

# CYPRESS NATURAL MEDICINE

## Confidential Patient Information

Name: \_\_\_\_\_ Gender: M / F

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Circle One:    Minor            Single            Married/Partnered            Divorced            Widowed

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone:(    ) \_\_\_\_\_

Name of Parent/Guardian (if minor): \_\_\_\_\_

Patient or Parent's Employer: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone:(    ) \_\_\_\_\_

Would you be interested in signing up for our health blog?    **Yes / No**

Would you prefer appointment reminders by email versus phone?    **Yes / No**

### How did you hear about our clinic?

- Internet Search – Which site or search engine? \_\_\_\_\_
- Bay Area Naturally
- Referred by a friend or acquaintance: \_\_\_\_\_
- Referred by another health care practitioner: \_\_\_\_\_
- Health Food Store – Which one? \_\_\_\_\_
- Bay Area Birth Information
- Blossom Birth Services
- Other? \_\_\_\_\_

\*\*\*Please ask a staff member if you would like a copy of our privacy policies

# CYPRESS NATURAL MEDICINE

## Comprehensive Health History Questionnaire (Confidential)

Please take the time to fill out this questionnaire carefully. If you have any questions, ask for assistance. If you have concerns that are not listed, please include them. The completed form will greatly assist us in providing a thorough evaluation of your health.

Name: \_\_\_\_\_ Gender: M / F Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_  
Blood Type: \_\_\_\_\_

**Chief Complaint:** *In this section please list in order of importance your health concerns.*

1. \_\_\_\_\_ 5. \_\_\_\_\_
2. \_\_\_\_\_ 6. \_\_\_\_\_
3. \_\_\_\_\_ 7. \_\_\_\_\_
4. \_\_\_\_\_ 8. \_\_\_\_\_

**Current Medication List:** *In this section please list all pharmaceutical medication(s) that you are currently taking along with dosage and frequency.*

1. \_\_\_\_\_ 5. \_\_\_\_\_
2. \_\_\_\_\_ 6. \_\_\_\_\_
3. \_\_\_\_\_ 7. \_\_\_\_\_
4. \_\_\_\_\_ 8. \_\_\_\_\_

Are you allergic to any medications? Yes / No If "Yes", please list: \_\_\_\_\_

\_\_\_\_\_

What happens when you have an allergy attack to medication? \_\_\_\_\_

Hospitalizations & Surgeries (include plastic surgery procedures), reason, year and duration: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Supplement List:** *In this section please include all homeopathics, herbs, vitamins, minerals you are currently taking with dosage.*

1. \_\_\_\_\_ 5. \_\_\_\_\_
2. \_\_\_\_\_ 6. \_\_\_\_\_
3. \_\_\_\_\_ 7. \_\_\_\_\_
4. \_\_\_\_\_ 8. \_\_\_\_\_

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**Social History:**

Are you currently (please circle):  Married  Divorced  Single  Long-Term Relationship  Widowed

Number of children: \_\_\_\_\_ Ages? \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Date of last blood work? \_\_\_\_\_

**Men:** Date of last prostate exam: \_\_\_\_\_ **Women:** Date of last pelvic exam: \_\_\_\_\_

Have you traveled outside the US in the past year? Yes / No If yes, where? \_\_\_\_\_

Health Habits Assessment	Yes	No	If "Yes", how long or how much per week
Do you exercise?			
Do you smoke tobacco currently or in the past?			
Do you drink alcohol currently or in the past?			
Do you use recreational drugs currently or in the past?			
Do you drink "diet" sodas or eat "diet" foods?			
Do you follow any dietary modifications / restrictions?			
Do you have any sleep difficulties?			Average hours per night:

**Food or Environmental Allergies:** *List any known allergens here.*

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

ENVIRONMENTAL EXPOSURE ASSESSMENT	Yes, Current	Yes, Past	No
Have you ever worked around known toxic chemicals?			
Have you ever been exposed to chemical solvents?			
Do you use oil paints?			
Do you have mercury amalgam fillings?			
Have you ever been excessively exposed to toxic fumes?			
Is there any known exposure to any heavy metals?			
Are you a gardener?			
Do you eat fish or shellfish?			
Do you have difficulty sleeping if you consume caffeine in the afternoon?			
Are you overly sensitive to alcohol consumption?			
Are you sensitive to any chemicals?			

## CYPRESS NATURAL MEDICINE

**Past Medical History:** Below, please check the appropriate box that applies to you.

Illness	Current	Past	Illness	Current	Past
Allergies			Gout		
ADD/ADHD			Headaches / Migraine		
Alcoholism			Heart Attack		
Anemia			Hemorrhoids		
Anxiety/Depression			High Blood Pressure		
Arthritis			HIV / AIDS		
Asthma			Hyperthyroid		
Bleeding Disorder			Hypothyroid		
Bloody Stools			Injury (Serious)		
Blurred Vision			Kidney Disease		
Cancer			Low Blood Sugar		
Candida (Yeast)			Numbness / Tingling		
Chemical Sensitivity			Obesity		
Chronic Fatigue Syndrome			Other: Please specify		
Colitis			Ovarian Cysts		
Diabetes			Pneumonia		
Dizziness/Vertigo			Post Traumatic Stress Disorder		
Eczema / Rash / Hives			Recreational Drug Use		
Emphysema			Rheumatoid Arthritis		
Fainting			Schizophrenia		
Fibromyalgia			Seizure / Epilepsy		
Genital Herpes			Stroke		
Gastrointestinal Ulcers			Syphilis		
Glaucoma			Tuberculosis		

Family Medical History	Mother	Father	Brother(s)	Sister(s)	Maternal Grandparents	Paternal Grandparents
Age if living (or death)						
Cause of death						
Alcoholism / Addiction						
Alzheimer's Disease						
Anemia						
Asthma / Allergies / Hives						
Autoimmune Disease						
Blood Disorders						
Cancer: Type?						
Depression / Suicide						
Diabetes						
Epilepsy						
Gastrointestinal Disease						
Glaucoma						
Heart Disease						
High Blood Pressure						
HIV / AIDS						
Mental Illness						
Obesity						
Parkinson's Disease						
Syphilis						
Tuberculosis						

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**Review of Systems:** *Below, please check the appropriate box.*

<b>GENERAL SYMPTOMS:</b>	<b>Yes, Currently</b>	<b>Yes, Past</b>	<b>Never</b>
Feel tired or worn out?			
Low blood sugar?			
Increased thirst?			
Weight gain or loss recently?			
Perspire a lot?			
Heat intolerance?			
Cold intolerance?			
<b>SKIN / HAIR / NAILS:</b>			
Changes in the color of your skin?			
Skin rashes, itching, hives, or eczema?			
Unusually dry skin?			
Growths on your skin?			
Sores or wounds that do not seem to heal?			
Warts?			
Peeling, cracking, or weakness of your fingernails?			
Discoloration of your fingernails or toenails?			
Irregular hair loss or growth?			
<b>EYES:</b>			
Eye pain?			
Blurry vision?			
Nearsighted or Farsighted? (circle one)			
Changes in your vision?			
Eye itching or watering?			
Redness or burning?			
Halos around lights?			
<b>EARS / NOSE / THROAT:</b>			
Difficulty hearing?			
Buzzing or ringing in your ears?			
Earaches or discharge from your ears?			
Nasal stuffiness or sinusitis?			
Post-nasal drip or frequent desire to clear the throat?			
Frequent or severe nose bleeds?			
Difficulty swallowing or choking on food?			
Constriction in the throat?			
Soreness of the tongue or mouth?			
Chancre sores?			
Excess saliva or drooling?			
Bad breath?			
Nasal congestion?			
<b>RESPIRATORY:</b>			
Frequent chest colds?			
Constant or bothersome cough?			
Coughing up blood?			
Difficulty breathing?			
Wheezing or whistling on inhaling or exhaling?			
Shortness of breath			

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<b>CARDIOVASCULAR:</b>	<b>Yes, Currently</b>	<b>Yes, Past</b>	<b>Never</b>
High blood pressure?			
Pain, tightness, or pressure in front or back of your chest?			
If yes, is it when walking fast, working hard, or when excited?			
Have you ever had a abnormal EKG?			
Swelling of your feet and ankles?			
Cramps in the calf muscles when you walk?			
Awaken at night with difficulty breathing or suffocation?			
Need to sleep on more than one pillow?			
Fast or irregular heartbeat such as palpitations?			
Do your fingers or toes ever get cold, become numb, or turn bluish?			
Low blood pressure?			
<b>GASTROINTESTINAL:</b>			
Recent change in your eating habits?			
Are there any foods that upset your stomach or cause pain?			
Frequently experience nausea or vomiting?			
Excessive gas, bloating, belching or flatulence?			
Have you ever vomited blood?			
Frequent indigestion, heartburn, or reflux?			
Frequent constipation?			
Frequent diarrhea?			
Poor appetite or easily satiated?			
Blood in the stools?			
Hemorrhoids?			
Frequent use of laxatives?			
Bloating or fatigue after meals?			
Abdominal pain or cramping?			
Does stool or flatulence have an abnormally offensive odor?			
<b>GENITOURINARY:</b>			
Burning or pain on urination?			
Urinary frequency or urgency?			
Urinary incontinence?			
Do you have to wake frequently at night to urinate?			
Frequent bladder or kidney infections?			
Men, any prostate trouble?			
Men, any erectile dysfunction?			
Dribbling urine?			
Frequent yeast infections or "jock itch"?			
<b>MUSCULOSKELETAL:</b>			
Frequent or chronic back pain?			
Pain in the legs or feet?			
Scoliosis?			
Joint pain or stiffness?			
Trouble walking or weakness?			
Do you experience regular pain in your body?			
Physical Trauma or injury?			
Concussion or head trauma?			

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<b>CENTRAL NERVOUS SYSTEM:</b>	<b>Yes, Currently</b>	<b>Yes, Past</b>	<b>Never</b>
Frequent or severe headaches?			
Dizzy spells, fainting, or lightheadedness?			
Loss of concentration?			
Disorientation?			
Have you ever lost the ability to speak?			
Have you ever lost consciousness or suffered a concussion?			
Seizures or convulsions?			
Insomnia?			
<b>PSYCHOLOGICAL / MENTAL/ EMOTIONAL</b>			
Nervousness?			
Anxiety or panic attacks?			
Sadness or depression?			
Poor memory?			
Moodiness, irritability, or anger?			
Restlessness?			
Hospitalized for a psychological condition?			
Have you ever attempted suicide?			
Suicidal thoughts?			
Have you been diagnosed with a psychological condition?			

## WOMEN ONLY - GYNECOLOGY & PREGNANCY:

Please specify the number of: Births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

Age at first period: \_\_\_\_\_ Age at menopause: \_\_\_\_\_ Menopausal symptoms: \_\_\_\_\_

Regular or Irregular cycles? (circle one) Duration of flow (days): \_\_\_\_\_ Time between cycles (days): \_\_\_\_\_

Flow (Check one):  Excessive  Moderate  Scanty

PMS (Check one):  Severe  Moderate  Mild  Never

Symptoms: \_\_\_\_\_

Cramping (Check one):  Severe  Moderate  Mild  Never

Date of last period: \_\_\_\_\_ Method of birth control: \_\_\_\_\_

Gynecological History: Below, please check those that apply:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Breast lumps       | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> History of genital warts | <input type="checkbox"/> Painful orgasm              |
| <input type="checkbox"/> Vaginal discharge  | <input type="checkbox"/> Nipple discharge  | <input type="checkbox"/> Painful intercourse      | <input type="checkbox"/> Mother/Sister breast cancer |
| <input type="checkbox"/> Vaginal dryness    | <input type="checkbox"/> Vaginal itching   | <input type="checkbox"/> Water retention          | <input type="checkbox"/> IUD                         |
| <input type="checkbox"/> Infertility issues | <input type="checkbox"/> Abnormal PAP      | <input type="checkbox"/> Spotting between periods | <input type="checkbox"/> Hysterectomy                |

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## Clinic Fees and Payment Policies

We make every effort to minimize the cost of your medical care. Full payment is required at the time of service. We accept payment by cash, check or credit card (Visa, Mastercard, American Express). Payment plans are available in cases of financial hardship. Checks or charges that are denied for lack of funds will incur a fee of \$35.00 per transaction. Slight fee increases will occur in January of each year to accommodate increases in expenses. We are committed to providing economical, quality health care. Thank you for your patronage.

## Cypress Natural Medicine Fee Schedule

### **Naturopathic Medicine Appointments**

First Office Visit for Adult	\$270
First Office Visit for Child	\$180
High Complexity Visit	\$180
Moderate Complexity Visit	\$150
Low Complexity Visit	\$125

### **Craniosacral Therapy Appointments**

First Office Visit for Adult/Child	\$180
Return Office Visit for Adult	\$150
Return Office Visit for Child	\$90

### **BioSET™ Appointments**

First Office Visit	\$270
Return Office Visit	\$125

### **Acupuncture Appointments with Jen Gunst**

First Office Visit	\$200
Return Office Visit	\$100

### **Acupuncture Appointments with Sarah Fink**

First Office Visit for Adult	\$150
First Office Visit for Child	\$100
Return Office Visit for Adult	\$90
Return Office Visit for Child	\$65

### **Osteopathic Appointments**

First Office Visit for Adult	\$260
First Office Visit for Child	\$180
Return Office Visit	\$160

### **Other Services**

Emergency Pager Service (per call)	\$50
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## Telephone Consultations/House Calls

Telephone consultations are available for new and existing patients. All telephone consultations are billed at the same rate as in-person visits. House calls are also available for patients who are physically unable to visit the clinic. Standard office visit fees apply plus travel expenses.

## Cancellation Policies

Appointments cancelled with greater than 48 hours notice will incur no charge. A full office visit fee will be charged for failure to provide 48 hours notice of cancellation.

**I agree to payment according to the policies provided above.**

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**Patient / Guardian Signature**

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**Date**

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**Patient / Guardian Printed Name**