	Excellent	Good	Fair	Poor
How would you describe your general state of health	☐	☐	☐	☐

How motivated are you to improve your health? (Zero motivation to very motivated)0 ● ● ● ● 5 ● ● ● ● 10

What are your goals for today?

Goal 1

Goal 2

Goal 3

What expectations do you have from this visit?

What long term expectations do you have from your ongoing care at Wellness Architecture?

What expectations do you have of me as your doctor?

What potential obstacles do you see in making changes in your lifestyle and following directions necessary to support your health?

New Patient Office Policy

Wellness Architecture is a cash office and payment is expected at time of service. Payment methods include check (preferable), Visa, Mastercard, or cash. If you have an insurance policy that will reimburse you for naturopathic medicine visits we will provide you with a superbill with appropriate diagnostic and billing codes that you can submit to the insurance company for reimbursement of your visit. We suggest that you make a copy of the superbill prior to submission because of consistent insurance clerical error. Our office will not interact with insurance companies on your behalf.

Cancellation Policy

We have a 48 hour cancellation/reschedule policy. If you do not call our offices 48 hours prior to your scheduled appointment, you will be charged a $100 missed appointment fee.

We require a credit card number for our records to schedule your first appointment. Your credit card will not be charged unless you do not provide adequate cancellation notice and will be kept on file for missed appointments or appointments with inadequate cancellation notice.

By signing below, I agree that I have read and understood the policy. I guarantee payment of all charges incurred as a patient of Wellness Architecture.

Signed:_____Date: _____

Printed Name: _____Date: _____

Parent or Guardian (minor): _____Date: _____

Notice of Privacy Practices

To our patients: 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 (HIPPA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

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. We will only make disclosures to a person or organization able to prevent the threat.

5. If you are a member of the 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 and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information 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.
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 Wellness Architecture, 841 El Camino Real, Menlo Park, CA 94025.

Note: We must respond to this request within 30 days.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Wellness Architecture, 841 El Camino Real, Menlo Park, CA 94025.

Note: We must respond within 60 days. The Privacy Officer or the patient's doctor will usually do this. If the doctor believes the information is complete and accurate, the doctor can refuse to make any changes.

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.

6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. McCully at Wellness Architecture. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or out health information privacy policies, please contact Dr. McCully at Wellness Architecture.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Wellness Architecture has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Dr. Samia McCully & Dr. Tanya Escobedo
650-233-7327

I also understand that I am entitled to receive updates upon request if Wellness Architecture amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature Relationship to Patient, if signed by someone other than patient.

_____
Date

THIS SECTION IS TO BE COMPLETED BY WELLNESS ARCHITECTURE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

_____ _____
Name and title of employee Date

INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Dr. Samia McCully/Dr. Tanya Escobedo, Naturopathic doctors of Wellness Architecture to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, radiography, laboratory, x-ray.
Minor office procedures: e.g., dressing a wound, ear cleansing.
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Psychological Counseling

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

Potential benefits: restoration of health and the body's maximal functional 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 doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Wellness Architecture or any of its personnel regarding cure or improvement of my condition. 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 the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit.

_____ _____
Date Signature of Patient

_____
Signature of Patient Representative or Guardian

Health History Questionnaire

Please take the time to fill out this questionnaire carefully. If you have any questions, ask for assistance. If you have concerns that are not listed, make note of them in the comments section. The completed form will greatly assist us in providing a thorough evaluation of your health.

Confidential Patient Profile

Name:_____ Age:_____ Date of Birth: _____Sex:_____

Address: _____ City:_____State: _____Zip Code:_____

Phone: Home ( ) _____Work ( ) _____Cell ( ) _____

E-mail:_____

Occupation:_____How did you hear about us? _____

Emergency Contact: _____Relationship: _____Day Phone: ( ) _____

Chief Complaint: In this section please list in order of importance your health concerns.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Current Medication List: In this section please list all pharmaceutical medication(s) that you are currently taking along with dosage and frequency

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Are you allergic to any medications? YES ☐ NO ☐

If "Yes", please list:_____

What happens when you have an allergic attack to medication? _____

Have you ever been treated with antibiotics? YES ☐ NO ☐ How many times: _____

Hospitalizations: Include reason, year and duration: _____

_____

Current Supplement List: In this section please include all homeopathics, herbs, vitamins, minerals you are currently taking with dosage.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Social History

Do you or have you used any of the following:	Never	Past	Daily	Weekly
Smoking	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Coffee or black tea	☐	☐	☐	☐
Energy drinks	☐	☐	☐	☐
Pain Medication	☐	☐	☐	☐
Laxative	☐	☐	☐	☐
Diet Pills	☐	☐	☐	☐
Soda/Sugary drinks	☐	☐	☐	☐

Are you currently: Married ☐ Divorced ☐ Single ☐ Long-Term Relationship ☐ Widowed ☐

Number of children and ages? _____

Have you traveled outside the US in the past year? Yes _____ No ____If yes, where? _____

With whom do you live? (including roommates, friends, partner, spouse, children, parents, relatives, pets)

Relationship	Age	Relationship	Age
_____		_____	
_____		_____	
_____		_____	
_____		_____	

What are the major stressors in your life? _____

What to you do to relax/relieve stress? _____

What interests/hobbies do you have? _____

Describe your energy level on a scale of 1-10 (10 high energy): Morning _____ Afternoon: _____ Evening: _____

Describe your sleep pattern (e.g., restful, interrupted etc.): _____

Nutrition

How many meals do you generally eat per day? _____Do you skip meals? _____How many servings of fruit per day?_____

How many servings of vegetables do you consume each day? (Svg: 1C raw, ½ C cooked) _____

Are you currently on a special diet? Foods you avoid? Please explain. _____

How would you describe your relationship with food? What motivates you to eat or not?

_____

_____

How often do you eat out?_____ Who prepares meals at home? _____

Family History

Indicate if a close relative (parent, child, sibling, grandparent) has had any of the following & indicate which member:

	NO	YES	Member
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Asthma/allergies/hives	☐	☐	
Alzheimer's	☐	☐	
Depression/suicide	☐	☐	
Other mental illness	☐	☐	
Drug/Alcoholism	☐	☐	
Kidney Disease	☐	☐	
Multiple Sclerosis (MS) or Parkinson's	☐	☐	
Autoimmune condition	☐	☐	
Epilepsy	☐	☐	
Gastrointestinal Diseases	☐	☐	
Glaucoma	☐	☐	
HIV/AIDS	☐	☐	
Obesity	☐	☐	
Syphilis	☐	☐	
Tuberculosis	☐	☐	

Review of Systems

Mental/Emotional	Currently	Past	Never
Depression	☐	☐	☐
Mood swings	☐	☐	☐
Anxiety/nervousness	☐	☐	☐
Seasonal depression	☐	☐	☐
Consider or attempted suicide	☐	☐	☐
Poor concentration	☐	☐	☐
Memory problems	☐	☐	☐
Schizophrenia	☐	☐	☐
PTSD	☐	☐	☐
Bipolar	☐	☐	☐
Endocrine			
Hypo/hyperthyroid	☐	☐	☐
Heat or cold intolerance	☐	☐	☐
Hypoglycemia/Low blood sugar	☐	☐	☐
Diabetes	☐	☐	☐
Increased thirst	☐	☐	☐
Night sweats	☐	☐	☐
Increased hunger	☐	☐	☐
Fatigue	☐	☐	☐
Headaches	☐	☐	☐
Unusual weight gain/loss	☐	☐	☐
Overweight or Obesity	☐	☐	☐
Neurological			
Seizures	☐	☐	☐
Paralysis	☐	☐	☐
Muscle weakness	☐	☐	☐
Numbness or tingling	☐	☐	☐

Neurological	Currently	Past	Never
Loss of memory	☐	☐	☐
Easily stressed	☐	☐	☐
Vertigo/dizziness	☐	☐	☐
Loss of balance	☐	☐	☐
Skin/Hair/Nails			
Rashes/Hives	☐	☐	☐
Brittle nails	☐	☐	☐
Eczema	☐	☐	☐
Dry skin	☐	☐	☐
Moles/growths/warts	☐	☐	☐
Athletes foot	☐	☐	☐
Itching	☐	☐	☐
Color changes	☐	☐	☐
Hair loss	☐	☐	☐
Head			
Migraines	☐	☐	☐
Jaw problems/TMJ	☐	☐	☐
Head injury	☐	☐	☐
Eyes			
Spots in eyes	☐	☐	☐
Cataracts	☐	☐	☐
Impaired vision	☐	☐	☐
Glaucoma	☐	☐	☐
Near/Farsighted	☐	☐	☐
Blurriness/hallows	☐	☐	☐
Eye pain/strain	☐	☐	☐
Tearing/dryness/redness	☐	☐	☐

Review of Systems

Ears	Currently	Past	Never
Difficulty hearing	☐	☐	☐
Ringing/buzzing	☐	☐	☐
Ear aches/pain	☐	☐	☐
Excess ear wax	☐	☐	☐
Frequent infections	☐	☐	☐

Nose	Currently	Past	Never
Stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Hay fever/rhinitis	☐	☐	☐
Sinus problems	☐	☐	☐
Loss of smell	☐	☐	☐
Post nasal drip	☐	☐	☐

Mouth/Throat	Currently	Past	Never
Frequent sore throat	☐	☐	☐
Chronic sore throat	☐	☐	☐
Teeth grinding	☐	☐	☐
Silver fillings	☐	☐	☐
Bleeding gums	☐	☐	☐
Hoarse voice	☐	☐	☐
Dental cavities	☐	☐	☐
Root canals	☐	☐	☐
Loss of sense of taste	☐	☐	☐

Neck	Currently	Past	Never
Lumps	☐	☐	☐
Swollen glands	☐	☐	☐
Goiter	☐	☐	☐
Pain or stiffness	☐	☐	☐

Lungs	Currently	Past	Never
Cough	☐	☐	☐
Phlegm	☐	☐	☐
Spitting up blood	☐	☐	☐
Wheezing	☐	☐	☐
Emphysema	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Pneumonia	☐	☐	☐
Tuberculosis	☐	☐	☐
Shortness of breath (SOB)	☐	☐	☐
SOB at night	☐	☐	☐
Difficulty breathing	☐	☐	☐
Pain on breathing	☐	☐	☐

Cardiovascular	Currently	Past	Never
Stroke	☐	☐	☐
Poor circulation	☐	☐	☐
Heart disease	☐	☐	☐
Angina	☐	☐	☐
High/low blood pressure	☐	☐	☐
Murmurs	☐	☐	☐
Swollen ankles	☐	☐	☐
Fainting	☐	☐	☐
Varicose veins	☐	☐	☐
Palpitations/fluttering	☐	☐	☐
Rheumatic fever	☐	☐	☐
Chest pain	☐	☐	☐
Irregular heart beat	☐	☐	☐

Review of Systems

Gastrointestinal	Currently	Past	Never
Heartburn	☐	☐	☐
Change in appetite	☐	☐	☐
Blood/mucous in stool	☐	☐	☐
Belching or Flatulence	☐	☐	☐
Nausea/vomiting	☐	☐	☐
Constipation	☐	☐	☐
Ulcers	☐	☐	☐
Loose stools/Diarrhea	☐	☐	☐
Jaundice (yellow skin)	☐	☐	☐
Liver or gallbladder disease	☐	☐	☐
Black stool	☐	☐	☐
Hemorrhoids	☐	☐	☐
Abdominal pain or cramps	☐	☐	☐
Troubles swallowing	☐	☐	☐
Travelers Diarrhea/Parasites	☐	☐	☐

Urinary	Currently	Past	Never
Pain on urinations	☐	☐	☐
Increased frequency	☐	☐	☐
Inability to hold urine	☐	☐	☐
Kidney stones	☐	☐	☐
Frequent infections	☐	☐	☐
Urgency	☐	☐	☐
Urination at night	☐	☐	☐

Musculoskeletal	Currently	Past	Never
Joint pain/stiffness	☐	☐	☐
Arthritis	☐	☐	☐
Broken bones	☐	☐	☐
Sciatica	☐	☐	☐

	Currently	Past	Never
Gout	☐	☐	☐
Muscle weakness	☐	☐	☐
Muscle spasms/cramps	☐	☐	☐

Peripheral Vascular	Currently	Past	Never
Cold hands & feet	☐	☐	☐
Anemia	☐	☐	☐
Deep leg pain	☐	☐	☐
Thrombophlebitis	☐	☐	☐
Easy bleeding/bruising	☐	☐	☐

Female	Currently	Past	Never
PCOS	☐	☐	☐
Ovarian Cysts	☐	☐	☐
STI	☐	☐	☐
Fibroids	☐	☐	☐

Length of cycle: _____ Length of menses: _____

Age of first menstruation: _____

Are cycles regular	YES ☐	NO ☐
HIV Positive	YES ☐	NO ☐
Breakthrough bleeding	YES ☐	NO ☐
Acne	YES ☐	NO ☐
Menstrual cramps	YES ☐	NO ☐
Breast tenderness	YES ☐	NO ☐
Mood changes	YES ☐	NO ☐
Bloating	YES ☐	NO ☐

Sexual orientation:_____

Date of last PAP & physical exam: _____

Children: _____ # Pregnancies: _____

Miscarriages: _____ # Abortions: _____