AWARENESS WELLNESS INC

Welcome!

Thank you for choosing Awareness Wellness for your whole-istic health needs. It is my goal to help empower you to achieve optimal health.

In order to give you the highest quality care **please fill out the enclosed forms with as much detail as possible and bring these forms to your first office visit.**

Your first visit will include a detailed review of your health history and your health goals. The first visit will last approximately 90 minutes**. PLEASE BRING IN ANY RECENT LAB WORK** from your physician, as well as, **all bottles of supplements and/or medications you are currently taking**, so we can utilize our time more effectively. Your second visit will include an individualized wellness plan based on your health goals and current research to help assist you towards optimal health. Please allow 30 minutes for your second visit.

If you are unable to keep your scheduled appointment time, please let me know at least 24 hours prior to the scheduled time. I will be glad to reschedule your visit.

Please note it is a fragrance-free office, **please refrain from wearing any perfumes or colognes on the day of your appointment.**

If you have any questions before your appointment, please do not hesitate to call me at 910-315-0905.

I look forward to meeting with you and having the opportunity to be a partner on your journey to optimal health.

Yours in health,

Jessica Patella ND

INFORMED CONSENT, FINANCIAL POLICY AUTHORIZATION AND POLICY STATEMENT

The below policies and informed consent is designed to inform you of our policies and it is important that you are fully aware of the laws surrounding Naturopathic Medicine in the state of North Carolina.

INFORMED CONSENT:

I, _____, hereby consent to receive consultation services of myself or my minor child from Awareness Wellness, Inc.

I understand that although Jessica Patella, N.D. holds a doctorate in naturopathic medicine from Southwest College of Naturopathic Medicine in Tempe, Arizona and is a licensed naturopathic physician in the State of Vermont, the State of North Carolina does not recognize naturopathy as a form of medicine. The title of "Dr." is used to indicate the achievement of a doctorate degree and does not imply that Dr. Jessica Patella is licensed to practice medicine in the State of North Carolina.
INITIAL _____

I understand that Awareness Wellness, Inc makes no representations, claims or guarantees regarding the efficacy of recommendations and/or consulting services. Recommendations are based upon a combination of education, experience and natural health literature of the staff of Awareness Wellness, Inc.
INITIAL _____

I understand that the consulting services provided are offered as an educational and informative consultation and are not meant to be used in the place of allopathic medical care. I agree that it is in my best interest, and my sole responsibility to retain an allopathic primary care physician (M.D.) to assess my health care needs and appropriate treatment. Awareness Wellness, Inc and it's staff do not diagnose illness or proclaim to treat, prevent, or cure illness.
INITIAL _____

I understand that Awareness Wellness, Inc makes nutritional supplements and other health products available. Many of these products are not available through retail outlets or the quality is superior to retail brands. These products are provided for the convenience of clients. I am in no way obligated to purchase these products from this office. I am free to purchase such products from any source(s) I wish. Awareness Wellness, Inc may profit from the sale of supplements and other products that are available to clients.
INITIAL _____

I agree to inform my practitioner immediately if:

- I am pregnant, as many supplements are contraindicated during pregnancy.
- If I experience any side effects from any medications or supplements I am taking.
- If I have any major changes in my health or prescriptive medications

INITIAL _____

My signature verifies that I have not been told to discontinue treatments with other medical specialists or other health care providers. My signature is being given prior to the rendering any service, advise, and/or recommendations whatsoever.
INITIAL _____

FINANCIAL POLICY AUTHORIZATION:

Awareness Wellness, Inc is a fee for service business. Clients are to assume all financial responsibility for the office visit. Consultations and services are not covered by any insurance plans. Full payment is expected at the time of services rendered. I understand that follow-up visits are billed based on complexity; they are not billed based on time. I understand a charge of $30.00 will be added for any bounced check. If a payment by check is not cleared due to insufficient funds, I understand Awareness Wellness, Inc will no longer accept personal checks from me.
INITIAL _____

PHONE SUPPORT POLICY:

Phone support is an aid to answering any questions or concerns that may arise, or to clarify instructions. This is not intended to take the place of an office visit. However, phone consultations that cover new material, require new information, take an extensive amount of time, or require a change in the current plan are considered substitutes for an office visit and will be billed for the same rate as the visit for which they substitute.
INITIAL _____

CANCELLATION POLICY:

If you are not able to keep your scheduled appointment, please notify us within 24 hours of the appointment. Appointments missed for which proper 24 hour advance cancellation notice is given will not be charged to you. Additionally, there will be no charge for the first missed appointment in which you fail to give proper notification of cancellation. However, if you fail to give proper notification of cancellation and miss your scheduled appointment a second time, a fee of 50% of your scheduled visit will be charged. Upon the third occurrence, and all additional occurrences thereafter, in which you fail to give proper notification for cancellation of an appointment, a fee of 100% of your scheduled visit will be charged. If the missed appointment or late cancellation is on a follow-up visit you will be charged based on the Comprehensive follow-up charge of $175.00.
INITIAL _____

I acknowledge that I have read and understood the contents of this agreement and have executed it freely and willingly.
INITIAL _____

By entering your signature below you are acknowledging that you understand all terms, verbiage (language) and concepts herein.

_____ _____
(Client or Guardian Signature) (Date)

_____
(Printed name)

Confidential New Client Information

Date:_____

New Client Information

Name:_____

DOB: ___/___/___ Age: _____ Sex: ☐ Male ☐ Female

Address:_____
Street City State Zip

Phones (Check Preferred) ☐ Home: _____-_____-_____ ☐Cell: _____-_____-_____

☐Work: _____-_____-_____ May we leave messages at your preferred phone? Y N

Email: _____

Primary Care Physician: _____ Physician's Phone:_____-_____-_____

Relationship Status: Single Married Partnership Separated Divorced Widow(er)

Spouse/Partner's Name:_____

Children (Names/Ages):_____

Emergency Contact:_____ Relationship to you:_____

Emergency Contact Phone: _____-_____-_____

Occupation:_____ Employer:_____

Hobbies/Interests:_____

Referral Information

How did you hear about us?

☐ Referral from an existing client (who)? _____

☐ Referral from another health care provider (who)? _____

If you were referred may we have your permission to thank the person that referred you?

☐ Yes ☐ Yes, but keep my name anonymous ☐ No

☐ Internet search ☐ Phone Book ☐ Newspaper/Magazine

☐ Speaking event (Which one)? _____

☐ Other (please specify) _____

Client Name: _____ DOB:____/____/____

Current Health Information

List in order of importance what your health concerns are:

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

Current Medications: Please include all prescription and over-the-counter medications

Medication	Dose/Frequency	For how long?	For what reason?

Current Supplements: Please include all vitamins, herbs, homeopathy or other supplements

Supplement	Brand	Dose/Frequency	For how long?	For what reason?

Client Name: _____ DOB:____/____/____

List **Y**es **(Y), N**o **(N)**, or **P**ast **(P)** regarding the use of the following:

Antacids: Y N P **Steroids:** Y N P **Soda:** Y N P **Ounces per day?**_____
Analgesics: Y N P **Laxatives:** Y N P **Coffee:** Y N P **Cups per day?**_____
Smoking: Y N P **Packs per day & number of years?** _____
Alcohol: Y N P **How often & how much?**_____
Recreational Drugs: Y N P **Addictions and/or treatment for addictions?** Y N P

Past Medical History

List previous surgeries & hospitalizations, including date occurred:

1._____ 2._____

3._____ 4._____

5._____ 6._____

Please note when and why you have had each of the following:

X-Rays:_____ MRI/Cat Scans: _____

Ultrasounds: _____ TB test:_____

HIV test: _____ Hepatitis C: _____

Last Eye Exam:_____ Last Dental Visit: _____

Last time you had blood work completed: _____

Did you have the following **D**isease **(D)**, Get **I**mmunized **(I),** or **N**either **(N):**

Measles:	D I N	**Mumps:**	D I N	**Rubella:**	D I N
Tetanus:	D I N	**Shingles:**	D I N	**Chicken Pox:**	D I N
Hepatitis B:	D I N	**HPV (Gardasil):**	D I N	**Hemophilis (Hib):**	D I N
		Whooping Cough:	D I N	**German Measles:**	D I N

Any vaccine reactions?_____

Allergies

List all known drug allergies and reaction from taking the drug:

_____

_____

List any known food allergies:

_____

_____

Family History

Family Member	Age if living	Age of Death	Reason of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

Please Circle "Y" for Yes if you or your family have had any of the following conditions:

	You	Father	Mother	Siblings	Grandparents	Children
Cancer **	Y	Y	Y	Y	Y	Y
High Blood Pressure	Y	Y	Y	Y	Y	Y
Heart Disease	Y	Y	Y	Y	Y	Y
Heart Attack	Y	Y	Y	Y	Y	Y
Stroke	Y	Y	Y	Y	Y	Y
Diabetes	Y	Y	Y	Y	Y	Y
High Cholesterol	Y	Y	Y	Y	Y	Y
Autoimmune Disease	Y	Y	Y	Y	Y	Y
Thyroid Disease	Y	Y	Y	Y	Y	Y
Obesity	Y	Y	Y	Y	Y	Y
Osteoporosis	Y	Y	Y	Y	Y	Y
Arthritis	Y	Y	Y	Y	Y	Y
Alcoholism	Y	Y	Y	Y	Y	Y
Anxiety	Y	Y	Y	Y	Y	Y
Depression	Y	Y	Y	Y	Y	Y
Allergies	Y	Y	Y	Y	Y	Y
Asthma	Y	Y	Y	Y	Y	Y
Mental Illness	Y	Y	Y	Y	Y	Y

**Please describe the type of cancer (if any):_____

_____

Client Name: _____ DOB:____/____/____

Social History

Do you enjoy your job?_____

How many hours worked per week? _____

What are your hobbies (if any)?_____

Quality of relationship with significant other? _____

Please describe your religious/spiritual practice: _____

_____

History of mental/physical/emotional abuse?_____

Lifestyle

Exercise

How often do you exercise?_____ For how long?_____

What type of exercise?_____

Sleep/Fatigue

How long per night?_____ Difficulty falling/staying asleep?_____

Do you wake refreshed?_____ Rate your energy level (1=low 10=high):_____

Do you experience fatigue? _____If so, when? ☐ Morning ☐ Afternoon ☐ Evening

Does fatigue limit your daily activities?_____

Weight

Current weight: _____ Your height: _____ Your ideal weight: _____

Have you experienced any unintentional weight loss or gain in the past 6 months?_____

Toxin Exposure

Did you grow up near any refinery, polluted area, or in a home with lead paint?_____

Have you had a job where you were exposed to solvents, heavy metals, or other toxic materials?

_____

Have you ever had health problems when you put in new carpeting, painted your home, put in new cabinets or did other refurbishing?_____

Are you particularly sensitive to perfumes, gasoline, or other vapors? _____

Do you use pesticides, herbicides or other chemicals in or around your home? _____

How Committed are you towards making changes: ☐ I will do whatever it takes ☐ I will make some changes ☐ I am willing to consider changes

Client Name: _____ DOB:____/____/____

Review of Systems

Please Indicate if you have had problems with any of the following **CIRCLE P for Past** or **C for Current**

Skin		
Rash	P	C
Hives	P	C
Psoriasis	P	C
Eczema	P	C
Dry skin	P	C
Acne	P	C
Moles/warts	P	C
Head		
Headache	P	C
Migraine	P	C
Head Injury	P	C
Dandruff	P	C
Hair Loss	P	C
Dizziness/Vertigo	P	C
Ears/Eyes/Nose/Throat		
Ear aches/infections	P	C
Tinnitus (ringing in ears)	P	C
Double vision	P	C
Blurry Vision	P	C
Cataracts	P	C
Glaucoma	P	C
Dry/Watery eyes	P	C
Frequent Colds	P	C
Seasonal Allergies	P	C
Post Nasal Drip	P	C
Nosebleeds	P	C
Sinus pain/infections	P	C
Sore Throat	P	C
Cold sores	P	C
Voice Hoarseness	P	C
Swollen Glands	P	C
Respiratory		
Asthma	P	C
Bronchitis	P	C
Shortness of breath	P	C
Coughing	P	C
Wheezing	P	C
Cardiovascular		
High Blood Pressure	P	C
Low Blood Pressure	P	C
Arrhythmias	P	C
Edema	P	C
Rheumatic Fever	P	C
Murmurs	P	C
Palpitations	P	C
Chest Pain	P	C

Urinary Tract		
Frequent Infections	P	C
Urgency/Frequency	P	C
Incontinence	P	C
Kidney stones	P	C
Pain with urination	P	C
Discharge/Blood in urine	P	C
Gastrointestinal		
Heartburn/Acid reflux/GERD	P	C
Ulcer	P	C
Bloating	P	C
Excessive flatulence	P	C
Nausea/Vomiting	P	C
Constipation	P	C
Diarrhea	P	C
Recent BM change	P	C
IBS	P	C
Crohn's/Ulcerative Colitis	P	C
Gallstones	P	C
Gallbladder disease	P	C
Hepatitis/Liver disease	P	C
Cirrhosis	P	C
Pancreatitis	P	C
Musculoskeletal		
Arthritis	P	C
Joint Pains	P	C
Joint Stiffness	P	C
Gout	P	C
Muscle aches/pain	P	C
Weakness	P	C
Tremors	P	C
Leg Cramps	P	C
Nervous System		
Paralysis	P	C
Tingling/numbness	P	C
Seizures	P	C
Sciatica	P	C
Fainting	P	C
Endocrine		
Diabetes (type I or II)	P	C
Thyroid Disease	P	C
Hormonal Problems	P	C
Mental/Emotional		
Suicidal	P	C
Fear/Panic	P	C
Anger/irritability	P	C
Psych Hospitalization	P	C

Women Only

Age of first menstrual period: _____ Date of last menstrual period:_____

How many days between periods: _____ How long does your period last: _____

Form of birth control:_____ Age at onset of Menopause: _____

# of pregnancies:_____ # of Births:_____ # of Miscarriages/Abortions:_____

Have you experienced any of the following? Circle P for Past or C for Current

Prolonged bleeding	P	C
Heavy flow	P	C
Light flow	P	C
Menstrual cramps	P	C
Uterine Fibroids	P	C
Endometriosis	P	C
Ovarian cysts	P	C
Yeast Infections	P	C
Abnormal discharge	P	C
Change in menses (regularity, flow, pain)	P	C

Hair growth on face	P	C
Pain with intercourse	P	C
Change in libido	P	C
Hot flashes	P	C
Hormone use	P	C
Osteoporosis	P	C
Osteopenia	P	C
Breast pain/tenderness	P	C
Fibrocystic breasts	P	C
Sexually transmitted disease	P	C

When was your last:

Pap smear:_____ Breast Exam:_____ Mammogram:_____ Bone Density:_____

Any irregular results from any of these tests/exams?_____

Men Only

Have you experienced any of the following? Circle P for Past or C for Current

Testicular pain/swelling	P	C
Hernia	P	C
Discharge from urethra	P	C
Difficulty Urinating	P	C
Incomplete urination	P	C
Rectal burning/itching	P	C
BPH	P	C

Change in sex drive	P	C
Erectile difficulty	P	C
Prostate Cancer	P	C
Testicular Cancer	P	C
Sexually transmitted disease	P	C

When was your last:

Rectal/Prostate Exam: _____ PSA Blood test:_____ Stool check for blood: _____

Any irregular results from any of these tests/exams?_____