protecting your health information. Please ask the front office staff if you would like a copy.

______ Do **not** want a copy ______ Received a copy

By signing I agree that I have read and understand the above and consent to treatment.

____

Signature Date