Sierra Nevada Holistic Services, LLC ("SNVHS")

407 W. Robinson St.
Carson City, NV 89703
775-720-2563

Client Intake Form

Patient Name: _____

Date of Birth: _____/_____/_____ Age: _____ □ Male □ Female □ Gender Neutral

Address: _____

City: _____, State_____ Zip: _____

Telephone: ( ) ____ - _____Email address: _____

Occupation: _____ Employer/School_____

Emergency Contact: _____ Telephone: ( ) _____ - _____

Marital Status: Single Married Separated Divorced Widowed Domestic Partner

Spouse/Partner's Name: _____

Children (ages, names): _____

_____

Whom may we thank for referring you to our office? _____

MEDICAL HISTORY AND MEDICAL INFORMATION

Height: _____Weight: _____Avg. blood pressure _____/_____ Avg. pulse rate _____

What are your health goals? _____

Any allergies to medications, foods, environmental (seasonal allergies), lotions, oils, or essences?

□**YES** □**NO:** _____

Are you currently under the care/supervision of a physician and/or alternative medicine provider (ex. Chiropractor, Oriental Medical Doctor, Medical specialist)? □**YES** □**NO**

Date of last Medical Exam(s): _____

May we contact them to coordinate care, if necessary? □**YES** □**NO**

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Please list any and all medications (prescribed OR over-the-counter), herbs, supplements, and vitamins that you are currently taking:

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

*Please mark an **(X) by all current conditions** and **(P) for all past conditions***

__ Abdominal/digestive problems
__ Allergies
__ Anxiety
__ Arthritis/tendonitis
__ Asthma or lung cond.
__ Athlete's foot
__ Blood clots
__ Cancer
__ Chronic pain
__ Circulatory/heart Problems
__ Cholesterol issues
__ Constipation/diarrhea
__ Depression
__ Diabetes
__ Drugs/Alcohol Use
__ Fatigue
__ Headaches, migraine
__ Hearing problems
__ Hernia
__ Blood pressure
__ Jaw pain/TMJ pain
__ Muscle/bone injuries
__ Muscle/joint pain
__ Numbness/tingling
__ Pain (Chronic or Acute)
__ Pregnancy Weeks/Trimester:____
__ Rash/fungus
__ Sexual issues
__ Sinus problems
__ Sleep difficulties
__ Spinal disorders
__ Sprain/strain
__ Tension/stress
__ Thyroid (High/Low)
__ Vision problems
__ Varicose veins
__ Other _____
_____

Please list any recent injuries or surgeries within the past 5 years:

_____

_____

Please list your stress-reduction activities, hobbies, exercise and/or sport participation:

_____

_____

Last Eye exam: _____ Last Pap Smear/Colonoscopy: _____ Last Mammogram:_____

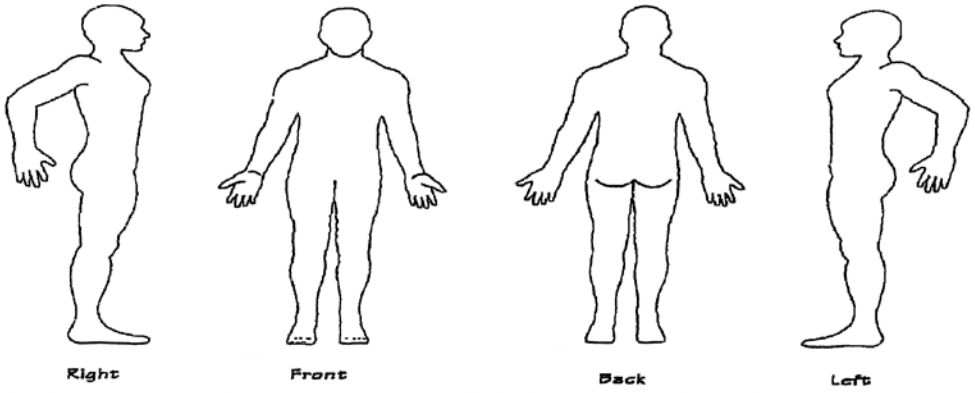
Prostate/PSA: _____ Last Skin exam: _____

Any abnormal findings from the above? □**YES** □**NO** If so, what was it? _____

_____When do you return to see the above specialists?

_____

Please indicate areas you experience pain/discomfort:



Pain Characteristics/Description: _____
Example: Throbbing, shooting, stabbing, cutting, pressing, cramping, pulling, dull, sharp, hot, tingling, aching, tiring, annoying, intense, numb, electric, pulsating…

When did, your pain start? _____
What do you think was the cause? _____

Pain Qualities: Continuous (24hrs non-stop) _____ OR Intermittent (comes & goes)____
If it is intermittent, how long does it last? _____

Pain Scale: On a scale of 1 through 10, with 10 being the worst pain you have ever had in your life, how would you rate your pain right now?_____/10

Any other symptoms or problems you have during the painful time (i.e., sweating, crying, nausea, anxiety, increased BP or respiration rate, exhaustion, etc.) _____
_____

Pain Radiation: Does the pain travel to other areas? Where? _____
_____
_____

Pain Provokers: What makes the pain worse? _____
_____

Pain Relievers: What lessens/reduces AND/OR relieves/stops the pain? _____
_____
_____
The worst pain you had over the last week? _____/10
The best/least pain you had over the last week? _____/10
Does your pain interfere with your life? □**YES** □**NO**
If yes, how so (i.e., mood changes, social functioning, basic daily living activities, work/school, family issues, etc.)? _____
_____
On your current pain relieving/reducing treatments (Including prescription, over-the-counter, and other remedies/measures), are you with your current treatment program? □**YES** □**NO** If yes, what are they?_____
If no, what would you prefer to see happen with your treatment program?
_____

SEXUAL HEALTH

The following are a few questions about your sexual health and sexual practices. I understand that these questions are very personal and can be uncomfortable or embarrassing to answer. Just so you know, I ask these questions to all of my adult patients, regardless of age, gender, or marital status. These questions are as important as the questions about other areas of your physical, social, mental, and spiritual health. Like the rest of this form, this information is kept in strict confidence.

Are you currently sexually active? (Are you having sex?) □**YES** □**NO**
If yes, are your sex partner(s) men, women, both, non-gendered? _____

If no, have you ever been sexually active? □**YES** □**NO**
If no, do you imagine your partner(s) as men, women, both, non-gendered? _____

How many partners have you had in the past month? _____ Six months? _____ Lifetime? _____

Do you have, or have you ever had, any risk factors for HIV or Hepatitis C? (List blood transfusions, needle stick injuries, IV drug use, STDs, partners who may have placed you at risk.) □**YES** □**NO**
_____
Have you ever had any sexually related diseases? □**YES** □**NO** _____
When? How were you treated? _____
Have you had any recurring symptoms or diagnoses?

To understand your risk for STDs, over the last 12 months:
What kind of sexual contact do you have or have you had? Genital (penis in the vagina)? Anal (penis in the anus)? Oral (mouth on penis, vagina, or anus)? Do you and your partner(s) use any protection against STDs? □**YES** □**NO**
_____
How often do you use this protection? _____
If not, could you tell me the reason? _____
If "sometimes," in what situations or with whom do you use protection?
_____
Have you ever been tested for HIV, or other STDs? □**YES** □**NO**
Would you like to be tested? □**YES** □**NO**
Has your current partner or any former partners ever been diagnosed or treated for an STD? □**YES** □**NO** Did you get tested for the same STD(s)? □**YES** □**NO**
If yes, when were you tested? What was the diagnosis? How was it treated?_____
_____
Have you ever been immunized against hepatitis? □**YES** □**NO** Would you like to be? □**YES** □**NO**
What method do you use for contraception? □**N/A** _____
Are you trying to become pregnant (or father a child)? □**YES** □**NO**

Do you or your partner(s) use any particular devices or substances to enhance your sexual pleasure? □**YES** □**NO**
_____

How satisfied with your (and/or your partner's) sexual functioning are you?
Very Mostly Somewhat Neutral Somewhat dissatisfied Mostly dissatisfied Frustrated
Has there been any change in your (or your partner's) sexual desire or the frequency of sexual activity? □**YES** □**NO**
_____
Do you ever have pain with intercourse? □**YES** □**NO**
If yes, when (upon initial penetration, throughout penetration, during deep penetration, during orgasm, after sex)?_____
Anything that helps or worsens this?_____
Women: Do you have any difficulty achieving orgasm? □**YES** □**NO**
Men: Do you have any difficulty obtaining and maintaining an erection? Difficulty with ejaculation? □**YES** □**NO**
_____
Any history of sexual, mental, or physical abuse? □**YES** □**NO**

Is there anything about your (or your partner's) sexual activity (as individuals or as a couple) that you would like to change? □**YES** □**NO**

Do you have any questions or concerns about your sexual functioning? □**YES** □**NO**

_____
_____

REPRODUCTIVE HEALTH

FEMALE:

Age at first period ____Date of last period _____ Number of pregnancies ____
Number of live births ____ Date of last Pap test _____ History of abnormal Pap tests? □**YES** □**NO**
History of irregular periods? □**YES** □**NO** Menstrual cycle length: ____ days. Duration of menstrual period: ____ days. Do you experience significant menstrual cramping? □**YES** □**NO**
Is heavy bleeding a problem? □**YES** □**NO**
Do you have a history of endometriosis? □**YES** □**NO**
Do you have a history of yeast infections? □**YES** □**NO**
Do you have a history of infertility? □**YES** □**NO**
Do you have excessive unwanted hair growth? □**YES** □**NO**
Do you have a tendency toward premenstrual syndrome? □**YES** □**NO** If yes, please describe symptoms:
_____
Do you have a family history of (check all that apply): □ breast cancer □ ovarian cancer □ osteoporosis □ colon cancer
Describe any current menstrual or menopausal symptoms or concerns: _____
_____
Describe any current breast problems: _____
Did/do you breast feed? □**YES** □**NO** If yes, please indicate duration for each child:
_____

MALE:

Do you have any problems with your genitals, such as burning or pain during urination, discharge from your penis, bumps or sores on your genitals, or pain or lumps in your genital area? □**YES** □**NO**
If yes: What color is the discharge? _____Is the sore painful? □**YES** □**NO**
When did you notice the discharge or sore? _____Has there been a change in the discharge or sore? □**YES** □**NO**
Do you have any pain, lumps, or heaviness in your testicles? □**YES** □**NO**
Do you have any other problems with urination, such as difficulty emptying your bladder, urinating frequently, having to get up during the night to urinate, or dribbling? □**YES** □**NO** If yes, what are your symptoms?
_____
Do you have lower abdominal pain? □**YES** □**NO**
Do you have dark urine or any yellowing of your skin or eyes? □**YES** □**NO**
Do you have any history of genital injuries or surgery? □**YES** □**NO**
Do you do routine exam of your testes and genitals? □**YES** □**NO**

NUTRITIONAL HEALTH

Describe any food intolerances you have:
_____
_____ Describe any digestive problems:
_____
_____
Your usual bowel movement frequency is (check one):□ >2 times daily □ 1 time daily □ 1 time every 2 days □ <1 time every 2 days.
Do you usually have to strain to have a bowel movement? □**YES** □**NO**
Are your bowel movements chronically loose? □**YES** □**NO**
Do you ever have blood with bowel movements? □**YES** □**NO**
Are your stools ever black or tarry? □**YES** □**NO**

When was the last time you received antibiotics? _____
Describe your typical: breakfast _____
lunch_____
dinner_____
snack _____ How frequently do you dine out: □ Daily □ Weekly □ Monthly □ Rarely □Never
How frequently do you eat fast food: □ Daily □ Weekly □ Monthly □ Rarely □ Never
How much water do you drink daily: □ < 1 qt. □ 1 qt. □ 2 qt. □ > 2qt.
Is it filtered water? □**YES** □**NO**
Foods you avoid and why (i.e. allergies, diet, dislike):
_____
Foods you crave: _____ Do you have (or have you had) an eating disorder? □**YES** □**NO**
Do you drink coffee? □**YES** □**NO** If yes, how many cups daily of decaf _____ and caffeinated _____ Do you drink tea? □**YES** □**NO** If yes, what kind _____ and how many cups do you drink daily ____ Do you drink soda? □**YES** □**NO** If yes, what kind _____ and how many do you drink daily _____

DEVELOPMENTAL HISTORY

Early Health History
List any known problems your mother had during her pregnancy with you (illness, stress, medication, smoking, alcohol, traumatic delivery): _____
_____ Were you breast fed? □**YES** □**NO**. If yes, please indicate duration if known _____ Was your home life as a child loving/supportive? □**YES** □**NO**
If there were significant stressors in your home, please describe _____
_____
Please check if you had any of the following childhood illnesses: □ Frequent ear infections □ Colic □ Eczema □ Recurrent colds □ Bronchitis □ Pneumonia
□ Meningitis □ Other _____ As a child were you on frequent or prolonged antibiotic therapy? □**YES** □**NO**
Did you receive immunizations? □**YES** □**NO** Did you experience any adverse reactions to immunizations? □**YES** □**NO** □**N/A** If yes, please describe _____
_____

PSYCHOSOCIAL HEALTH

Current Stress Factors
Please indicate if any of the major stresses listed below apply to you (check all that apply): □ Job □ New retirement □ New baby □ Change of marital status □ Health problems □ Family stress □ Financial concerns □ Abusive relationship □ Other: _____.
Please describe the quality of major relationships in your life:
_____
_____
Indicate job satisfaction (if applicable): □ Excellent □ Good □ Fair □ Poor Have you experienced physical, emotional, sexual, or verbal abuse? □**YES** □**NO**

Lifestyle Habits
Describe your sleep pattern: Time arise _____Time retire _____ Naps?
Your quality of sleep is:□ Well-rested □ Tired upon awakening □ Awaken during night.
Do you: □ Sleep in total darkness □ Sleep near electric clock, outlet, or other electronic device.
Your typical sleep position is: □ Side □ Back □ Stomach
Is your mattress firm? □**YES** □**NO** Pillow type (check all that apply): □ Firm □ Soft □ Thick □ Thin □ Feather □ Synthetic □ Orthopedic
What is the frequency of your vacations: ____ times / year. How frequently do you travel: □ Annually □ Semi-annually □ Monthly □ Weekly

Do you live/work in a damp or moldy home/office? □**YES** □**NO**
Do you exercise? □**YES** □**NO** If yes, type: _____Frequency: _____
How do you relax or relieve stress? _____
_____
Do you use tobacco? □**YES** □**NO** If yes, list amount you smoke/chew per day and week _____Years using tobacco _____. If you no longer use it, when did you quit _____ Do you use recreational drugs? □**YES** □**NO** If yes, list type and
frequency_____ Did you formerly use recreational drugs? □**YES** □**NO** If yes, specify _____
_____
Do you drink alcohol? □**YES** □**NO** If yes, list type and amount per day and week
_____
Do you have (or have you had) a problem with alcohol or drug overuse? □**YES** □**NO**
Answer the following questions indicating the number: **0** = Not at all **1** = Several days **2** = More than half the days **3** = Nearly every day
1. Over the last 2 weeks, how often have you been bothered by any of the following problems?
   a. Little interest or pleasure in doing things - _____
   b. Feeling down, depressed, or hopeless - _____
   c. Trouble falling/staying asleep, sleeping too much - _____
   d. Feeling tired or having little energy - _____
   e. Poor appetite or overeating - _____
   f. Feeling bad about yourself or that you are a failure or have let yourself or your family down - _____
   g. Trouble concentrating on things, such as reading the newspaper or watching television. - _____
   h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual. - _____
   i. Thoughts that you would be better off dead or of hurting yourself in some way. - _____

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Choose 1 answer:
Not difficult at all - _____
Somewhat difficult - _____
Very difficult - _____
Extremely difficult - _____

SPRITUAL HEALTH

Do you use prayer in your life? □**YES** □**NO**
How do you express your spirituality? □**YES** □**NO**
How does your spiritual/religious beliefs affect your health or illness? _____
_____
What are your spiritual goals? _____
_____
Do you have rituals or other spiritual practices that you use for illness(es)? _____
_____
Does your family also have the same spiritual/religious practices? □**YES** □**NO**
Is your family supportive of your spiritual/religious practices? □**YES** □**NO**
Do you consider yourself spiritual or religious? □**YES** □**NO**
Is spirituality something important to you? □**YES** □**NO**
Do you have spiritual beliefs that help you cope with stress/ difficult times? □**YES** □**NO**
What gives your life meaning? _____
_____
What importance does your spirituality have in your life? _____
_____
Has your spirituality influenced how you take care of yourself, your health? □**YES** □**NO**
Does your spirituality influence you in your healthcare decision making (e.g. advance directives, treatment etc.)? □**YES** □**NO**

Are you part of a spiritual and/or a religious community (i.e., churches, temples, and mosques, or a group of like-minded friends, family, or yoga, can serve as strong support systems for some patients)? □**YES** □**NO**
Is this of support to you and how? _____
Is there a group of people you really love or who are important to you? □**YES** □**NO**
How would you like me, your healthcare provider, to address these issues in your healthcare?
_____
Do you want your spirituality/religious believes incorporated into your care? □**YES** □**NO**

FAMILY MEDICAL HISTORY

Adopted: □**YES** □**NO** □ **Unknown Family Medical History** □ **No Significant Family Medical History**

Family Member	**Illness(es)**	**Age of Onset/Diagnosis**	**Alive/Deceased**
Mother			
Father			
Brother (s)			
Sister (s)			
M. Aunt (s)			
M. Uncle (s)			
P. Aunt (s)			
P. Uncle (s)			
M. Grandma			
M. Grandpa			
P. Grandma			
P. Grandpa			

SNVHS Medical Care/Bodywork Consent & Release of Liability Form

Please take a moment to carefully read the following information and sign where indicated.

Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. The session will be terminated immediately and you will be responsible for the cost of the session in full.

Initials: _____

Cancellations & Late Fee Policy

Your business is valued and your cooperation is appreciated. We make a commitment to you to guarantee your appointment time and refusing all other's requests once you have made the appointment. A 24-hour cancellation notice is required for any scheduled appointments. ***Missed or no-call/no-show appointments will result in you being charged the FULL amount of appointment ($120).*** **Depending on the booking schedule, late appointments may not receive the full session time allotted for the service booked, but full payment is required.** Emergency cancellations are determined by the provider's discretion. All fees will need to be paid PRIOR to your next appointment. If no-shows or late cancellations happen more than two times, you may be asked to pay for your session at the time the appointment is made OR you may be discharged from any further services. Fees must be paid by cash or credit card. If the provider is 15+ minutes late, the client will receive a $15 discount with the option to reschedule for a fully timed appointment or keep the current reduced time & discounted cost appointment.

Initials: _____

Consent for Treatment of a Minor/Dependent

By my signature below, I hereby authorize a State Licensed Medical Provider at Sierra Nevada Holistic Services, LLC to administer care, treatment, and/or body work to my child or dependent, as they deem necessary.

Guardian Signature: _____Date: _____

Your signature & initials indicate that you have read and agree to the terms listed herein.

Client Signature: _____ Date: _____

Provider Signature:_ _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With this consent, Sierra Nevada Holistic Services, LLC ("SNVHS") may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to SNVHS' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. SNVHS reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at SNVHS, 407 W. Robinson St., Carson City, NV 89703.

With my consent, SNVHS may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist SNVHS in carrying out TPO, such as appointment reminder, and any call pertaining to my clinical care. With my consent, SNVHS may mail to my home or other designated location any items that assist SNVHS in carrying out TPO, such as appointment reminder cards, as long as they are marked "Personal and Confidential".

I have the right to request that SNVHS restrict how it uses or discloses my PHI to carry out TPO. However, SNVHS are not required to agree to my requested restrictions, but if it does, it is bound by this Agreement.

By signing this form, I am consenting to SNVHS use and disclosure of my PHI to carry out TPO.

 SNVHS do not transmit any health care information in electronic form outside SNVHS. SNVHS do not file claims to any health plans, private or Medicare/Medicaid, or utilize a billing service or clearinghouse to file on their behalf. Nothing in these privacy procedures should be construed to voluntary or involuntarily waive SNVHS' status as a "non covered entity" under HIPAA. The HIPAA regulations are used merely as a guide for accepted privacy practices.

When my information is used or disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the applicable privacy laws. I have the right to revoke this Authorization in writing except to the extent that SNVHS have acted in reliance upon this authorization. My written revocation must be submitted to SNVHS' Privacy Officer at SNVHS, 407 W. Robinson St., Carson City, NV 89703.

_____ _____

Date Signature of Patient or Legal Guardian

_____

Relationship to Patient

_____

Patient's Name

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Sierra Nevada Holistic Services, LLC 407 W. Robinson St., Carson City, NV 89703

Patient name: _____ **Date of Birth:** _____

Address: _____

SECTION A: Psychotherapy Notes

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, it must *not be* used as an authorization for any other type of protected health information.

SECTION B: The Use and/or Disclosure Being Authorized

Protected Health Information to be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing to be used and/or disclosed:

☐ Discharge Summary
☐ Admission Note
☐ Physical Examination
☐ Psychiatric Assessment
☐ Psychological Evaluation
☐ Treatment Plan Evaluation

Other: _____

_____

_____

SECTION C: Entities Authorized to Receive, Use or Disclose:

Name or specifically identify the persons or *organizations (or the classes of persons and/or organizations)*, including Sierra Nevada Holistic Services, LLC, who you are authorizing to receive, to make use of, and/or to disclose the protected health information described above:

I authorize information to be: *(check one or both)* ☐ released **TO** Sierra Nevada Holistic Services, LLC

_____ _____
(Name/Title/Organization) (Address)

(Receipt of protected health information is limited to one health care provider per authorization form.)

☐ released **FROM** Sierra Nevada Holistic Services, LLC to

_____
(Name/Title/Organization) (Address)

_____ _____
(Name/Title/Organization) (Address)

_____ _____
(Name/Title/Organization) (Address)

_____ _____
(Name/Title/Organization) (Address)

SECTION D: Purpose

The information is being used/disclosed for the following purpose:

_____

SECTION E: Expiration and Revocation

Expiration: This authorization will expire *(complete one)*:

☐ On_____(DD/MM/YR).

☐ On occurrence of the following event:
(which must relate to the patient or to the purpose of the use and/or disclosure being authorized)

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Sierra Nevada Holistic Services, LLC Privacy Officer. I understand that revocation of this authorization will *not* affect any action taken by Sierra Nevada Holistic Services, LLC in reliance on this authorization before my written notice of revocation was received. Written revocation should be sent to: Sierra Nevada Holistic Services, LLC Privacy Officer; 407 W. Robinson St., Carson City, NV 89703.

SECTION F: Alcohol & Drug Abuse Information

I understand that this authorization may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse. I also understand that HIV, or AID's-related information may be released.

SECTION G: Facsimile Communication

I understand that this information may be communicated by facsimile.

SECTION H: The Patient (or the Patient's Legal Representative) Confirming the Authorization

I understand that:

- this authorization is voluntary (you may refuse to sign);
- my health care and payment for my health care will not be affected if I do not sign this form;
- if the organization authorized to receive and/or use the information is not a health plan, health care provider, or health care clearinghouse subject to federal health information privacy laws, the released information may no longer be protected by federal privacy.
- information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and no longer protected.

SIGNATURE:

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Sierra Nevada Holistic Services, LLC. I understand that, by signing this form, I am confirming my authorization that Sierra Nevada Holistic Services, LLC may receive, use, and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature of Patient:_____Date: _____

Signature of Legal Representative: _____

42 CFR PART 2:

This information is from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of other information is not for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.