Name _____ Date _____

Address_____

City_____ State _____ Zip _____

Phone (H)_____ (C) _____(W) _____ Ext:_____

Date of Birth _____ Age _____ Gender: Female ☐ Male ☐ Other ☐

Email _____ SSN _____

Blood Type: _____ Ethnicity _____

Religion/Belief System: _____

Occupation _____ ☐ Full Time ☐ Part Time

Highest Level of Education _____

Name and Phone of Primary Physician: _____ Phone: _____

Pharmacy (Name, Address, Phone #) _____

_____

Referred By/ How did you hear about us? _____

For Confidential Information (i.e. test results), OK to leave detailed message: (check all that apply)

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-Mail ☐ US Mail ☐ Other _____

**EMERGENCY CONTACT INFORMATION**

Emergency Contact _____ Relationship _____

Telephone Number(s) _____

Additional Contact_____ Relationship _____

Telephone Number(s) _____

**Insurance Information**

Name of Insured if Different then Patient: _____

Primary Insurance Name & Plan/ Medicare/ Medicaid: _____

Policy I.D. Number: _____

**E-MAIL CONTACT**

E-mail offers a convenient way for us to communicate, however there are certain things to keep in mind.

- E-mail is never appropriate for urgent problems. For emergency, call 911, or go directly to the Emergency Department.
- E-mail is great for quick questions, prescriptions, referrals, etc. However, for topics that require extensive discussion, please make an appointment.
- E-mail is not confidential. If you correspond via e-mail at work, your employer has a legal right to read your e-mail.
- E-mails are saved and become part of your permanent medical record.
- Either one of us may revoke permission to e-mail at any time.
- **By signing below, I agree to communicate via e-mail. I have read the above information and understand the limitations of security on information transmitted inside these communications.**

_____ _____

Signature of patient or legal guardian Print name

**PLEASE COMPLETE THIS FORM AS THOROUGLY AS POSSIBLE. THANK YOU**

**Height: _____ Weight: _____**

**Main Reason for Visit(s): _____**

**Please describe the history of your illness in detail. (i.e. symptoms, and any medical testing you've had done)**

_____

_____

_____

_____

Any Major Health Conditions You Have Been Diagnosed With:
**PLEASE MARK WITH THE <u>YEAR DIAGNOSED</u> (Do not mark with a "check")**

| | | |
|---|---|---|
| _____ Acne | _____ Diverticulosis/Diverticulitis | _____ Lupus |
| _____ ADD/ADHD | _____ Eczema | _____ Lyme Disease |
| _____ Anemia | _____ Epilepsy | _____ Migraine |
| _____ Anorexia | _____ Fibromyalgia | _____ Multiple Sclerosis |
| _____ Anxiety | _____ Gallbladder Disease | _____ Neuropathy |
| _____ Asthma | _____ Glaucoma | _____ Osteoarthritis |
| _____ Autoimmune Disorder | _____ Head Injury | _____ Osteoporosis |
| Describe: _____ | _____ Headache | _____ Parasites |
| _____ Bleeding/Blood Clot(s) | _____ Heart Attack | _____ Parkinson's |
| _____ Bronchitis | _____ Heart Disease | _____ Psoriasis |
| _____ Cancer/Tumors | _____ Heart Murmur | _____ PTSD |
| _____ Cataracts | _____ Hepatitis (B / C) | _____ Reflux/Hiatal Hernia/Ulcer |
| _____ Cholesterol (High) | _____ Herpes Virus (Type 1/ Type 2) | _____ Restless Leg Syndrome |
| _____ Chronic Fatigue Syndrome | _____ High Blood Pressure | _____ Rheumatoid Arthritis |
| _____ Chronic Pain | _____ HIV/AIDS | _____ Seizures |
| _____ COPD | _____ Irritable Bowel Syndrome | _____ Sleep Apnea |
| _____ Coronary Artery Disease | _____ Irritable Bowel Disease | _____ Stroke/ TIA |
| _____ Covid-19 | _____ Kidney Stones | _____ Substance Abuse |
| Crohn's | _____ Liver Disease | _____ Thyroid Disease (Hypo/ Hyper) |
| _____ Depression | _____ Lung Disease | _____ Ulcerative Colitis |
| _____ Diabetes (Type 1/ Type 2) | | |

**Hospitalizations/Procedures/ Surgeries:** Please list all past hospitalization reason, with dates:

1) _____ Date: _____
2) _____ Date: _____
3) _____ Date: _____
4) _____ Date: _____

**Family History:** Please fill out thoroughly.

| | DOB / AGE | Health Condition(s) | Status (i.e Living, deceased) | Comments |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Sister(s)_ | | | | |
| Brother(s) | | | | |
| Daughter(s) | | | | |
| Son(S) | | | | |

Any other comments pertaining to your family history:

_____

_____

_____

**Social/ Lifestyle:**

**Marital Status:** Married ☐ Partner ☐ Single ☐ Widowed ☐ Divorced ☐

**Living Will:** Yes ☐ No ☐

**Power of Attorney:** Yes ☐ No ☐

**Highest Level of Education:** _____

**Employment Status:** _____

**Occupation:** _____

**Recent Foreign Travel:** Yes ☐ No ☐ If Yes, where: _____

**Smoker:** ☐ Currently ☐ Past ☐ Never Quit (year): _____

**Cigarettes (**# per day) _____ # of Years_____

**Alcohol:** Yes ☐ No ☐ If Yes, how much: _____ Quit(year): _____

**Recreational drugs:** Yes ☐ No ☐ Describe: _____

**Coffee:** Yes ☐ No ☐ # cups per day: _____

**Tea:** Yes ☐ No ☐ # cups per day: _____

**Water:** # of glasses per day _____

**Other caffeine sources:** Yes ☐ No ☐ Type: _____

**Physical Exercise:** Yes ☐ No ☐ Type: _____

How often per week and duration? _____

**Diet:** ☐ Vegan ☐ Vegetarian ☐ Omnivore Other: _____

Any dietary restrictions: _____ Have you had an eating disorder? _____

**Sleep**: (hours/night) _____ Quality? _____ Do you feel rested on waking? _____

Do you have trouble falling asleep or staying a sleep? _____

**What are the significant stressors in your life?** _____

_____

**Allergies:**

| **Type:** | **Start Date:** | **Reaction:** | **Severity:** | **Status:** |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

**CURRENT MEDICATIONS**

**Prescription Medications:**

| Name | Dosage | Reason Taken | Taken for How Long? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Over the Counter Medications, Vitamins, Supplements:**

| Name | Dosage | Reason Taken | Taken for How Long? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Preventative Care:** (i.e. blood tests, colonoscopy, pap smear, mammograms, bone density, PSA test etc.)

| Date | Preventative Care | Comments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Are you up to date on your vaccines? ☐ Yes ☐ No

Did you receive the usual childhood vaccinations? ☐ Yes ☐ No

Did you receive any COVID vaccinations?

What Brand? _____ How Many? _____ Please list months and year received _____

Have you reacted to a vaccination in the past? _____

Which Vaccine? _____

**Review of Systems:**

Please check **ANY AND ALL** of the following that applies to you (if you are filling this form out on your computer please use the letter "Y" instead of a check.

| **1. Constitutional** | |
|---|---|
| Fever | |
| Appetite Change | |
| Malaise | |
| Chills | |
| Sweats | |
| Unexplained Weight Loss | |
| Unexplained Weight Gain | |
| **2. Skin** | |
| Rash/Itching | |
| Mole Change | |
| Increased/Unusual Hair Growth | |
| Hair Loss/ Thinning | |
| Nail Changes | |
| **3. Eyes** | |
| Change in Vision | |
| Watery | |
| Dry | |
| Itching | |
| Blurring | |
| Irritation | |
| **4. Ears/ Nose/ Mouth & Throat** | |
| Earache | |
| Difficulty Hearing | |
| Infection | |
| Tinnitus | |
| Congestion | |
| Runny Nose | |
| Loss of Smell | |
| Frequent Sore Throat | |
| Bleeding Gums | |
| Mouth Sores | |
| Swollen Glands | |
| Tonsil Issues | |
| Dental Problems | |
| **5. Respiratory** | |
| Coughing | |
| Wheezing | |
| Difficulty Breathing | |
| Coughing up Blood | |

| **6. Cardiovascular** | |
|---|---|
| Chest Pains/Discomfort | |
| Palpitations | |
| Murmurs | |
| **7. Breast** | |
| Breast Lump(s) | |
| Nipple Discharge | |
| Pain | |
| Fibrocystic Breasts | |
| **8. Gastrointestinal** | |
| Abdominal Pain | |
| Diarrhea | |
| Undigested Food In Stool | |
| Blood in Bowel Movement | |
| Constipation | |
| Nausea | |
| Heartburn/ Reflux | |
| Vomiting | |
| Excess Gas/ Bloating | |
| Ulcer | |
| Hemorrhoids | |
| Rectal Itchiness | |
| Bowel Movements Per Day _____ | |
| **9. Blood/ Lymphatic** | |
| Easy Bruising | |
| Swollen Glands | |
| Clotting Issues | |
| Easy Bleeding | |
| **10. Musculoskeletal** | |
| Muscle or Joint Pain | |
| Muscle Weakness | |
| Back/Neck Pain | |
| Muscle Spasms | |
| **11. Endocrine** | |
| Hot or Cold Intolerance | |
| Abnormal Thirst | |
| Hypoglycemia | |
| Excessively Dry Skin | |
| Hot Flashes/Flushes | |
| Hypoglycemia | |

| 13. Neurological | |
|---|---|
| Headaches | |
| Loss of Coordination | |
| Dizziness/Lightheaded | |
| Brain Fog | |
| Numbness | |
| Vertigo | |
| Memory Loss | |
| Fainting | |
| Balance Issues | |
| **14. Genitourinary/ Women's Reproductive Health** | |
| Nighttime Urination | |
| Excessive Urination | |
| Kidney Pain | |
| Discomfort, Burning, Irritation, Itching of the Vulva | |
| Blood in Urine | |
| Leaking Urine | |
| Vaginal/ Vulvar Dryness | |
| Vaginal Bleeding | |
| Painful Intercourse | |
| Vaginal Discharge | |
| Lesions | |
| Irregular Cycles | |
| Dysmenorrhea | |
| PMS | |
| Heavy Menses | |
| Last Menstrual Period: _____ | |
| STD: Describe: _____ | |
| **15. Genitourinary (Male)** | |
| Nighttime Urination | |
| Excessive Urination | |
| Kidney Pain | |
| Leaking Urine | |
| Blood In Urine | |
| Penile Discharge | |
| Testicular Mass(es) | |
| Testicular Pain | |
| Lesions | |
| STD: Describe: _____ | |

| 16. Sexual Function (M/F) | |
|---|---|
| Low Desire | |
| Low Arousal | |
| Orgasm Difficulty | |
| Erectile Dysfunction | |
| **17. Psychiatric** | |
| Anxiety | |
| Stress | |
| Insomnia/ Sleep Disturbances | |
| Depression | |
| Mood Disorders | |
| History of Abuse | |
| ADD/ ADHD | |
| Addiction | |
| Do you enjoy your job? | |
| **18. Other** | |
| Mold Exposure | |
| Parasitic Disease | |
| Candidiasis | |

**Pain:** Please list anywhere you are currently experiencing pain:

1._____

2._____

3._____

Please use the space below to add any information that has not been covered in this questionnaire.

_____

_____

_____

_____

_____

_____

## FOR PRACTITIONER USE ONLY

Notes:

_____

_____

_____

_____

Assessment & Diagnosis:

_____

_____

_____

Plan: _____

_____

_____

Follow- up:_____

_____

Health Care Practitioner Signature: _____ Date: _____

# Patient Notice of Privacy Practices

**This notice describes how health information about you may be used and disclosed, and how you can get access to this information.**

## PLEASE REVIEW THIS NOTICE CAREFULLY

**If you have any questions about this notice or if you need more information, please contact**

**Isadora Guggenheim FNP, ND, RN**
**845-358-8385**
**8 Rockland Pl**
**Nyack, NY 10960**

## ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive from Isadora Guggenheim, FNP, ND, RN We need this record to provide care (treatment), for payment of café provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

## WHAT IS PROTECTED HEALTH INFORMATION ("PHI")

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:

- Your past, present, or future physical or mental health or conditions
- The provision of health care to you, or
- The past, present, or future payment for your health care.

## HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

- Treatment.
- Payment.
- Health Care Operations.
- Appointment Reminders / Treatment Alternatives/ Health- Related Benefits and Services.
- Minors.
- As Required by Law.
- To Avert a Serious Threat to Health or Safety.
- Military and Veterans.
- Public Health Risks.
- Abuse, Neglect, or Domestic Violence.
- Lawsuits and Disputes.
- Coroners, Medical Examiners, and Funeral Directors.

- **Uses and Disclosures that Required Us to Give You an Opportunity to Object and Opt Out.**
- **Individuals Involved in Your Care**. Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement.
- **Payment for Your Care.** Unless you object in writing, you can exercise your rights under HIPAA that your healthcare provider not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.

**Your Written Authorization if Required for Other Uses and Disclosures**
The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures or PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

## Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- **Inspect and Copy.** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to **30 days** to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs –based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed health care professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Receive Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured PHI.
- **Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.
- **Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by visiting our website: **http:**//www.secondnaturecare.com or contact our office.
- **Changes to This Notice**
  We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.
- **Complaints.**
  If you believe your privacy rights have been violated, you may file a complaint with the Isadora Guggenheim FNP, ND, RN Privacy Officer, at the address listed at the beginning of this Notice or with the Department of Health and Human Services of the United States. **You will not be penalized for filing a complaint.**

***Notice Effective 9/23/2013***

**Isadora Guggenheim FNP, ND, RN**
**ACKNOWLEDGEMENT OF RECEIPT OF**
**PATIENT NOTICE OF PRIVACY PRACTICES**

I acknowledge that I read and/ or received a copy of the Isadora Guggenheim FNP, ND, RN: Patient Notice of Privacy Practices/ HIPAA effective January 1, 2015

Date: _____

Print Name: _____

Patient Signature: _____
(or guardian, if applicable)

Please be advised that I _____ do not want give any authority or consent to give out any information of my medical history or diagnosis with any party. Under no circumstances should my medical history be given to anyone.
Date: _____

Patient Signature: _____

PRACTICE POLICY & PAYMENT AGREEMENT:

Payment for all services including; ALL CONSULTS, and recommendations for treatment must be paid in full at the time of the visit for services rendered.

Payment can be made with credit card, cash or check. All payments made with credit/debit card will incur a 3% processing fee. We charge a processing fee for all returned checks. Outstanding balances beyond 30 days will be charged a monthly interest fee of 1.5%.

The above services are not typically covered by medical health insurance companies including Medicare. Upon request, we can provide a receipt for services rendered. All services above are non-refundable.

I, _____, understand that I am responsible for the balance of my account, for any and all professional services rendered on my behalf. I accept full responsibility for the payment of these services.

## Cancellation Policy

Cancellations for all appointments must be made within 24 hours of the scheduled appointment. This can be done by leaving a message at 845-358-8385 or email at office@secondnaturecare.com. If the appointment is not canceled within this time period then you will be charged 75% of the cost of service. Exceptions will be made with the discretion of practitioner.

Print Name _____

Signature _____ Date _____