NouvelleHEALTH

Date:______/______/_______

First Name:____

Last Name: ____ Date of Birth: _____/_____/_____

Address:____

City:____ State:____________ Zip:_______________

Cell Phone:___________________________________ Home Phone:____________________________

Email Address: ____

Sex:____________ Wt: _____________ Ht: ___________ Age: _________

Insurance:____

REFERRED BY: ___________________________________

What are primary concerns as a patient:

____

____

____

Are you presently under a doctor's care for any reason? □ No □Yes, please explain: __________

____

Please check the answer that applies to each question.

Do you have a history of:

	Myself	Siblings	Parents	Grandparents
Migraine headaches	□	□	□	□
Diabetes	□	□	□	□
Heart disease	□	□	□	□
Cardiovascular disease	□	□	□	□
Arthritis	□	□	□	□
Liver disease (hepatitis, cirrhosis?)	□	□	□	□
Psychiatric illness (depression, panic attacks,	□	□	□	□
Schizophrenia?)	□	□	□	□
Autoimmune disease (Lupus, etc?)	□	□	□	□
Endocrine gland abnormalities (thyroid, etc?)	□	□	□	□
High blood pressure	□	□	□	□
Neurological disease (stroke, seizures,	□	□	□	□
Parkinson's disease?)	□	□	□	□
Lung disease (asthma, emphysema?)	□	□	□	□
Kidney disease (stones, infections?)	□	□	□	□

	Myself	Siblings	Parents	Grandparents
Liver Disease	□	□	□	□
Stomach disease (ulcers, etc?)	□	□	□	□
Bowel disease (malabsorption, lactose intolerance, diverticulitis, Crohn's disease?)	□	□	□	□
Alcoholism, prescription or recreational	□	□	□	□
Rheumatic Fever	□	□	□	□
Convulsions	□	□	□	□
Gout	□	□	□	□
Hepatitis	□	□	□	□
Tuberculosis	□	□	□	□
Colitis	□	□	□	□
Epilepsy	□	□	□	□
Fibroids, Ovarian Cysts, or Endometriosis	□	□	□	□
History of Cancer (Please list)	□	□	□	□

____

____

____

____

Are you currently receiving: Radiation therapy or Chemotherapy? Yes No

Surgical procedures:
Please list all procedures with dates you've had, including plastic surgery:
Date: _____________Procedure:____

Date: _____________Procedure:____

Date: _____________Procedure:____

Date: _____________Procedure:____

Are you allergic to eggs? Yes No Are you allergic to latex? Yes No
Please list drug allergies:

____

____

Medications
Are you currently taking any medications? □Yes □ No
Please specify all medications that you are currently taking, including hormones:
Name: ____________________________________ Dose (mg): __________________ Times/Day: _________

Name: ____________________________________ Dose (mg): __________________ Times/Day: _________

Name: ____________________________________ Dose (mg): __________________ Times/Day: _________

Name: ____________________________________ Dose (mg): __________________ Times/Day: _________

Your Pharmacy Information:
Name:____
Phone: _______________________________________
Address: ____City: ________________________

These questions refer to your current status:.
Marital status: Single Married Divorced Widowed
Number of children: _________________ Number living in your household: _______________
Occupation: ____
Water, 8 oz. cups/day: ____________________
Coffee: Cups/day: __________________________________
Diet soda or other drinks with aspartame/day: ________________________
Alcohol consumption: Number of drinks: _________________ per: ________________ week / month
Smokers: Currently smoke: ____________________________________at ______________per day
Previously smoked: _________________________at _______________per day For: ______(years).

Current recreational drug use ____

Are you currently experiencing the following symptoms to a degree you consider substantial or unusual?
Yes No (Put Y or N next to symptom)
_____ Headaches
_____ Visual problems
_____ Hearing loss
_____ Ringing in ears
_____ Sore throat
_____ Allergy symptoms (nasal congestion, watery eyes, post nasal drip?)
_____ Loss of smell or taste
_____ Lumps in neck, armpits, groin or breast
_____ Chest pain
_____ Shortness of breath at rest
_____ Shortness of breath with exertion
_____ Palpitations
_____ Abdominal pain
_____ Diarrhea
_____ Constipation (hard or effortful bowel movements?)
_____ Blood in stool or black stool
_____ Difficulty urinating
_____ Leaking urine
_____ Genital discharge or sores
_____ Urinating at night – Specify times/night:____
_____ Muscle, bone or joint pain **SPECIFY:** ____

Are you currently experiencing the following symptoms to a degree you consider substantial or unusual?
Yes No (Put Y or N next to symptom)

FEMALES ONLY

_____ Missed periods
_____ Pelvic soreness
_____ Menstrual pain
_____ Heavy menstrual bleeding
_____ Hot flashes
_____ Infertile

Are you pregnant _______ Attempting to get pregnant _______ Breast Feeding ________
Form of birth control: None Pill IUD (Copper or Hormonal) Sponge Foam Condom
Diaphragm Other: ________________________

Date of last: Menstrual period: ________________
Breast exam: ________________________
Pap smear: __________________________
Mammogram: ________________________
Were any of the above tests abnormal? Please describe:
____
____
____

MALES AND FEMALES

Date of last: Colonoscopy (or sigmoidoscopy): ______________
Rectal Exam: ___________
Stress EKG (treadmill stress test): _____________
Chest x-ray: ___________________
Were any of the above tests abnormal? Please describe:
____
____
____

CURRENT EXERCISE SUMMARY

How often do you engage in aerobic exercise? (walking, jogging, biking, swimming) Times/week: __________

How often do you engage in flexibility and/or stretching exercises (yoga, tai chi, stretch & toning classes, brief stretching after aerobics or weights)? Times/week: ____
____

Are you currently a member of a health club? _______________________
Have you ever worked with a professional trainer? No Yes, for how long? _______________________

Are you still with a personal trainer? No Yes, did you enjoy working with a trainer? ________________

Do you have any exercise equipment at home (bike, treadmill, free weights, etc.)? No Yes, what type?
____
____

Are you presently receiving physical therapy? No Yes, what type?
If "Yes", please describe: ____

If exercise is not part of your weekly routine, please explain why: (circle)
Lack of time No motivation Physical limitations
Unsure of what to do Don't enjoy it Other: _____________________________

SUPPLEMENTATION
Are you taking vitamins, minerals or herbs on a regular basis? Yes No
If yes, please list what you are taking or copy labels and send in with questionnaire.
____
____
____

SYMPTOMS
Check the box that best describes the following symptoms you might have:
Never / Rare Occasional / Often & Mild / Moderate / Severe
Water retention _________________
Inflamed or bleeding gums _________________
Nosebleeds _________________
Indigestion after eating _________________
Flatulence (gas) _________________
Allergy/Food sensitivities _________________
Please List ____
____
____
____
Lactose intolerance _________________
Dependency on antacids_________________
Toe and fingernail fungus_________________
Boils or sties_________________
Vaginal yeast infection (women) _________________
Jock itch (men) _________________
Bad breath (no relief by brushing) _________________
Body odor (no relief by washing) _________________
Memory problems_________________
Energy loss_________________
Decreased self-image_________________
Back/spine problems_________________
Please describe ____
____
____

Never / Rare Occasional / Often & Mild / Moderate / Severe

Sleep problems___________________
Poor concentration___________________
Rapid mood swings___________________
Impatient, moody, nervous___________________
Lack of mental alertness___________________
Depression___________________
Dry/flaky hair and/or dry brittle skin___________________
Acne___________________
Hair thinning or falling out___________________
Premenstrual tension (females only) ___________________

Do you have any other health issue that is causing you problems or you would like discuss? _______________
____
____

YOUR PHYSICIAN(S) INFORMATION:

NAME:____

PHONE: ____

ADDRESS: ____

CITY: ____ STATE:_________ZIP:__________________

FAX: _________________________________

NAME:____

PHONE: ____

ADDRESS: ____

CITY: ____ STATE:_________ZIP:__________________

FAX: _________________________________

Nouvelle Health HIPPA Form
(PLEASE PRINT)

I understand that my healthcare information at Nouvelle Health is protected.

In order for Nouvelle Health to leave detailed messages on my voicemail, I need to give permission to Nouvelle Health.

Consent to Leave Messages (Please check box) ☐ **Yes** ☐ **No**

I consent to information regarding my (or my child's) test results or detailed appointment reminders/instructions to be left on my voicemail.

Consent to Share information with Family and/or Friends ☐ **Yes** ☐ **No**

I wish family members to have access to my appointments and health information. The name(s) listed below are individuals whom I grant access. I will rely on the professional judgment of my provider and his designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my Protected Health Information will be provided without my signature on a Medical Release form.

NAME	RELATIONSHIP
1. ______________________________	______________________________
2. ______________________________	______________________________
3. ______________________________	______________________________

______________________________________ ______________________________
PATIENT NAME DATE OF BIRTH

______________________________________ ______________________________
PATIENT/GUARDIAN SIGNATURE DATE

NouvelleHEALTH
Unlocking Nature's Benefits

NATUROPATHIC MEDICINE INFROMED CONSENT FOR TREATMENT

***General Information*:** Dr. Xochitl Palomino ND, LLC is practicing under the NouvelleHEALTH clinic which integrates a number of medical treatment modalities. Dr. Xochitl Palomino ND as a clinician will, with other clinicians in the clinic (e.g. Dr. Meridee Senick, DC), address your health concerns. Your medical history, treatment plan and progress will be discussed (with identifying information) among clinicians with NouvelleHEALTH and Synergy Wellness only with the consent of the patient for integrated complete holistic health purposes at the clinic. Due to the diversity of modalities offered by Dr. Xochitl Palomino ND, your treatment may include any or all of the following general modalities: Primary Care, Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling and Nutritional Counseling.

Methods, Procedures and Therapeutic Approaches: Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

I,________________________________, hereby authorize Dr. Xochitl Palomino, a private practitioner, to perform the following specific procedures necessary to facilitate my diagnosis and treatment.

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments)

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions

Topical Treatments and Prepping: Biofreeze or other topicals

Herbs/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials) Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)

Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)

Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)

Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa.)

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that all fees for labs, blood draws, imaging and diagnostic tests are my responsibility and such my responsibility to discuss with my health care insurance as to what is covered and not the responsibility of Dr. Xochitl Palomino ND, LLC nor of NouvelleHEALTH Inc.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Xochitl Palomino, ND, LLC or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the 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 me or otherwise permitted or required by law.

______________________________	______________________________
PATIENT NAME	DATE OF BIRTH
______________________________	______________________________
PATIENT SIGNATURE	DATE

If Patient is under the age of 18 years old

____

Guardian/Personal Representative's Signature

____

Relationship/Representative's Authority