PACIFIC NATUROPATHIC
MEDICAL CENTER

Today's Date _____

Contact Information

Name _____ **Age** _____ **DOB** _____

Sex ❑ **M** ❑ **F** **Your relationship status:** ❑**Single** ❑**Married** ❑**Life partner** ❑**Widowed**

Address _____

_____

Phone numbers and E-mail (please check numbers to call or leave a message)

❑ **Home** _____ ❑ **Cell** _____

❑ **Work** _____ ❑ **E-mail** _____

Children (if applies, please list names and ages)

_____ _____ _____

_____ _____ _____

Emergency contacts (Name/phone/relationship)

_____

_____

_____

Medical History (for additional information, please attach an additional sheet)

List other doctors and healthcare practitioners you are seeing (name/phone)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Prescription drugs and over-the-counter medications you are currently taking

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Nutrition and herbal supplements you are currently taking (list by brand name, dosage and frequency)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medical History continued…

Health Concerns (please list your concerns in order of importance and describe in detail the history of your symptoms and the effect they have on your life):

Known allergies (drug, food, chemical and environmental)

Former Treatments (please list both conventional and alternative treatments you have had and the effectiveness of each treatment)

Date of last physical exam _____ **Performed by whom?** _____

Surgeries and/or hospitalizations (conditions and dates)

Serious accidents and/or severe injuries(list any head injuries or broken bones with dates)

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Pain Descriptions

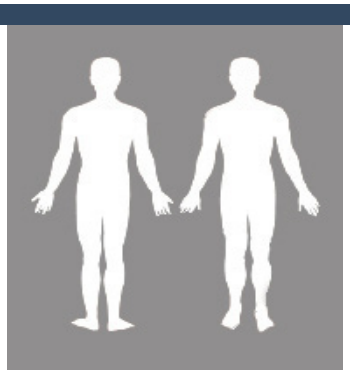

Diagram (mark an **X** on the diagram to indicate where you are currently experiencing pain, numbness and/or tingling)

Rate your PAIN on a scale of 1 to 10 (1=least pain)
How often do you have this pain? _____
Is it consistent or does it come and go? _____

Type of PAIN:

❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other _____

Activities that are PAINFUL:

❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other _____

Symptom and Infection History

Have you had the following? (check all that apply)

❑ Alcoholism	❑ Anemia	❑ Anorexia/Bullimia	❑ Psychiatric Care	❑ Diabetes
❑ Arthritis	❑ Asthma	❑ Back Trouble	❑ Ulcers	❑ Epilepsy
❑ Bleeding/Bursting	❑ Blood Transfusion	❑ Breast Lump	❑ Prostate Problems	❑ Migraines
❑ Bronchitis (chronic)	❑ Cancer	❑ Cataracts	❑ Thyroid Disease	❑ Glaucoma
❑ Heart Disease	❑ High Blood Pressure	❑ Kidney Disease	❑ Hemorrhoids	❑ Emphysema
❑ High Cholesterol	❑ Liver Disease	❑ Mitral Valve Prolapse	❑ Low Blood Pressure	❑ Gout
❑ Multiple Sclerosis	❑ Varicose Veins	❑ Hives/Eczema	❑ Hernia	❑ Migraines
❑ Pacemaker	❑ Stroke	❑ Other: _____	_____	_____
❑ AIDS/HIV	❑ Bladder Infections	❑ Bronchitis	❑ Chicken Pox	❑ Diphtheria
❑ Hepatitis	❑ Herpes	❑ Measles	❑ Mono	❑ Mumps
❑ Pneumonia	❑ Polio	❑ Rheumatic Fever	❑ Scarlet Fever	❑ Rubella
❑ Shingles	❑ Typhoid Fever	❑ Tonsillitis	❑ Tuberculosis	❑ Sinusitis
❑ Vaginal Infections	❑ Whooping Cough	❑ Sexually Transmitted		

For Women

Age at first period _____
Period frequency (ie; 28 days?)_____
Days of flow _____
Any problems with PMS_____
Any irregularities with periods_____
Last menstrual period_____
Extreme menstrual pain? ❑ Yes ❑ No
Any history of infertility? ❑ Yes ❑ No
Any hot flashes or night sweats? ❑ Yes ❑ No
Are you experiencing any sexual dysfunction? ❑ Yes ❑ No

Last pap_____
Ever have an abnormal pap? ❑ Yes ❑ No
If YES, describe _____
_____
Do you do self breast exams? ❑ Yes ❑ No
Last mammogram _____
History of breast lump? ❑ Yes ❑ No
If YES, describe _____
_____

List each pregnancy including abortions, miscarriages and births with dates. If complications with pregnancy or delivery including C-section, please describe: _____

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For Men

Last prostate exam _____ Last PSA _____

Number of times you get up at night to urinate _____

Are you experiencing any sexual dysfunction? ❑ Yes ❑ No

If YES, describe _____

Medical Services

Please indicate the date you last received the following or put N/A for services that do not apply to you.

Tetanus Shot _____ Flu Shot _____ Pneumonia Shot _____

Blood Tests _____ EKG _____ Chest X-ray _____

Colonoscopy _____ Coronary Calcium Score _____

Lifestyle

Diet

Do you have any dietary restrictions? _____

Do you have any cravings for any particular type of food (be specific) _____

_____

Are you satisfied with your diet? ❑ Yes ❑ No

If NO, please explain _____

How much water do you drink daily? _____ Other liquids? _____

What did you eat yesterday? (be specific)

Breakfast _____ Snack _____

Lunch _____ Snack _____

Dinner _____

Snack _____

Drink

Do you drink alcohol? Indicate what type and what frequency per week _____

If you used to drink but quit, please indicate date of quitting _____

Do you drink caffeine? Indicate type and frequency per week _____

Smoking/Chewing Tobacco and Drugs

If you currently smoke/chew please indicate what you use and frequency per day _____

Are you a former smoker? Please indicate date of quitting _____

Do you use recreational drugs? Please indicate type and frequency per week _____

Weight

Usual weight? _____ Are you happy with your weight? ❑ Yes ❑ No

Sleep and Exercise

How much sleep do you get per night? _____ Do you feel rested? ❑ Yes ❑ No

Please describe the exercise you do each week and include minutes per session and days per week:

_____

Do you enjoy exercise? _____

Stress Level and Stress Reduction

Describe your stress level (check one) ❑ NONE ❑ MILD ❑ MODERATE ❑ SEVERE

Describe any stress reduction you practice including minute per session and frequency:

_____

_____

Lifestyle continued…

Daily and New Routines

Do you enjoy your work/what you do during the day? _____

Do you enjoy the people/pets in your life? _____

Do you live near an agricultural/industrial area? _____

Do you use paint, chemicals or solvents at home, for hobbies or during work? _____

Have you moved to a new home recently? _____

Have you done any remodeling recently _____

Do you have any mold in your home or work area? _____

Do you suffer from allergies? _____

How many times have you used antibiotics in the past two years? _____

List dental history and procedures: _____

_____

List any cosmetic surgery or procedures _____

_____

List travel history and vaccinations _____

Family History

Please include any family member who has had the following illnesses:

	Relationship		Relationship
❑ Allergies/Asthma		❑ Anemia	
❑ Arthritis		❑ Bleeding	
❑ Cancer		❑ Depression	
❑ Diabetes		❑ Drugs/Alcohol	
❑ Gout		❑ Heart Disease	
❑ High Blood Pressure		❑ High Cholesterol	
❑ Kidney Disease		❑ Mental Illness	
❑ Migraines		❑ Obesity	
❑ Stroke		❑ Thyroid Disease	
❑ Other			

Current status of family members (please include present age, or age and cause at death and if living indicate level of health as good, fair or poor)

Paternal Grandmother _____

Paternal Grandfather _____

Maternal Grandmother _____

Maternal Grandfather _____

Father _____

Mother _____

Siblings _____

_____

_____

Spouse _____

Children _____

Are you considering Dr. Thoring as your Primary Doctor? ❑ Yes ❑ No

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MEDICAL CENTER

I, _____, hereby authorize the physician of the Pacific Natural Medical Centre to perform, with my approval and consent, the following procedures to facilitate my diagnosis and treatment:

- **Common Diagnostic Procedures:** Venipuncture, laboratory, X-ray, radiography, etc.
- **Minor Office Procedures:** Wound dressing, ear cleansing and wart treatment, etc.
- **Medicinal Use of Nutrition:** Therapeutic nutrition, nutritional supplements, intra-muscular and intravenous/mineral injections, etc.
- **Physical Medicine:** Therapeutic ultrasound and electrical muscle stimulation, muscle stretching/massage, etc.
- **Botanic Medicine:** Botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters or suppositories, etc.
- **Homeopathic Medicine:** The use of highly dilute quantities of naturally occurring plants, animals and minerals to stimulate the body's healing responses, etc.
- **Natural Bio-identical Hormones**
- **Chelation:** (Non-IV) Detoxification, heavy metal detoxifications, etc.
- **Lifestyle Counseling and Hygiene:** Diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

I recognize the potential risks and benefits of these procedures as described below:

- **Potential Risk:** Allergic reactions to prescribed herbs, supplements and medications, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or other procedures.
- **Potential Benefits:** Restoration of health and the body's maximum functional capacity relief of pain and symptoms of disease, assistance in injury and disease recover and prevention of disease of its progression.
- **Notice to Women:** All female patients must inform the doctor if they know, suspect or may be pregnant as some of the therapies used could cause present risk to the pregnancy and fetus.

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With this knowledge, I voluntarily consent to the above procedures; realizing that no guarantees have been given to me by the Pacific Natural Medical Center or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand the Pacific Natural Medical Centre will keep a record of the record of the health services provided to me. This record will be kept confidential and will not be released to others unless directed by myself of my representative in writing or unless required by law. I understand that I may look at my medical record and can request a copy of it by paying the appropriate fee. I understand that my medical record will not be kept more than seven years after the last day of my treatment. I understand that any questions concerning this form can be asked of the doctor.

Signature of Patient **Date**

Signature of Representative or Guardian **Date**

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Policy Agreement

Cancellation Policy:
We have a 48-business hour cancellation policy stating that we require at least 48-business hours (2-business days) advanced notice for cancellation of an appointment. This agreement is acknowledged by a credit card number on file to hold any appointments. In the event that you do not give a 48-business hour (2-business day) notice or fail to show for a scheduled appointment your credit card on file will be charged up to the full amount of the missed appointment.

Return Policy:
Supplements can only be returned if they are unopened AND if it has been less than 30 days since the product was purchased, with a receipt present. Please note that there is a 20% restocking fee for all supplements returned. Perishable supplements including probiotics and fish oils cannot be returned. *Special order supplements (supplements NOT normally carried in store) are NON REFUNDABLE and must be paid in full at time of order. Skin care products may only be returned if there was an allergic reaction to the product and if our office is notified immediately (within 1 week of the purchase date). Our skin care professional must also observe the reaction.
All returns will be in the form of an office credit, available for use towards your next purchase.

Medicare/MediCal Patients:
We regret to inform you that Medicare and MediCal are not covering any services provided by Naturopathic Doctors, including but not limited to office visits, blood work, prescriptions etc. Please be sure to check with your insurance provider regarding their policies for Naturopathic Doctors and reimbursement for office visits, as we are private pay office.

Parents:
Children need to be supervised at all times. We cannot have children running in the halls or being loud as we have spa treatments being done in our facility. You are welcome to go for a walk while waiting for your appointment if necessary.
When the fireplace is on it is very hot to the touch. If touched there is a risk of being burned. Please supervise your child at all times. By signing this policy you agree to release PNMC of any liabilities caused by failure to comply.
_____ (Initials)

Cell Phones:
Please do not use cell phones in the office. You are welcome to step outside to make or receive a call. By signing this policy agreement you consent to comply with our policies. We look forward to serving you and your healthcare needs.

PLEASE NOTE: Patients are advised to maintain continued care and follow up with their current specialist. Patients being treated for Tick Born diseases must maintain primary care, in addition to consulting with Dr. Thoring.

I have read, understand, and agree to comply with the terms of your office Policy.

_____ _____
Signature of Patient/Guardian **Date**

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Communication and Prescription Refill Policies

GENERAL COMMUNICATION:

All staff members of Pacific Naturopathic Medical Center are committed to offering accessible communication to our patients. Every effort is made to respond to questions on the same day, if not, within (24-48) hours. We encourage patients to keep in contact between appointments to monitor progress and address questions/concerns as they arise. We are committed to helping each patient achieve success in his or her health goals, which begins with clear and ongoing communication. It is our hope that patients are improving between appointments and tolerating the treatment plan set forth. Please contact our office if you do not feel you are progressing with your treatment plan.

1. **OUR preferred communication is via email pacificnaturalmedicalcenter@gmail.com or fax 805-473-7879**.
2. **Please call only if you have NOT received an inquiry acknowledgement or if your situation is of an urgent matter**. _____***(initial)***
3. **FOR ANY URGENT NEED**, the only acceptable form of communication is the telephone. **Any medical emergency call 911!** _____***(initial)***
4. **When faxing or emailing, PLEASE keep information brief, in bullet-point format, and do not exceed (3) three questions.** If concerns require more attention and detail, a brief phone consult may be required. _____***(initial)***
5. **Phone conversations with Dr. Thoring's Medical Assistant, need to be kept brief and concise**. Have your questions ready and take notes. It is very important to us to give personalized care to each patient. _____***(initial)***

PRESCRIPTIONS/REFILLS/SUPPLEMENT ORDERS:

1. **Prescription refills are the responsibility of the patient.** Please plan ahead and contact your pharmacy directly for prescription refills at least 4 days prior to your last dose; unless refilling compounded hormones/medications, which may take 7-10 days. _____***(initial)***
2. **"Prior Authorization" need at least (72) hours to process** from our office and a second attempt for approval will have a fee of $25-$50 applied. For any updates, it is your responsibility to contact the pharmacy. _____***(initial)***
3. **Office policy allows for 48-hour to respond to refill requests.** Pharmacy will contact our office via fax for refill authorizations; allow 48 hrs for response. Please call with any questions/concerns pertaining to medication changes several days prior to completion of current prescription. _____***(initial)***
4. For supplement refills/purchases we recommend calling, emailing or faxing your order (3) three days ahead to make sure we have your item(s) in stock and we can have your order prepared for you to pick up or to be mailed at your convenience. _____***(initial)***

PNMC is here to serve our community and we are dedicated to improving the care of our patients and strive for the highest quality of service. We encourage your input on how we, as your health care providers can help you accomplish your heath goals and look forward to being a part of your team.

(Name)_____**(Date)**_____

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Refund Policy

We are dedicated to helping each patient meet their health goals and it is our hope that patients are improving between appointments and tolerating the treatment plan set forth. Consultations/appointments are billed after completing each session and the fee for services rendered are determined by time and complexity, accordingly.

It is our policy here at Pacific Naturopathic Medical Center & Advanced Skin Care to bill each patient, acknowledged by the card we have on file for them, for the services rendered at the time of appointment.

A patient may provide an alternative card if they decline the use of the default card.

Supplements: Patients may also be reimbursed in **office credit** upon the manager's approval for issues relating to supplements only. No supplements are to be returned after 30 days of purchase date. If item is open it will not be accepted.

Consultations/Appointments: If there are concerns about billing regarding to consultations/appointments, please contact the office for clarifications. No refunds will be given for consultations. Deposits will not be refunded once appointments are confirmed, patients acknowledge the policy by providing their credit card information with us along with signature.

Skin Care Products: Products may be returned if there has been an allergic reaction caused by the product and we are notified immediately (within one week of purchase date). **The reaction must be observed by our skin care professionals**.

By receiving this notice, our policies are acknowledged and we appreciate your compliance.

PLEASE review the following information, complete and return before your upcoming appointment.

NEW PATIENT CHECK LIST

- ☐ New patient paperwork completed with signed policies.
- ☐ List of current medications.
- ☐ Copies of recent lab work and/or any other applicable medical records.
- ☐ Chronology of - symptoms, diagnosis, treatment & medication history.
- ☐ Insurance card - ideal to have on file if referrals or authorizations are needed.

This information helps provide Dr. Thoring with the best understanding of your medical history and allow you to get the most from your initial appointment.

We ask you arrive 15 minutes early to allow proper check-in time.

Please keep in mind our 48-business hour cancellation policy; acknowledged by the credit card you have on file with your office. Should you have any questions or concerns, please give our office a call.
We look forward to meeting you!