Nature's Way Medicine®

Name: _____ **Date:** _____

Email: _____ **DOB:** _____ **Age:** _____

Cell Phone: _____ **Home Phone:** _____

Address: _____ **City/State/Zip:** _____

Gender: M / F **Relationship Status:** Married/Single/Other **Dominant Hand:** L/R

Reason for Consultation: (*pain, ptsd, cancer, etc.*) _____

How did you hear about us? Doctor/Friend _____ Website _____

Google Search for "_____" Other: _____

Occupation: _____ Employer: _____

Spouse / Significant Other: _____ Contact #: _____

List All Drug ALLERGIES (Including Latex): _____

_____

_____

Current MEDICATIONS and Dosages:

_____

_____

_____

_____

_____

_____

Past SURGERIES with Approximate Dates:

_____

_____

_____

PAIN DESCRIPTION *(If any)* Severity (1 – 10): _____ Describe Your Pain: _____

Location: _____

Duration: _____

Frequency: _____

Limits Activities / Responsibilities? Explain: _____

_____

_____

MEDICAL HISTORY

Personal History of:	Yes	No	Explain
ALS			
Autism			
Cancer			
Crohn's Disease			
Depression/Anxiety			
Diabetes			
DVT/PE			
Glaucoma			
Heart Disease			
High Blood Pressure			
High Cholesterol			
HIV / AIDS			
Kidney Disease			
Liver Disease			
Multiple Sclerosis			
Muscle Spasms			
Parkinsons/Huntingtons			
PTSD			
Respiratory / COPD			
Seizures			
Sickle Cell Anemia			
Stroke			
Thyroid Disease			
Ulcerative Colitis			
Other:			

FAMILY HISTORY (*Use M – Mother F – Father S – Sibling C – Child)*

Family History of:	Yes	Who	Explain
Adopted			
Abnormal Bleeding			
Abnormal Clotting			
Autoimmune Disorder			
Brain Tumor			
Breast Tumor			
Colon Cancer			
Diabetes			
Endocrine Disease			
Heart Disease			
High Blood Pressure			
Hemophilia			
Kidney Disease			
Liver Disease			
Lung Cancer			
Malignant Melanoma			
Ovarian Cancer			
Prostate Cancer			
Seizures			
Thyroid Disease			
Other Cancer			
Von Willebrand			
Other:			

SOCIAL HISTORY

Tobacco: Current / Prior / Never Years _____ Daily Amount_____
Alcohol: None / Occasional / Daily Frequency _____ Amount _____
Marijuana : Never / Current Amount and types _____
Other Drug Use: Y / N Details: _____

Review of Systems

Please circle "Yes" or "No" as they relate to your health.

Constitutional:				Genitourinary:		
Unplanned Weightloss	Yes	No		Burning/Frequency	Yes	No
Fever	Yes	No		Blood in Urine	Yes	No
Chills	Yes	No		Hematology/Lymph:		
Eyes:				Easy Bruising	Yes	No
Glasses/Contacts	Yes	No		Enlarged Glands	Yes	No
Double Vision	Yes	No		Musculoskeletal:		
Cataracts	Yes	No		Joint Pain/Swelling	Yes	No
Ear, Nose, Throat:				Muscle Pain	Yes	No
Difficulty Hearing	Yes	No		Muscle Spasms	Yes	No
Sinus Trouble	Yes	No		Skin:		
Nasal Stuffiness	Yes	No		Rash/Sores/Itching	Yes	No
Cardiovascular:				Lesions	Yes	No
Chest Pain	Yes	No		Tears Easily	Yes	No
Murmur	Yes	No		Neurological:		
Fainting Spells	Yes	No		Numbness	Yes	No
Difficulty Lying Flat	Yes	No		Weakness	Yes	No
Palpitations/Heart Racing	Yes	No		Headaches	Yes	No
Respiratory:				Endocrine:		
Cough	Yes	No		Loss of Hair	Yes	No
Wheezing	Yes	No		Heat/Cold Intolerance	Yes	No
Shortness of Breath	Yes	No		Allergic/Immunologic:		
Gastrointestinal:				Hives/Eczema	Yes	No
Heartburn/Reflux	Yes	No		Psychiatric:		
Abdominal Pain	Yes	No		Anxiety/Depression	Yes	No
Constipation	Yes	No		Difficulty Sleeping	Yes	No
Nausea	Yes	No		Mood Swings	Yes	No

CERTIFICATION AND CONSIGNMENT

I certify that t**he above** information is correct and true to the best of my knowledge**.** I understand that it is my responsibility to inform this office of any changes with regards to the above information.

Patient/Guardian Signature _____ Date _____

Patient Name: _____ DOB: _____ Today's Date:_____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ___ = Add Columns ___ + ___ + ___

If you checked off any problems, 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?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

(/File:GAD-7_Pic.png)

Scoring: The total score for the 7 items can range from 0-21. Scores of 5, 10 & 15 are the cut-offs for mild, moderate and severe anxiety.

Goodman and Snyder suggest that during the subjective examination of a patient, one may want to ask specific questions regarding anxiety/depression.[5]

- Have you been under a lot of stress lately?
- Are you having some trouble coping with life in general and/or life's tensions?
- Do you feel exhausted or overwhelmed mentally or physically?
- Does your mind go blank or do you have trouble concentrating?
- Do you have trouble sleeping at night (difficulty getting to sleep, staying asleep, restless sleep, feel exhausted upon awakening)?
- Do you have trouble focusing during the day?
- Do you worry about finances, work, or life in general?
- Do you get any enjoyment in life?
- Do you feel keyed up or restless?
- Irritable and jumpy?
- On edge most of the time?
- Do you have a general sense of dread or unknown fears?
- Do you have any of these symptoms: a racing heart, dizziness, tingling and tingling, muscle or joint pains?

The authors also list questions specific to Asian patient/clients:[5]

- Do you feel you are having any imbalance of yin and yang?
- Is your chi (internal energy) low?
- Do you believe it is your destiny to have this condition or your destiny not to have this condition? (fatalism versus well-being approach to illness.)

Associated Comorbidities

Comorbidities play an essential role in describing and understanding general anxiety disorders. The conditions of GAD may not be recognized as an emotional problem until the secondary disorder/ co-morbidity develops. Hoyer et al. state that epidemiological studies have found high rates of co-morbidity in GAD.[15]

Generalized anxiety disorder is most often associated with other disorders that can include other anxiety disorders, depression, and substance abuse. GAD can also lead to or worsen pre-existing conditions such as insomnia, digestive or bowel problems, headaches, and bruxism (teeth grinding).[2][9]

Other associated anxiety disorders can include panic disorder, phobias, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), or adjustment disorder with anxious mood (those with an organic illness).[1][5]

Telemedicine Consent Form

Telemedicine provides access for therapeutic services using interactive video conferencing tools, such as Skype, in which the doctor and the patient are not at the same location. Telemedicine will allow the patient to receive treatment without the need to visit the office and travel long distance. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in any evaluations and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in errors in judgment. Alternative to telemedicine include traditional face to face sessions.

I understand that using marijuana may cause short-term side effects like elevated mood, increased appetite, red eyes, dry mouth, and paranoia. More serious problems like pneumothorax are rare but have been documented. There may be a decreased ability to operate machinery and drive a vehicle. For this reason, it is advised not to drive or use heavy machinery while under the influence of marijuana. These short-term side-effects decrease with use and familiarity to its effects.

Your Rights:

1) I understand that the laws that protect the privacy and confidentiality of medical information also apply to telemedicine.
2) I understand that Skype is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data but, like email, may not be HIPAA compliant. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.
3) I have the right to withdraw my consent to the use of telemedicine during the course of my care at any time.
4) I understand that Nature's Way Medicine has the right to withhold or withdraw consent for the use of telemedicine during the course of my care at any time.
5) I understand that all rules and regulations which apply to the practice in the Commonwealth of Pennsylvania also apply to telemedicine.

Your Responsibilities:

1) I will not record any telemedicine sessions, and I understand that Nature's Way Medicine will not record telemedicine sessions.
2) I will inform my doctor that my environment is secure and confidential. Likewise, my doctor will inform me that the environment in their office is secure and confidential before the session begins.
3) I understand that I MUST be a resident of Pennsylvania to be eligible for telemedicine services from Nature's Way Medicine.
4) I understand that my Intake will not be done by telemedicine except in special circumstances under which I will be required to verify my identity to Nature's Way Medicine staff's satisfaction before the evaluation.

Your signature below indicates that you have read and understand the information provided above regarding teletherapy, and that you authorize Nature's Way Medicine and doctors to use telemedicine in the course of diagnosis and treatment.

_____ _____

Signature of Client Date