Danielle Schwaderer, ND
Sonoma Roots Natural Medicine
651 1st St West, Suite B
Sonoma, CA 95476
(707) 996-4656
www.SonomaRoots.com

New Patient Checklist:

Naturopathic Medicine

- ☐ Please mail, email, or drop off completed **new patient intake packet** one week prior to new patient appointment.
- ☐ Allow 60-90 minutes for your first visit.
- ☐ **Parking is available to patients in the underground parking lot. Please park in business guest parking spots.**
- ☐ Please be courteous and **call us** if you're running late.
- ☐ All **payments** are due at the time of service. We accept cash, check, and all major credit cards.

Please **bring** to your first appointment the following items:

- ☐ Recent blood work, imaging, and/or medical records if necessary.
- ☐ A **list of all medications & Supplements** you are currently taking (including dose, frequency, and duration). Or bring the bottles to the visit.

Thank you! We look forward to meeting you!

ADULT NATUROPATHIC NEW PATIENT INFORMATION AND HEALTH HISTORY

Patient's Name: _____ _____
First Middle Last

Date of Birth: _____ Age: _____ Male / Female (circle)

In order to provide the best natural medical care, Dr. Danielle requests that you fill out the following information to the best of your ability. Your physical, mental, and emotional information along with family history, lifestyle, and health expectations will help her understand your individual needs and allow us to properly guide you as you continue your journey to wellness.

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Information (**Please circle preferred number for contacting you**):

Home telephone: _____ Email address: _____

Cell phone: _____ ☐ Please do not add me to mailing list

Please check box regarding how the office of Dr. Danielle Schwaderer may contact you:

- ☐ Danielle Schwaderer, ND may leave a detailed message with identifying information.
- ☐ Danielle Schwaderer, ND may only state who is calling and contact phone number.
- ☐ Danielle Schwaderer, ND may only leave a phone number and may not state who is calling.

Number and ages of children you have: _____

Occupation: _____ Hours per week: _____

Employer: _____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ In a committed relationship ☐ Widowed

With whom do you live? ☐ Spouse ☐ Partner ☐ Children ☐ Parents ☐ Roommates ☐ Alone

Spouse/partner name: _____ His/Her telephone: _____

Emergency contact: _____ Relationship: _____

Emergency contact telephone number: _____

How did you hear about us? _____

Are you currently receiving health care? Y N **If yes, please provide contact information below:**

Name of provider/ clinic: _____

Address: _____

If no, why have you discontinued care? _____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the office of Danielle Schwaderer, ND to release information necessary to secure payment.

Signature: _____ Date: _____

PERSONAL HEALTH HISTORY

When did you last visit a doctor's office, medical clinic, or hospital? Please explain: _____

_____

What hospitalizations or surgeries have you had? Please list date_____

_____

_____

What are your primary health concerns? Please list in the order of their importance to you.

1) _____ Past treatment given: _____
2) _____ Past treatment given: _____
3) _____ Past treatment given: _____

What are the primary expectations you have for your visit today?

_____

_____

ALLERGIES: Are you aware of any allergies to foods, drugs, or other environmental allergens (cats, mold, dust)? If yes, please explain: _____

_____

MEDICATIONS AND SUPPLEMENTS:

Do you take or use any of the following?

☐ Pain relievers (aspirin, ibuprofen)	☐ Antacids	☐ Digestive Aids
☐ Diet pills, appetite suppressants	☐ Laxatives	☐ Anti-depressants
☐ Cortisone (pills or cream)	☐ Sleeping pills	☐ Tranquilizers
☐ Thyroid medication	☐ Antibiotics	☐ Birth control pills

Please list any prescription medications, over-the-counter medications, or other supplements you are taking:

_____

_____

_____

GENERAL:

Height: _____ Current Weight: _____lbs. Weight 1 year ago: _____lbs.

Maximum weight: _____lbs. When? _____

ENERGY:

Average daily energy: (circle) 1 2 3 4 5 6 7 8 9 10

Generally, what time of day is your energy the best? _____ The worst? _____

STRESS:

Current level of stress: (circle) 1 2 3 4 5 6 7 8 9 10

FAMILY HISTORY:

Mother
Age:_____ Health_____
Age at death (if deceased)_____ Cause of death _____
Father
Age:_____ Health_____
Age at death (if deceased)_____ Cause of death _____
Siblings
Age(s):_____Health_____
Age at death (if deceased)_____ Cause of death _____
Children
Age:_____ Health_____
Age at death (if deceased)_____ Cause of death _____

Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.
□Anemia □Arthritis □Asthma □Cancer □Diabetes □Epilepsy □Gallbladder disease □Hay fever
□Heart Disease □High blood pressure □Kidney Disease □Mental Illness □Multiple Sclerosis
□Parkinson's □Alzheimer's □Stroke □Thyroid disorders

Please list other significant personal or family medical history not listed above:

_____

_____

REVIEW OF SYSTEMS:
Please circle Y =Yes, present condition P = Problem of the past N = No, never had the problem

Head			
Headaches	Y	P	N
Migraines	Y	P	N
Dizziness	Y	P	N
Ears			
Ringing	Y	P	N
Impaired hearing	Y	P	N
Earaches	Y	P	N
Neck			
Swollen glands	Y	P	N
Goitre	Y	P	N
Pain / stiffness	Y	P	N
Skin			
Rashes, Eczema	Y	P	N
Loss of hair	Y	P	N
Acne, boils	Y	P	N
Itching	Y	P	N
Hives	Y	P	N
Color changes	Y	P	N

Musculoskeletal			
Joint pain	Y	P	N
Muscle spasms	Y	P	N
Weakness	Y	P	N
Arthritis	Y	P	N
Broken bones	Y	P	N
Sciatica	Y	P	N
Eyes			
Blurred vision	Y	P	N
Eye pain/strain	Y	P	N
Dryness	Y	P	N
Excess tearing	Y	P	N
Nose/ Sinuses			
Sinus problems	Y	P	N
Hayfever	Y	P	N
Nose bleeds	Y	P	N
Frequent colds	Y	P	N
Mouth / Throat			
Gum problems	Y	P	N
Frequent sore throats	Y	P	N
Jaw clicks	Y	P	N

Please circle Y =Yes, present condition P = Problem of the past N = No, never had the problem

Respiratory

Asthma	Y	P	N
Wheezing	Y	P	N
Cough	Y	P	N
Breathing pains	Y	P	N
Sputum	Y	P	N
Pneumonia	Y	P	N
Emphysema	Y	P	N
Tuberculosis	Y	P	N
Shortness of Breath	Y	P	N
At night	Y	P	N
Lying down	Y	P	N

Cardiovascular

Heart disease	Y	P	N
Chest Pain	Y	P	N
Blood clots	Y	P	N
Fainting	Y	P	N
Rheumatic fever	Y	P	N
Murmur	Y	P	N
High blood pressure	Y	P	N

Gastrointestinal

Diarrhea	Y	P	N
Constipation	Y	P	N
Abdominal pain	Y	P	N
Ulcers	Y	P	N
Hemorrhoids	Y	P	N
Gallbladder disease	Y	P	N
Heartburn/Reflux	Y	P	N
Blood in stool	Y	P	N

How many bowel movements per day? _____
Have you had a colonoscopy? _____
When? _____

Urinary

Incontinence	Y	P	N
Painful urination	Y	P	N
Frequent infections	Y	P	N
Kidney stones	Y	P	N
Frequency night	Y	P	N

Blood / Peripheral vascular

Anemia	Y	P	N
Leg pain	Y	P	N
Cold hands/feet	Y	P	N
Easy bruising	Y	P	N
Varicose veins	Y	P	N

Neurological

Fainting	Y	P	N
Paralysis	Y	P	N
Numbness/tingling	Y	P	N
Seizures	Y	P	N
Weakness	Y	P	N
Loss of memory	Y	P	N

Emotional

Anxiety	Y	P	N
Depression	Y	P	N
Mood swings	Y	P	N
Nervousness	Y	P	N

Endocrine

Hypothyroid	Y	P	N
Cold intolerance	Y	P	N
Excessive thirst	Y	P	N
Hyperthyroid	Y	P	N
Heat intolerance	Y	P	N
Excessive hunger	Y	P	N

Male reproductive (males only)

Hernias	Y	P	N
Prostate issues	Y	P	N
Testicular pain	Y	P	N
Sexual difficulty	Y	P	N
Premature ejaculation	Y	P	N
STD's	Y	P	N
Discharge	Y	P	N

Female reproductive (females only)

Age of first menses _____ Date of last menses _____
Length of cycle _____ Duration of menses _____
Date of last annual exam _____

Painful menses	Y	P	N	Heavy flow	Y	P	N	Fertility issues	Y	P	N
Tender breasts	Y	P	N	Cycles regular	Y	P	N	Sexually active	Y	P	N
Abnormal pap	Y	P	N	PMS	Y	P	N	Bleeding between cycles	Y	P	N
Sexual difficulty	Y	P	N	Breast lump(s)	Y	P	N	Menopausal symptoms	Y	P	N
Nipple discharge	Y	P	N	Do self breast exams	Y	P	N				
Birth control	Y	P	N	If yes, what type? _____							

Number of pregnancies _____ Number of live births _____
Number of miscarriages _____ Number of abortions _____

LIFESTYLE:

What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

_____

_____

What behaviors or lifestyle habits do you currently engage in that you believe are **self-destructive?** How often do you engage in these activities? _____

_____

What do you **love** to do with your time? _____

OPTIONAL: Your needs as a patient of Danielle Schwaderer, ND:

Why did you choose Dr. Schwaderer? _____

_____

What do you know about our approach to healthcare?_____

_____

_____

What long term expectations do you have from working with Dr. Danielle? _____

_____

_____

What expectations do you have of me personally as your doctor? _____

_____

Is there anything else you would like us to know in order to better serve you?

_____

_____

Consent for Treatment

Naturopathic Medicine

I hereby request and consent to the performance of naturopathic treatments and other procedures within the scope of the practice of naturopathic medicine on myself (or on the patient named below, for I am legally responsible) by Danielle Schwaderer, ND.

I understand that methods of treatment may include, but are not limited to: homeopathy, botanical medicine, nutritional counseling, flower essence therapy, intravenous and intramuscular nutritional supplementation, energy medicine, bio-identical hormone replacement, physical medicine, and massage. I understand that all treatments should be consumed according to the instructions provided orally and in writing. I will immediately notify the office of Dr. Schwaderer with any unanticipated or unpleasant effects associated with the treatment.

I have been informed that naturopathic medicine generally provides safe methods of treatment, yet the potential for side effects exists. The herbs, remedies and nutritional supplements that have been recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy or breastfeeding. I will notify the office of Danielle Schwaderer, ND if I am or become pregnant or am currently breastfeeding.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

I have fully read and understand the above agreements.

_____ _____

Signature (Patient 18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date

Dr. Danielle Schwaderer, ND
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Notice of Privacy Practices

The purpose of this notice is to inform you of the office of Danielle Schwaderer, ND uses and discloses your protected health information. Your protected health information is information that you have given to us regarding your health condition and treatment, our notes regarding your health condition and treatment and information that we have gathered from other sources regarding your health condition and treatment.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
With respect to your protected health information, Danielle Schwaderer, ND is required by law to
1.) maintain your privacy and confidentiality
2.) provide you with explanation of our privacy practices
3.) provide you with information about your rights and how to exercise those rights
4.) abide by the terms of this Notice.

STANDARD PRACTICE DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION
Please be aware that the office of Danielle Schwaderer, ND makes every effort possible to protect your privacy and the confidentiality of your protected health information. We may disclose your healthcare information for the following reasons:

- Treatment: We may disclose your protected health information to other healthcare professionals for the purpose of treatment, when the patient has signed a release form. For example, it may be necessary to seek consultation regarding your condition from other healthcare providers associated closely with Dr. Danielle Schwaderer
- Healthcare Operations: We may review your protected health information in order to meet our goals as a healthcare provider.

ADDITIONAL DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION
We may use or disclose your protected health information, as required by law, in the following circumstances:

- Public Health: As required by law, we may disclose your protected health information to public health authorities for purposes related to: preventing or controlling disease, reporting births or deaths, infection exposure, reporting child abuse, neglect or domestic violence, audits by oversight agencies, and concerns regarding products or medical devices to the Food and Drug Administration. Law Enforcement, Court and Administrative Agencies: We may disclose your protected health information to listed agencies in order to comply with a subpoena, court order or search warrant or to protect the safety of the public.
- Emergency Situations: We may use or disclose your protected health information in order to provide treatment to you under emergency circumstances. Also, in an emergency, we may determine that it is in your best interest to disclose information to your family or friends. We will only disclose the protected health information that is directly relevant to that person's involvement in your healthcare.
- Coroners and Medical Examiners: We may disclose your protected health information to coroners or medical examiners, as necessary, in order to facilitate the duties of their jobs.
- Worker's Compensation: We may disclose your protected health information to your employer in order to comply with state worker's compensation program laws.
- Specialized Government Functions: We may disclose your health information for military, national security, and government benefits purposes, as required by these agencies.

AUTHORIZED DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Third party uses and disclosures other than for the above-referenced purposes will be made only with your written authorization. As provided by law, this authorization may be revoked at any time. Revocations will be honored as of our receipt date. Examples of such disclosures include the following:

- State disability claims.
- Research – must be approved by an Institutional Review Board.
- Release of medical records to yourself or healthcare providers.

Please be aware that once your protected health information has been disclosed due to your written permission, it may no longer be protected under these privacy laws.

It is Dr. Danielle Schwaderer's policy to call your home from time to time to confirm appointment times or check in when communication has been delayed. We may leave a reminder message on your answering machine or with a person answering the phone – no personal health information will be disclosed. You may request an alternative method of communication by Dr. Danielle Schwaderer at any time.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

The office of Dr. Danielle Schwaderer reserves the right to amend this Notice of Privacy Practices at any time in the future. These changes may be required by federal or state laws. New provisions will be effective for all information that we maintain. In the event of amendments, we will make a revised Notice of Privacy Practices available to you.

YOUR PROTECTED HEALTH INFORMATION RIGHTS

By law, you have the following rights with respect to your protected health information:

- The right to request restrictions on certain uses and disclosures of your health information. We may honor this request, however, the office of Danielle Schwaderer, ND is not required to agree to the restriction that you requested.
- The right to receive confidential communications of your protected health information.
- The right to inspect and copy your health information.
- The right to request that Dr. Danielle Schwaderer amend your protected health information. Please know, however, that we are not required to agree to this request.
- The right to receive a summary or accounting of Danielle Schwaderer's disclosures of your protected health information.
- The right to a printed copy of this Notice.

EXERCISING YOUR PROTECTED HEALTH INFORMATION RIGHTS

Comments, concerns, or complaints regarding your privacy rights or Dr. Danielle Schwaderer's privacy practices may be submitted to the office of Danielle Schwaderer, ND. If she is not available, you may schedule an appointment to either meet or speak with her at her next available appointment. Our commitment to you and the quality of your healthcare will not be altered should you choose to exercise these rights.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

Office of Civil Rights U.S. Department of Health and Human Services
200 Independence Avenue S.W. Room 509F
HHH Building Washington, D.C. 20201

Effective date of this notice: 12/12/2010

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HIPAA Notice of Privacy Practices and Consent

I hereby consent to the use and disclosure of my protected health information by Danielle Schwaderer, ND, for the purposes of treatment, payment and healthcare operations, or as otherwise required by law. The office of Dr. Danielle Schwaderer has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my protected health information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.

I have the right to request restrictions to the usage and disclosure of my protected health information. I have the right to request an alternative to the standard method of communication of my protected health information. I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by the office of Danielle Schwaderer, ND at the following address:

651 1st St W, Suite B Sonoma, CA 95476

I understand that while the office of Dr. Danielle Schwaderer may honor these requests, they are not required by law to do so. I am aware that Danielle Schwaderer, ND reserves the right to change the terms of her Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, the office of Dr. Danielle Schwaderer will make available a revised Notice of Privacy Practice for my review.

I have fully read and understand the above agreements and authorizations.

_____ _____

Signature (Patient 18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date

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STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree to the following general responsibilities:

I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including apothecary items. I am responsible for providing all accurate and thorough documentation required to support any discounts I am receiving. I acknowledge that I am financially responsible for all charges.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the office of Dr. Danielle Schwaderer to release information necessary to secure payment.

There will be a flat fee of $50 for any naturopathic appointment not cancelled within 24 hours of that appointment.

I understand and agree that Danielle Schwaderer, ND operates as a cash based practice and does not accept any form of insurance. A super bill will be provided per visit with all necessary information in order for the patient to submit for insurance re-reimbursement, when requested by patient. Danielle Schwaderer, ND and office staff are not responsible for ensuring insurance reimbursement.

I have made myself familiar with the return policy of Sonoma Roots Natural Medicine for supplements and goods purchased. I understand that supplements can be returned in unopened condition with the original receipt within 30 days of purchase.

I have fully read and understand the above agreements and authorizations.

_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date