



Sierra Nevada Holistic Services, LLC (“SNVHS”)

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

Medical Patient 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: () ____ - _____

Social Security Number: _____ - _____ - _____ Blood Type _____

Marital Status: Single Married Separated Divorced Widowed Domestic Partner Spouse

Spouse/Partner’s Name: _____

Children (ages, names): _____

Do you have - Living Will: YES NO Healthcare POA: YES NO POLST Order: YES NO

DNR: YES NO

Race/Ethnicity(circle): White/Caucasian Black/African Amer. Asian Hispanic/Spanish Other Race
Native Hawaiian/Other Pacific Islander Amer. Indian/Alaska Native Ashkenazi Jewish

Preferred Pronouns (Circle): He/Him/His; She/Her/Hers; They/Them/Their

Do you give consent for communication including diagnosis, test results, or treatment planning by phone, text and/or email? YES NO

MEDICAL HISTORY AND MEDICAL INFORMATION

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 primary care physician and/or alternative medicine provider (ex. Chiropractor, Oriental Medical Doctor, Medical specialist)? YES NO

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

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Please list any and all medications and amounts (prescribed OR over-the-counter), herbs, supplements, and vitamins that you are currently taking. **Please bring all medication bottles with you.**

Medication: _____ Reason for taking it: _____

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

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

Date of last Medical Exam(s): _____ Last Eye exam: _____ Last Mammogram: _____

Last Pap Smear: _____ Prostate/PSA exam/test: _____ Colonoscopy: _____

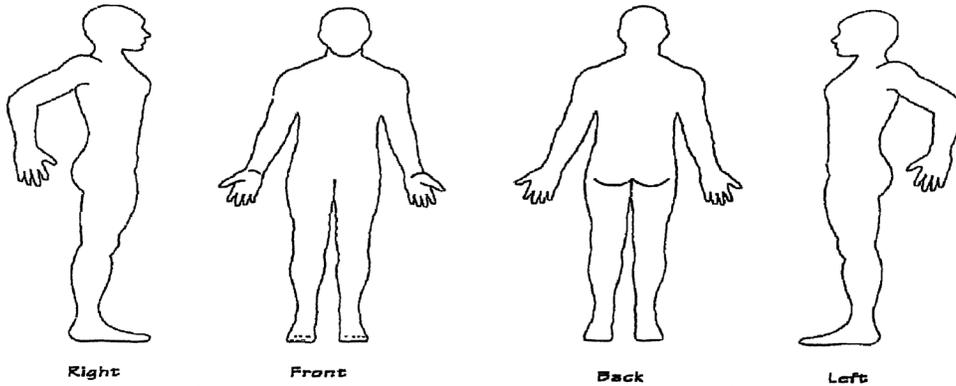
Last Skin exam: _____ Last DEXA Scan: _____ Last Dental exam: _____

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

Do you return for follow-up appointments? YES NO

When was the last time you took antibiotics? _____ For what? _____

Please indicate areas you experience pain/discomfort:



Pain Characteristics/Description: _____
Examples: 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? _____

What pain relieving techniques/methods/treatments have you tried in the past that failed? _____

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 medications/topicals, and other remedies/measures), are you happy with your current treatment program? YES NO
If yes, tell why? _____

If no, what would you prefer to see happen with your treatment program? _____
Are you seeing a pain specialist? YES NO If yes, who _____

If no, do you want a referral? YES NO

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, partners who may have placed you at risk.) YES NO **If yes, what and when?**

Have you ever been immunized against Hepatitis C? YES NO Would you like to be? YES NO

To understand your risk for STDs, over the last 12 months:

What kind of sexual contact do you have or have you had? Circle all applicable: 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

Have you ever had any sexually-related diseases? YES NO _____

When? How were you treated? _____

Have you had any recurring symptoms or diagnoses? 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

Do you or your partner(s) use any devices or substances to enhance your sexual pleasure? YES NO **If yes,**

What are they? _____

Please circle/mark the best answer: 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

Cause for the change? _____

Any history of sexual, mental, or physical abuse? YES NO

Circle all that apply: sexual, mental, emotional or physical abuse

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

Women: 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? _____

Do you have any difficulty achieving orgasm? YES NO

Men: Do you have any difficulty obtaining and maintaining an erection? YES NO

Difficulty with ejaculation? YES NO _____

REPRODUCTIVE HEALTH

FEMALE:

Do you have any problems with your genitals, such as burning or pain during urination, vaginal discharge, bumps or sores on your genitals, or pain or lumps in your genital area? YES NO

If yes: What color is the discharge? _____; are the sore(s) painful or itchy? YES NO BOTH

When did you first notice the discharge or sore(s)? _____

Has there been a change in the discharge or sore? YES NO

Age at first period ____ Date of last period _____ Number of pregnancies ____ Number of miscarriage/abortions ____; Number of live births ____ History of abnormal Pap tests? YES NO What was abnormal? _____ Did you have this treated? YES NO

When? _____ What treatment was done? _____

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 or urinary tract infections? YES NO If yes, which? _____

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 do routine self-exam of your breasts? YES NO Describe any current breast problems: _____

Describe any current menstrual or menopausal symptoms or concerns: _____

Do you use any type of menstrual or menopausal supplements or herbs? YES NO What? _____

Did/do you breast feed? YES NO

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? _____; are the sore(s) painful or itchy? YES NO When did you first notice the discharge or sore(s)? _____ 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 do routine self-exam of your testes and genitals? YES NO

BOTH:

1. During the past three months, have you leaked urine (even a small amount)? Yes No
2. When do you leak urine: (check all that apply) A. With physical activity like jumping, or exercising, during coughing, sneezing, lifting? B. When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough? C. Without physical activity and a sense of urgency? D. About equally as often with physical activity as with a sense of urgency?
3. Do you have lower abdominal pain? YES NO
4. Do you have dark urine or any yellowing of your skin or eyes? YES NO
5. Do you have any history of genital injuries or surgery? 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

Describe your typical: Breakfast _____

Lunch _____

Dinner _____

Snacks _____

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 Diagnosis? _____

Did you receive treatment? YES NO If yes, when: _____

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 Asthma Meningitis Other _____ As

a child were you on frequent or prolonged antibiotic therapy? YES NO

Did you receive childhood immunizations? YES NO Did you experience any adverse reactions to immunizations? YES NO N/A If yes, please describe

_____ Are you up-to-date on your current vaccinations/
immunizations? YES NO

If not, why: _____

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 in the past? YES NO

Are you experiencing fearfulness of being home because of a specific person, unwanted/hurtful physical, emotional, sexual, or verbal treatment at home? 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 currently 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 kind and amount per day or week _____

Do you have (or have you had) a problem with alcohol or drug overuse or abuse or dependency? YES NO

Have you ever been treated for an addiction problem? YES NO If yes, when: _____

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?

- Little interest or pleasure in doing things - _____
- Feeling down, depressed, or hopeless - _____
- Trouble falling/staying asleep, sleeping too much - _____
- Feeling tired or having little energy - _____
- Poor appetite or overeating - _____
- Feeling bad about yourself or that you are a failure or have let yourself or your family down - _____
- Trouble concentrating on things, such as reading the newspaper or watching television. - _____
- 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. - _____
- Thoughts that you would be better off dead or of hurting yourself in some way. - _____

2. If you checked off any problem above, 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 - _____

SPIRITUAL HEALTH

Do you use prayer in your life? YES NO

How do you express your spirituality? _____

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? _____

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

Do you want your spirituality/religious beliefs incorporated into your care? YES NO

How would you like me, your healthcare provider, to address/incorporate your spirituality in your healthcare?

FAMILY MEDICAL HISTORY

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

<u>Family Member</u>	<u>Illness(es)</u>	<u>Age of Onset/Diagnosis</u>	<u>Alive/Deceased</u>
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 Clinic Policies

Sexual Harassment and/or Violence Policy

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.

Acts or threats of physical violence, including intimidation, harassment and/or coercion, which involve or affect SNVHS, or which occur on Company property, will not be tolerated. This prohibition against harassment, threats and acts of violence applies to all patients and persons

involved in the operation of SNVHS, including, but not limited to, SNVHS employees, contract and temporary workers and anyone else on SNVHS property. Violation of this policy, by any individual, will lead to immediate termination of the treatment relationship and/or legal action as appropriate. If termination occurs, you will be provided written notice of termination and a prescription for a one (1) month supply of any medications prescribed by SNVHS to give you an opportunity to find another provider.

Initials: _____

Personal responsibility and accountability

As patients or clients of SNVHS, you are agreeing to work together with your health care team. This means that in addition to coming to appointments/follow-ups as agreed, you will also agree to follow to the best of your ability the recommendations/directions provided by your health care team in relation to your agreed treatment plan(s).

Changing or altering these recommendations/directions should be done in collaboration with your SNVHS health care team to ensure everyone on the team is knowledgeable of changes. If you choose not to comply with the health care team recommendations, it is SNVHS' right to terminate the relationship. If the relationship is terminated, you will be provided a prescription for a one (1) month supply of any medications prescribed by SNVHS to give you an opportunity to find another provider. You will also receive a letter indicating the termination date once the termination decision has been made.

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 the appointment (not to exceed \$150). If you arrive late to your appointment, you may not receive the full session time allotted for the service booked, but full payment is required. Fees and all amounts owed must be paid prior to your next appointment. Emergency cancellations are allowed at the provider's discretion. Repeat no-shows or failure to provide appropriate time for cancellations, you may be asked to pay for your session at the time the appointment is made, OR SNVHS may choose to terminate services.

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.

Patient Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____



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:

- | | |
|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative & Pathology Reports |
| <input type="checkbox"/> Admission Note | <input type="checkbox"/> Laboratory & Imaging Reports |
| <input type="checkbox"/> Psychiatric Assessment | <input type="checkbox"/> Treatment Plan & Evaluation |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Psychiatric/Psychological Assessment(s) |
| <input type="checkbox"/> Emergency Reports | <input type="checkbox"/> Psychological Evaluation |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> 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. (Receipt of protected health information is limited to one health care provider per authorization form.)

I authorize information to be: *(check one or both)* released **TO: Sierra Nevada Holistic Services, LLC**
407 W. Robinson St., Carson City, NV 89703 Fax #: 775-884-4986

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: Coordination of Care and Treatment Planning; continuity of care.

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.