



# Empowered Vitality

Health is to the Body as the Soul is to Life©

## Patient Intake Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Sex: M F  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Highest level of education: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hours work/week: \_\_\_\_\_  
 Marital Status: Single Married Separated Divorced With Partner Widow(er)  
 Person to call in case of Emergency: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
 Phone number contact for them: \_\_\_\_\_  
 Regular Physician: \_\_\_\_\_  
 How did you hear about Dr. Tehranian: \_\_\_\_\_

List in Order of Importance what your concerns are:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Last time you had blood work done and with what doctor: \_\_\_\_\_

## Family History

Father Mother Siblings Grandparents Spouse Children

Age if living

Age when died

Reason for death

|                      |     |     |     |     |     |     |     |
|----------------------|-----|-----|-----|-----|-----|-----|-----|
| Cancer (type if app) | Y N | Y N | Y N | Y N | Y N | Y N |     |
| High Blood Pressure  | Y N | Y N | Y N | Y N | Y N | Y N |     |
| Heart Attack/stroke  | Y N | Y N | Y N | Y N | Y N | Y N |     |
| Heart disease        | Y N | Y N | Y N | Y N | Y N | Y N |     |
| Asthma/allergies     | Y N | Y N | Y N | Y N | Y N | Y N |     |
| Mental illness       | Y N | Y N | Y N | Y N | Y N | Y N |     |
| TB                   |     | Y N | Y N | Y N | Y N | Y N | Y N |
| Auto-immune disease  | Y N | Y N | Y N | Y N | Y N | Y N |     |

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|                   |     |     |     |     |     |     |
|-------------------|-----|-----|-----|-----|-----|-----|
| Diabetes Mellitus | Y N | Y N | Y N | Y N | Y N | Y N |
| Osteoporosis      | Y N | Y N | Y N | Y N | Y N | Y N |

List All Surgeries and Hospitalizations—including date occurred:

- |    |    |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

Please Note When and Why You Had Each of The Following:

- X-rays:
- MRI/Cat Scans:
- Ultrasounds:
- Accidents:

Please List All Sensitivities/Allergies/Reactions

- Drugs:
- Foods:
- Environment:

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

|                 |       |                   |       |
|-----------------|-------|-------------------|-------|
| Measles:        | D I N | Diphtheria:       | D I N |
| Mumps:          | D I N | Tetanus:          | D I N |
| Rubella:        | D I N | Whooping Cough:   | D I N |
| Chickenpox:     | D I N | Hemophilus (Hib): | D I N |
| German Measles: | D I N | Hepatitis B:      | D I N |

Any vaccination reactions:

List Yes, No, or Past regarding use of the following:

|                              |                               |
|------------------------------|-------------------------------|
| Antacids: Y N P              | Steroids: Y N P               |
| Smoking: Y N P               | Packs per day or in the Past: |
| Analgesics: Y N P            | Laxatives: Y N P              |
| Coffee: Y N P                | Cups per day if Yes/Past:     |
| Soda Pop: Y N P              | Ounces per day if Yes/Past:   |
| Alcohol: Y N P               | How often & how much:         |
| Any alcohol addiction: Y N P |                               |
| Any alcohol treatment: Y N P |                               |
| Recreational drugs: Y N P    |                               |
| Any drugs addiction: Y N P   |                               |
| Any drug treatment: Y N P    |                               |

List all Prescription Medicines and Nutrient Supplement/Herbs Taking:

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Canker sores: Y N P  
 Sore throat: Y N P  
 Dentures: Y N P  
 Loss of taste: Y N P

## Mouth/Throat:

Cold sores: Y N P  
 Gum disease: Y N P  
 Cavities: Y N P  
 Hoarseness: Y N P

Stiffness: Y N P  
 Full movement: Y N P

## Neck:

Swollen glands: Y N P  
 Tension: Y N P

Cough: Y N P  
 Shortness of breath with exertion: Y N P  
 Shortness of breath sitting/lying: Y N P  
 COPD: Y N P  
 Wheezing: Y N P

## Respiratory:

TB: Y N P  
 Bronchitis: Y N P  
 Pneumonia: Y N P  
 Asthma: Y N P  
 Painful breathing: Y N P

High blood pressure: Y N P  
 Low blood pressure: Y N P  
 Arrhythmias: Y N P  
 Edema: Y N P  
 Angina: Y N P

## Cardiovascular:

Rheumatic Fever: Y N P  
 Murmurs: Y N P  
 Palpitations: Y N P  
 Chest pain: Y N P  
 CHF: Y N P

Heartburn: Y N P  
 Indigestion: Y N P  
 Bloating: Y N P  
 Nausea: Y N P  
 Vomiting: Y N P  
 Change in Appetite: Y N P  
 Pancreatitis: Y N P  
 Bloody Stool: Y N P  
 Pancreatitis: Y N P

## Gastrointestinal:

Bowel movement frequency:  
 Recent change in BM: Y N P  
 Diarrhea or constipation: Y N P  
 Hemorrhoids: Y N P  
 Gall bladder disease: Y N P  
 Liver disease: Y N P  
 Ulcer: Y N P  
 Hernia: Y N P  
 Jaundice: Y N P

Incontinence: Y N P  
 Frequent infections: Y N P  
 Urgency: Y N P

## Urinary Tract:

Pain with urination: Y N P  
 Kidney stones: Y N P  
 Discharge/blood: Y N P



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Testicular pain/swelling: Y N P  
Hernia: Y N P  
Discharge: Y N P  
Impotency: Y N P

**Male Genitalia:**  
Sexually active: Y N P  
Sexually transmitted disease: Y N P  
Prostate disease/symptoms: Y N P  
Sexual orientation: Hetero Homo Bi

Age periods began:  
How long periods last:

**Women's Health:**  
How often period occurs:  
Menopausal since what age:

Periods:  
Heavy Bleeding: Y N P  
Cramping: Y N P  
Pain: Y N P  
PMS: Y N P  
Food Cravings: Y N P  
Last Pap Smear:  
Diagnosis:  
Any abnormal paps: Y N P  
When was abnormal: Y N P

Times Pregnant:  
How many births:  
Miscarriages:  
Abortions:  
Sexual Active: Y N P  
Healthy Libido: Y N P  
Pain With Intercourse: Y N P  
Dry Vagina: Y N P  
Vaginitis: Y N P

Any Birth Control (please list types and ages used):  
Sexually Transmitted Diseases: Y N P  
Mammography: Y N P  
Dexa Scan: Y N P If Yes, what were the results:  
Use of Hormones: Y N P Please list name(s):

Pain: Y N P  
Discharge: Y N P

**Breasts:**  
Lumps/Masses: Y N P  
Last Mammogram:

Weakness: Y N P  
Stiffness: Y N P  
Tremors: Y N P

**Musculoskeletal:**  
Arthritis: Y N P  
Leg cramps: Y N P  
Pain: Y N P

Paralysis: Y N P  
Tingling/numbness: Y N P  
Seizures: Y N P  
Stroke: Y N P

**Nervous:**  
Sciatica: Y N P  
Carpal tunnel syndrome: Y N P  
Fainting: Y N P

Depression: Y N P  
Suicidal: Y N P  
Anxiety: Y N P

**Mental/Emotional:**  
Anger/irritability: Y N P  
High-strung/tense: Y N P  
Fear/Panic: Y N P



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## Exercise:

How often:

What type(s):

For How long:

## Hobbies:

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## Sleep:

How long per night:

If you wake up frequently, what is the reason:

Nightmares: Y N P

Wake refreshed: Y N P

Must Nap during the day: Y N P

Sleep walk: Y N P

Grind Teeth: Y N P

Snore: Y N P

## Food:

Appetite Good?: Y N P

Foods crave:

Foods Dislike:

Foods that don't sit well:

Breakfast:

Lunch:

Dinner:

Fluid Intake (type and quantity):

## Toxin Exposure:

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Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?

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

Are you particularly sensitive to perfumes, gasoline, or other vapors?  
Do you use pesticides, herbicides, other chemicals around your home?

## Social Life:

Enjoy job?: Y N P

Active Spiritual practice: Y N P

Quality of most significant relationship?

History of sexual, mental/emotional, physical abuse?: Y N

If so, at what age and by whom?:

What is your greatest health concern?

How does it limit you the most?

How committed are you towards making valuable changes: Little Moderately Very

## Physician Use Only

Assessment:

Plan:

F/U:

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Physician Signature



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## Notice of Privacy Practices

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### **Commitment to your privacy:**

This practice is dedicated to maintaining the privacy of your health information. Healthcare practices are required by law to maintain the confidentiality of your health information. Also in accordance with the law, you must be provided the following information:

### **Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary, to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Disclosures will only be made to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation or similar programs.

### **Your rights regarding your health information:**

1. You can request that this practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask to be contacted at home, rather than work. Any reasonable requests will be accommodated.
2. You can request a restriction in the use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that disclosure of your health information be restricted to only certain individuals involved in your care or the payment for your care, such as family member and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.



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- 3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. Nirvana, c/o Birch St #206, NB, CA 92660 Note: This request must be responded to within 30 days.
- 4. You may ask that your health information be amended if you believe it is incorrect or incomplete, and as long as the information is kept by or for this practice. To request an amendment, your request must be made in writing submitted to Dr. Nirvana, ND 4341 Birch St #206, NB, CA 92660. You must provide a reason that supports your request for an amendment.

Note: This practice must respond to your request within 60 days. If a physician believes the information is complete and accurate, that physician can refuse to make any changes.

- 5. You are entitled to receive a copy of the Notice of Privacy Practices. You may ask us to give you a copy of the Notice at any time. To obtain copy of the notice, contact Dr. Nirvana.
- 6. If you believe your privacy rights have been violated, you may file a complaint with this practice or with the Secretary of the Department of Health and Human Services. To file a complaint with this practice, contact Dr. Nirvana, Birch St #206, NB, CA 92660. All Complaints must be submitted in writing. You will not be penalized for filing a complaint.
- 7. This practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
- 8. If you have any questions regarding this notice or our health information privacy policies, please contact Dr. Nirvana, Birch St #206, NB, CA 92660

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Dr. Nirvana's Notice of Private Practices.

|  |                         |
|--|-------------------------|
| Patient or legally authorized individual signature | Date                    |
| Printed Name if signed on behalf of the patient :  | Relationship to Patient |
| Revisions (if any)                                 |                         |

=====For Office use only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please specify reason): \_\_\_\_\_



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## Informed Consent and Request for Naturopathic Medicine

I understand that naturopathic evaluation and treatment may include, but is not limited to:

- Physical exam (general and female)
- Dietary advice and therapeutic nutrition (use of foods, diet plans, nutritional supplements, intravenous and intramuscular vitamin injections)
- Herbs/natural medicines (prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures-which may contain alcohol, suppositories, topical creams or other forms.
- Homeopathic remedies (highly diluted natural occurring substances)
- Over the counter and prescription medications

I understand and I am informed that in the practice of Naturopathic Medicine that there are some risks and benefits with evaluation and treatment including, but not limited to the following:

- **Potential risks:** pain, discomfort; allergic reaction to prescribed herbs, supplements, prescription medications; an aggravation of pre-existing symptoms.
- **Potential benefits:** restoration of the body's maximal functioning 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 provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

By signing below, I, \_\_\_\_\_ acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explains therapies and procedures to my satisfaction. I further acknowledge that no guarantees or services have been made to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that a record will be kept of health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted by law.

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Signature

Date

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## Financial Policy

Thank you for trusting Dr. Nirvana with your care, she is committed to providing the best holistic health care possible. Please understand that the payment of your bill is considered part of your treatment. The following statement explains our financial policy. Please read the policy, sign and return it to us prior to your treatment.

I, \_\_\_\_\_, understand I am responsible for payment of any charges and agree to pay Dr. Nirvana the regular charges for all medical services rendered to me. It is my responsibility to check with my insurance provider to determine if this is a covered benefit. I am responsible for payment in full which is due at the time services are provided. Dr. Nirvana reserves the right to accept periodic installment payments without waiving its right to demand payment in full.

Forms of acceptable payment include: cash or check. A receipts can be provided for you, upon request for you to send to your insurance provider for reimbursement if you have out-of-network benefits. For checks returned as unpaid by your bank, \$35.00 fee will be charged. Any legal fees that the Doctor incurs to secure past due balances will be added to your account.

### **Missed Appointments**

Please provide at least **24 hours notice of cancellation** as a courtesy. The policy is to charge \$75.00 for missed appointments without appropriate notice. Please help Dr. Nirvana to serve you better by keeping scheduled appointments.

Credit Card Information Required: \_\_\_\_-\_\_\_\_-\_\_\_\_-\_\_\_\_

Exp: \_\_-\_\_

I understand that I am financially responsible for the charges that I incur during my treatment under the care of Dr. Nirvana. This includes all Naturopathic therapies, supplements, office visits, laboratory and imaging charges.

I have read and agree to all the terms of the financial policy.

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

Name of Guardian \_\_\_\_\_

Relationship \_\_\_\_\_

Signature of Guardian \_\_\_\_\_

Date \_\_\_\_\_