



Carefree Health Path Naturopathic Clinic

Personal Health Information

Last Name: _____ First Name: _____ Date: ____/____/____
Address: _____ City: _____ State: _____ Zip Code: _____
Social Security# _____ - _____ - _____ Date of Birth: _____ Age: _____ Gender: Female Male
Email Address: _____ would you like to subscribe to our online special? Y N
Height _____ Weight _____ Are you: Married Separated Divorced Widowed Single
Home Phone: _____ Work: _____ Cell: _____
Emergency Contact: _____ Phone: _____ Relationship _____
May we communicate with them re: appt's, RX's, and lab results? Y N
Preferred phone number to contact you: Home Work Cell May we leave a message: Y N
Have you ever seen a Naturopathic Physician before? Y N Reason: _____
How did you hear about us? Friend Physician Relative Internet Magazine Other
Referring person's name: _____
Primary Care Physician: _____ Phone: _____
Address: _____ City: _____ State: _____
Specialist Physician: _____ Phone: _____
Specialty: _____
When was your last healthcare visit? _____ Where? _____ Reason? _____
Pharmacy: _____ Phone: _____
Please list in order of importance your main health concern(s): _____
Do you have ANY allergies to medications, food, latex, or other substances? Y N Please list: _____
Have you ever been hospitalized? Y N If yes, when and what reason: _____
Have you had any surgeries? Y N If yes, when and for what reason: _____
Do you drink alcohol? Y N If yes, what type, how much and how often? _____
Have you ever smoked cigarettes, cigars, marijuana, pipe or chewed tobacco? Y N If yes, how long did you/have you smoked/tobacco? _____ If yes, do you still smoke? Y N Year you quit smoking: _____ What do you smoke? Cigarettes, cigars, marijuana or pipe Other _____ How much do you smoke/tobacco? _____

Male Only *****

If you are known to have had any abnormalities of the prostate, please select any that may apply:
 Benign prostatic hypertrophy (enlarged prostate or BPH) Prostate Cancer Prostate Infections None Other _____
Please select any prostate procedures you have had: PSA (prostate specific antigen) Resection TURP None Other _____
Have you have any problems with erections? Check all that apply: Difficulty maintaining erections Erections are soft
 Unable to achieve erections None Other _____
Have you had any procedures or medications for an erection problem? If yes, What? _____
Please select any problem(s) you have had with your testicles: Chronic pain Lumps Tumor Other _____
Have you had any procedures done for a testicle problem? Y N If yes, what? _____

Female Only *****

Age at first period: ____ Date of last period: ____ Age at menopause: ____ Number of pregnancies: ____ Number of abortions: ____
Number of live births: ____ Number of miscarriages: ____
Date of last mammogram: More than one year ago Never had one Within the last year
Mammogram results: Normal Abnormal Don't Know
If you have had an abnormal mammogram, what was the follow-up? Biopsy Repeat mammogram Surgery Ultrasound
Follow-up results: Fibrocystic disease Malignant Tumor Other _____
Date of last Pap smear: More than one year ago Never had one Within the last year
Results of Pap smear: Normal Abnormal Borderline
If you have had an abnormal Pap smear, what was the follow-up? Conization Cryosurgery Laser Surgery Repeat Pap
 Return exam in 3 months None Other _____
Do you have any gynecologic problems? Check all that apply: Abnormal bleeding Endometriosis Herpes HPV/Warts
 Hysterectomy Ovarian Cysts Ovaries removed Tubal surgery Sexually transmitted disease None Other _____

Lungs: *****

Do you experience shortness of breath during any of these activities? Daily walking Lay down Climbing stairs None Other

If you had pneumonia, what was the diagnosis? Bacterial Fungal Viral None Other_____

Do you suffer from any of the following lung-related problems? Asthma Chronic coughing Recurrent infections

Chronic Bronchitis Tuberculosis Cough up blood Pleurisy Tuberculosis None Other_____

Have you ever had any of the following treatments for an abnormal chest X-ray? Biopsy Bronchoscope CT or CAT scan

Normal Chest x-ray Results of test _____ Treatment_____

Heart: *****

If you have been diagnosed with heart disease, what was the diagnosis? Angina (chest pain) Cardiac Arrest Cardiomyopathy

Congestive Heart Failure Coronary Artery Disease Heart attack Heart valve problems Murmurs

Peripheral Vascular Disease Other_____

Hearth Diagnosis Treatment: Angioplasty Angioplasty with stent(s) Diet Coronary artery bypass (CABG) Exercise

Surgery other that CABG None Other_____

Do you experience swelling in any of these areas? Ankles Feet Hands None Other_____

Do you have or experience any of the following problems? Blood clots in legs/lungs Cold/numb feet

Enlarged veins in legs Fainting spells Heart murmur Irregular pulse Leg cramps Pain of pressure in chest

Palpitations Phlebitis (vein inflammation) None Other_____

If you have abnormal or high blood fats (cholesterol, triglycerides), what was the treatment? Diet Exercise Medications

None Other_____

If you have been diagnosed with high blood pressure, what was the treatment? Diet Exercise Medications None Other_

If you have been diagnosed with low blood pressure, what was the treatment? Diet Exercise Medications None Other_

Gastrointestinal: *****

If you have been diagnosed with liver disease/hepatitis, what was the diagnosis? Autoimmune hepatitis Cirrhosis Hepatitis A

Hepatitis B Hepatitis C I do not have liver disease/hepatitis Other_____

Describe your appetite: Present Absent Always hungry

What food do you avoid? Acidic Spicy I do not avoid any foods Other_____

Do you have any experience with any of the following gastrointestinal problems? Blood in stool Change in bowel movements

Cirrhosis Colitis Colon Polyps Constipation Cramping Crohn's Disease Diarrhea Hemorrhoids Hernia

Jaundice Nausea Pancreas problems Vomiting None Other_____

Kidney/Urogenital: *****

Have you experienced or been diagnosed with any of the following kidney/urogenital problems? Bed wetting Blood in urine

Difficulty starting urination Frequent or painful urination Increased urination at night Loss of urine on coughing Protein in urine

Recurrent bladder infections Recurrent kidney infections Urinate less that before Urinate more than before

Urgency None Other_____

Musculoskeletal: *****

If you have arthritis, please select the diagnosis: Osteoarthritis Rheumatoid None Other_____ If you have arthritis, what joints are involved? Feet Hands Hip-Left Hip-Right Knee-Left Knee-right Spine Neck Other_____

Please list the location of any broken bones you have had_____

If you have bursitis, please list the joints involved_____

If you have a deformity, please select the location: Bone Joint Spine None Other_____

Have you experienced or been diagnosed with any of the following musculoskeletal conditions? Backaches Dislocations Foot trouble

Gout Joint swelling Osteoporosis Pain is shoulder or elbow Recurrent back pain Recurrent sprains

Redness or hot joints Tremors Muscle spasms None Other_____

Nervous System: *****

Have you ever had a head injury? Y N

Do you have permanent problems from the injury? Y N If yes, what?_____

Have you had a stroke/TIA (mini-stroke)? Y N If yes, have you had any permanent problems from the stroke? Y N what?_____

Have you experienced or been diagnosed with any of the following nervous system conditions? Chronic headaches

- Cluster headache
- Difficulty sleeping
- Difficulty with concentration
- Problems with memory
- Experienced paralysis
- Dizzy spells
- Frequent headaches
- Loss of sensation in hands and feet
- Memory loss
- Migraine headaches
- Periods of unconsciousness
- Seizures
- Tingling in hands or feet
- Weakness in hands or feet
- None
- Other _____

Endocrine: *****

If you have been diagnosed with diabetes, please indicate the type: Gestational (during pregnancy) Type 1 Type 2 None
 Describe current treatment: Diet Exercise Insulin Oral Medication None Other _____
 If you are known to have thyroid problems, please indicate the diagnosis? Euthyroid Graves's Disease Hyperthyroid
 Hypothyroid Hashimoto's Nodules None Other _____
 Have you experienced or been diagnosed with any pituitary problems? Y N If yes, What? _____

Infections: *****

If you have ever contracted any STDs (sexually transmitted diseases), please indicate which ones: Gonorrhea/Chlamydia Herpes
 Syphilis Warts None Other _____
 If you have been diagnosed with an immune system disorder, please indicate the type: Chronic infections (3 or more per year)
 Recurring infections (same location 2-3 times a year) HIV/AIDS None Other _____

Mental Health: *****

If you are known to have had or now have a psychiatric illness, what was the diagnosis? Agitation Anorexia Anxiety
 Attention Deficit Disorder (ADD) Bulimia Depression Moodiness Nervousness Panic attacks Phobias
 Schizophrenia Suicidal thought None Other _____

Cancer: *****

Have you had any of the following cancer warning signs? Change in bowel or bladder habits Change in freckle or mole
 Chronic indigestion or difficulty in swallowing Persistent cough Persistent sore throat Thickening of lump in breast
 Unexplained weight loss Unusual bleeding or discharge None
 If you have ever been diagnosed with cancer, please indicate the type: Breast Cervical Colon/rectum Kidney Leukemia
 Lung Lymphoma Oral Ovarian Pancreas Prostate Skin Stomach Uterine None Other _____
 Has any family member had the following: If yes, please identify the family member?

Family History *****

- Anemia Y N _____
 - Asthma Y N _____
 - Cancer Y N _____
 - Diabetes Y N _____
 - Epilepsy Y N _____
 - Glaucoma Y N _____
 - Heart Disease Y N _____
 - High Blood Pressure Y N _____
 - Kidney Disease Y N _____
 - Mental Illness Y N _____
 - Pneumonia Y N _____
 - Stroke Y N _____
 - Tuberculosis Y N _____
 - Venereal Disease Y N _____
- Were any of these a cause of death? Y N If Yes, which family member and what age? _____

Childhood Illnesses: *****

Scarlett Fever Y N Diphtheria Y N Rheumatic Fever Y N Mumps Y N Measles Y N German measles Y N

Immunizations:
 Polio Y N Diphtheria Y N Rubella Y N Anthrax Y N
 Pertussis Y N Hepatitis Y N Pneumonia Y N Measles/Mump Y N
 Small Pox Y N Tetanus Y N Date of last Tetanus Shot: ____/____/____

Medications and Supplements:

Please list **All** medications currently taking: include all over-the-counter medications and vitamins.

Medications	Daily Dosage	Side Effects, Results
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Release of Record: In completion of this form, I hereby acknowledge and authorize the release of my records to myself at the above contact information at any requested time. This request may be denied where applicable laws compel **Carefree Health Path** to do so.

Patient Consent

If you have any questions, please ask:

- I acknowledge that no guaranties, either expressed or implied have been made to me regarding the outcome of any treatments or procedures.
- I agree to accept responsibility for payment of all charges relating to the services provided to me. The amounts due for services rendered and that payments must be made directly to Carefree Health Path and that no special arrangements have been made for payment. I understand that all treatments, therapies, medicines and nutritional supplements are non-refundable, and there are no refunds. The services offered are not included in the Medicare program and that if I inadvertently file a Medicare claim it will be denied. Most insurance companies do not pay for these services and any claims I make may be denied.
- I accept t the risks and complications. I agree to follow-up as recommended and to follow any and all of the pre-procedure and/or post-treatment instructions that have been provided to me. I understand that failure to do so can affect my results.
- I have been advised whether, on the days surrounding the treatment or procedure, I should take any and/or all of the medications I informed the doctor I have been taking.
- I understand that some of these therapies are not recognized or approved by the Food and Drug Administration as a standard therapy. I therefore, hereby release Carefree Health Path, and their designates, physician(s), staff, employees, and relatives of such from any liability arriving out of the status of the approval or lack of approval of this therapeutic process.
- As with any therapy, some patients may experience side effects from the therapy(s) chosen and/or agreed to. If they occur, most are likely to be minor or temporary. However, some may be serious or life threatening and need medical attention.

By signing below, you, the patient of Carefree Health Path (or the legal representative or parent of the patients), are requesting and authorizing Carefree Health Path to perform services and to provide you with recommendations on optimizing your present and long-term health goals.

Patient / Legal Guardian Signature: _____ **Date:** ____/____/____

Consent for use and disclosure of health information

Privacy Terms: We keep a record of healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the records we keep. Moreover, if you believe that information in your record is inaccurate, you may request that we make corrections or amend that record. These requests must be made in writing. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Carefree Health Path is required to provide you, at your request, with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have reviewed it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please

read it carefully. If you have questions concerning the management of you healthcare information at our clinic, or wish to inquire about your right, please call the Carefree Health Path at (623) 748-9106.

I hereby acknowledge that I have been offered a copy of the Carefree Health Path Notice of Privacy Practices.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ AND REVIEW IT CAREFULLY.

Please read the following statements carefully.

Purpose of Consent: By signing this form you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, and the uses and disclosures we may make of your protected health information, as well as other important matters regarding your protected health information. A copy of our Notice is available and has been provide with this Consent. We encourage you to read the Notice carefully signing this Consent. We reserve the reserve the right to change our privacy practices as described in our Notice of Privacy Practices at any time. If we change our privacy practices, we will issue a revised Notec of Privacy Practices that will contain the changes. This is in accordance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations")Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of any revisions to our Notice at any time by contracting:

Contact Person: Eugene Eihausen, N.M.D. **Phone:** 623-748-9106

Right to Revoke: You will have the right to revoke this Consent at any time by submitting written notice of your revocation to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

Notice:

Carefree Health Path and many other organization and individuals including physicians, hospitals and health plans are required by law to keep your health information confidential. If you authorize the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights:

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity’s obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative and delivered to **Carefree Health Path at 2525 W. Carefree Hwy. Bldg. 3, Suite 118, Phoenix, Arizona 85085**. The revocation takes effect when **Carefree Health Path** receives, except to the extent others have already relied on it.

Expiration of Authorization Unless otherwise revoked, this Authorization expires ____/____/____ (insert a date or leave blank). If no date indicated the Authorization expires 12 months after the date of my signing this form.

I _____ (**PRINT NAME**) have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that by signing this Consent, I am consenting to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient / Legal Guardian Signature: Relationship **Date** ____/____/____

Placed in Chart



Carefree Health Path & Medical Spa

Authorization For Release of Records

Patient Legal Name (Please print) _____

Date of Birth ____/____/____ Social Security # _____

Address _____

Phone # (____) _____ Cell # (____) _____ Fax (____) _____

Please send the following records and information:

- Complete medical records, Previous 2 years of records, Dates of service from... to..., Any lab/diagnostic reports, Previous 5 years of records, Current and ongoing medical/protocol updates

Release the Above Information to: Carefree Health Path & Med Spa

Dr. Eugene Eihausen, N.M.D
2525 W. Carefree Hwy. Bldg. 3, Suite 118
Phoenix, AZ 85085
Phone: 623-748-9106
Fax: 623-748-9574

Records released for the purpose of: Concurrent Care, Transfer of Care, Other: _____

FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL:

- 1. Confidential HIV-related information
2. Confidential communicable disease-related information
3. Confidential alcohol or drug abuse-related information
4. Confidential mental health diagnosis/treatment information
5. Confidential Genetics diagnosis/treatment information.

I have given my consent freely, voluntarily, and without coercion. I understand that a photocopy/fax of this authorization is considered acceptable in lieu of the original. This consent expires one (1) year after the signed date below. If you wish for this authorization to expire prior to one (1) year, please indicate the date of expiration: ____/____/____

Patient or Legally Authorized Representative Signature: _____ Relationship _____ Date ____/____/____

Notice to recipient: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information without express written consent of the person to whom it pertains.

Records prepared/transmitted by: _____ Date _____ to: _____