Health Matters

AN INTEGRATIVE APPROACH TO FAMILY MEDICINE

Welcome! We are honored that you have decided to join our practice! With a preventative and integrative approach to your health, we take your care seriously. Our goal is to treat each patient completely and carefully, leveraging complementary methods – both all-natural and science-driven, researched and organically rich, to improve your overall wellness. Our staff is available by phone (480-993-3331) for any concerns or questions.

How you can prepare for your first visit:

1) Be sure to complete your new patient paperwork before your arrival and bring it with you to your first visit; or, fax (480-800-3240) directly before your visit.

2) If you would like for us to receive a copy of your records from your previous doctor, you can electronically sign a records release form online at www.healthmattersaz.com/records-release-form/

3) Feel free to bring your current medications and supplements or a list of questions you would like answered.

What to expect during follow up visits:

1) If you had labs done, a comprehensive discussion and explanation of your results will take place

2) Recommendations will be typed and given to you at the end of each visit, including when to take medications/ supplements, with or without food, etc.

3) A plan of when to follow up in the future to monitor progress

4) How to contact our office in between visits with any concerns or questions

Medication refills

There are specific instances when pharmaceutical medications are necessary and following a thorough discussion of the pros and cons, many times we can electronically-prescribe your medicines to a pharmacy of your choice. PLEASE NOTE: if you need a refill on a medication, please call your pharmacy directly for a refill and anticipate 48-hours for our office to authorize the refill.

Cancellation and No Show Policy

Our goal is to provide high-quality, individualized care in a timely manner and appointments are in high demand. “No-shows” and late cancellations (less than 24-hour notice) prevent us from offering to another patient access to same day consultations.

If you need to cancel or reschedule your appointment, please call at least 24-hours before your scheduled time. By signing below, you are acknowledging that you understand there may be a $50 fee if an appointment is cancelled with less than 24-hour notice.

Phone Consultations

We are happy to provide phone consultation opportunities to patients who are unable to come into the office for follow up visits. While telephone consultations are not a substitute for seeing a physician in person and having a regular physical exam, phone consults can be useful for lab review and follow up care. You will receive a call from your physician at the number you provided at the time of your scheduled visit (Mountain Standard Time).

Signed. . . . . Date . . . .

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PATIENT CONTACT

In order to provide you with the most appropriate treatment, please complete the following questionnaire. All information is strictly confidential. **PLEASE USE INK**

Name . . . . Date of Birth . . . .

Address. . . . .

City . . . . State . . . . Zip . . . .

Phone (. . . . . . .) . . . .

Email Address . . . .

Emergency Contact & Phone . . . .

Height . . . . Weight . . . . Age. . . . . Gender: Male O Female O

Is it okay to leave brief messages (appointment reminders, lab results, or prescription information) on your voicemail?

Yes O No O

Can we email you medical information? Yes O No O

If you would like us to be able to speak with your significant other/ family member regarding your personal care, please list their name:

. . . .

Marital Status: Single O Married O Divorced O Widowed O

Name of Spouse/Significant Other . . . . If you have children, how many? . . . .

If you are the parent or guardian of the patient, what is your name? . . . .

How did you hear about us (if referred, by whom)? . . . .

- Word of Mouth
- Internet Search
- Facebook/ Social Media
- Newspaper
- Other

Do you have insurance? Yes O No O What is the name of your insurance provider? . . . .

What is the name of your pharmacy and main cross streets or phone number? . . . .

What health-related concerns prompted today's visit? (List in order of importance)

1. . . . .

2. . . . .

3. . . . .

4. . . . .

Who is your Primary Care Physician? . . . .

If you would like us to be your primary care, please indicate. Yes ○ No ○

Please list your other health professionals (not to be contacted without your consent)

Name . . . . Specialty . . . .

Name . . . . Specialty . . . .

Name . . . . Specialty . . . .

Drug allergies and reactions you have . . . .

Food allergies and reactions you have . . . .

PERSONAL AND FAMILY HEALTH HISTORY ✓**Check any that apply**

Disease	Self	Parent	Grandparent	Child	Sibling
Alcohol/ Drug Abuse					
Allergies					
Anemia/Blood Disorder					
Autoimmune (lupus, rheumatoid)					
Cancer (please list type)					
Depression/Anxiety					
Diabetes					
Gastrointestinal Disease					

Heart Disease/ High blood pressure					
Lung Disease					
Overweight/Obesity					
Osteoporosis					
Stroke					
Surgeries/ Hospitalizations					
Thyroid Disease					
OTHER					

REVIEW OF SYMPTOMS- Circle all that apply

DIGESTIVE Diarrhea Constipation Passing Gas Bloating Abdominal Cramping Heartburn Belching Nausea Vomiting Hemorrhoids	**FEMALE** Irregular cycle Hot flashes Painful periods Heavy periods PMS Low libido Vaginal dryness Infertility Currently pregnant Vaginal Infections (candida, BV, STIs)	**MUSCULOSKELETAL & NERVOUS SYSTEM** Joint pain Swelling Arthritis Muscle pain Stiffness/weakness Nerve pain Numbness Tremors Fainting	**MOUTH AND THROAT** Gingivitis Sore throat Difficulty swallowing Hoarseness Cold sores/Canker sores Post nasal drip Tongue or throat pain Loss of taste Dental pain Swollen glands	**ENERGY/MOOD** Fatigue Insomnia Depression Restlessness Irritability Aggression Anxiety Mood Swings Thoughts of harming self or others Physical/mental abuse
HEAD/ COGNITION Headaches/ Migraines Hair Loss Dry Hair Vertigo Poor Focus/ ADD Weak memory Confusion	**MALE** Prostate disease Testicular pain/ concerns Hernia Low libido Infertility Infections or STIs Erectile Dysfunction	**EARS** Ear drainage Ear aches or pain Ringing Frequent Infections Hearing loss	**EYES** Itchy/dry eyes Redness Eye pain Blurred vision Recent vision changes	**NOSE** Congestion Sneezing/runny nose Frequent sinus infections Dryness Nose bleeds Allergies Snoring or sleep apnea
KIDNEY/URINARY Frequent urination Kidney infection/ stones Bladder infections Pain with urination Difficulty starting urine Urinary incontinence	**SKIN/NAILS** Acne Moles/spots Hives Sweating Eczema Psoriasis Bruise easily Brittle nails Skin cancer	**WEIGHT** Weight gain Weight loss Compulsive eating Bulimia Anorexia Lack of appetite Water weight Cravings	**LUNGS** Shortness of breath Asthma Bronchitis Wet Cough Dry Cough Chest congestion	**HEART** Palpitations Chest pain/ heaviness Murmur/ arrhythmias High blood pressure Low blood pressure Poor circulation (cold hands and feet) Edema

How many 8 oz glasses of water do you drink daily? . . . . Other beverages . . . .

Alcohol use? Yes O No O Frequency. . . . . Drug use? Yes O No O

Caffeine use? Yes O No O Frequency . . . .

Soda/candy/sugar use? Yes O No O

Tobacco use? Yes O No O Types . . . . Daily usage: . . . . Number of years . . . .

Do you exercise? Yes O No O Types . . . . Frequency . . . .

Do you meditate/relax? Yes O No O Types . . . . Frequency . . . .

What is your occupation? . . . . How many hours do you work each week? . . . .

Rate your stress level (1 low – 10 high) . . . . Current stressors? . . . .

Please list all current prescription medications, over the counter meds, herbs and dietary supplements you take:

Medication/ Supplements	Dosage	Purpose	How long have you taken it?	Prescribed by Dr's name or self	Side Effects

Mo/Yr of last medical exam . . . .

Last blood tests . . . . (If you have a copy within the past year please bring it with you to your office visit.)

List any specialty labs that you have had tested (food allergy, cortisol, heavy metal, stool, etc.).

Women: Last pap. . . . . Mammogram. . . . . Menses. . . . .

Bone Density. . . . . Skin exam. . . . . Chiropractic Exam. . . . .

Colonoscopy. . . . . Number of Pregnancies. . . . . Births. . . . .

Miscarriages. . . . . Hysterectomy. . . . .

Men: Last digital rectal exam. . . . . Skin exam. . . . . Colonoscopy. . . . . . .

Chiropractic Exam. . . . . Bone Density. . . . .

TOXIC EXPOSURES

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

. . . .

Are you particularly sensitive to new carpeting, paints, perfumes, gasoline or other vapors?

. . . .

DIET

- ○ Typical American Diet
- ○ Vegan/ Vegetarian
- ○ Could use improvement
- ○ Paleo
- ○ Healthy
- ○ Skips meals

Do you eat breakfast every day? Yes O No O What do you usually have for breakfast?. . . . .

CONTEXT OF CARE REVIEW

What are your long-term health goals?

. . . .

To what extent are you open to changes in lifestyle and diet? Eager O Receptive O Resistant O

What potential obstacles or self-destructive habits do you foresee holding you back from achieving your health goals?

. . . .

What supportive behavior, friend, or lifestyle habit do you foresee pushing you forward to achieving your health goals?

. . . .

What do you love to do?

. . . .

Thank you for taking the time to thoughtfully answer the above questions!
This is the first step toward better health!

Signed. . . . . Date . . . .

(Please give responsible guardian's signature if patient is a minor)

This form is designed to present benefits and risks of the therapies offered by Health Matters and must be signed before treatment is rendered. *Ask your doctor if you have any questions or concerns regarding your consent to treat prior to signing this Informed Consent form.* **Treatments, procedures and/or products used in your treatment at Health Matters may or may not be FDA approved.**

Treatments may include one or a combination of the following:

- Dietary and nutritional counseling
- Nutritional and other supplementations, either orally, topically or as injection/IV therapy such as: vitamins, minerals, enzymes, amino acids, essential fatty acids, homeopathic remedies, homotoxicological preparations and others
- Physical medicine (manipulation), acupuncture, trigger point injection, nutritional or other IV therapy, mesotherapy, chelation ('detox') therapy, hormone replacement therapy, Botox, therapeutic massage, and more.

I am seeking medical health care services, including alternative medical therapies at Health Matters. I hereby request and consent to the performance of physical medicine (including but not limited to various modes of physical therapy and diagnostic testing/examination) or to the performance of acupuncture (including but not limited to needle puncture, point injection, and infrared therapy) or to the performance of naturopathic procedures (including but not limited to examination, diagnostic testing and the use of natural substances such as vitamins, minerals, botanical medicines and prescription drugs) on me (or on the patient named, for whom I am legally responsible) by the doctors and staff of Health Matters.

I understand and am informed that results from treatments may vary and are not guaranteed. In addition, I understand that my compliance with diet recommendations, supplements, prescribed medications, prescribed exercises and lifestyle modification will increase the effectiveness of my care and enhance or maintain the results.

I understand a referral to another physician or specialist may be necessary due to the nature of my condition and limitations in the scope of practice of Naturopathic Medicine.

I acknowledge that the scope of practice of a Naturopathic Physician has limitations including limited prescription privileges and lack of hospital privileges. Consequently a referral to a specialist or emergency room may be deemed necessary under
certain circumstances and is in my best interest. Referrals may not be covered by your insurance carrier.

I understand that this medical practice uses diagnostic and treatment methods that are known as investigational, complementary, alternative, holistic, nutritional, and herbal oriented. Some of these methods have not been accepted by consensus mainstream medicine or the FDA.

I understand that I am in no way obligated to purchase the products or run lab recommended by physicians or staff at Health Matters.
I am free to purchase these products from any source that I may choose.

I do not expect the doctor to be able to anticipate and explain all the risks and complications that could possibly happen during or because of treatment and I wish to rely on the doctor to be able to exercise judgment during the course of the procedure based upon the facts known at that time.

I understand and am informed that, as in the practice of medicine, in the practice of naturopathic medicine, in the practice of spinal manipulative care, in the practice of intravenous therapy, in the practice of acupuncture, in the practice of prolotherapy, in the practice of nutritional and other supplementation, in the practice of hormone therapy, in the practice of any treatment we administer or order there are some risks.

Some of the potential side effects to treatments and therapies are but are not limited to:

- Bruising/Local Tenderness (with venipuncture, acupuncture, Botox, mesotherapy, cupping, manipulation, and other)
- Allergy (with drugs, supplements, anesthesia, nutritional IVs, chelation, and other)
- Drug Side-effects (with drug, supplements, herb-drug interactions)
- Fainting (with supplements, acupuncture, nutritional IVs, chelation, and other)
- Infection (with acupuncture, minor surgeries, venipuncture, implants, injections and other)
- Burns (with cryosurgery, hydrotherapy, infrared therapy, and other)
- Scars (with cryosurgery, acupuncture, moxabustion, venipuncture, hormone implants, minor surgery, and other)
- Vaginal Bleeding in females (with hormone balancing and replacement therapy)
- Fractures, Dislocation, Sprains, Disk Injuries (with manipulation, and other)
- Strokes (with manipulation, and other)
- Organ Puncture (with acupuncture, prolotherapy, minor surgery, and other)
- Organ Failure (with IV chelation, detox, and other)
- Dizziness, weakness, lightheadedness (with injections, IV, prolotherapy, PRP, hormone implants, and other)

Below is a more in-depth explanation of some of the various therapeutic modalities used at Health Matters:

Naturopathic Medicine | A Naturopathic physician is trained as a general family practitioner. Naturopathic physicians combine modern laboratory and physical diagnostic tools with natural, nontoxic therapies that encourage the body's inherent healing abilities. Some of the treatments may include nutrition, herbal medicine, homeopathy, counseling, hormone replacement therapy, hormone pellet insertion, hormone reduction therapy, heavy metal chelation, natural supplementation and other natural remedies.

Nutritional and herbal supplements | At times, your organ systems and tissues may need nutritional and/or herbal support. Make sure to tell your doctor about any medication you are currently taking so that drug/herb/supplement interactions are minimized. Potential side effects of any herb/supplement recommended to you will be discussed by your doctor. **Acupuncture and Traditional Chinese Medicine |** Acupuncture is a 2000 year old medical tradition based on clinical
observation and treatment. Diagnosis in Traditional Chinese Medicine and Acupuncture is based on observation, interview, pulse and tongue diagnosis, and other tools. Following an assessment, treatment may involve acupuncture, TDP heat lamp, or other traditional treatments. Acupuncture involves the placement of sterile one-time use disposable needles into specific points on the body. As with any technique that pierces the skin, infection, although extremely rare with sterile acupuncture needles, is possible. Also extremely rare, permanent nerve damage from acupuncture is possible.

Homeopathy | A system of medicine based on the Law of Similars that was founded over 200 years ago by Samuel Hahnemann, MD (1755-1843). A homeopathic remedy is an FDA approved medicine that consists of a very dilute substance. When given to someone who is healthy, a homeopathic remedy can bring about the same symptoms it can cure. When given to someone suffering from those symptoms, the body is stimulated to heal on its own and the symptoms resolve. Hence, the name, the Law of Similars, or like cures like. There are no known side effects when using homeopathic remedies and no known interactions with any other medication or herb/supplement. These remedies are safe to use on the youngest and most elderly of patients.

Prolotherapy and PRP | Injection of nutrients, precursors and/or a patient's own growth factors into a tendon, ligament or joint needing to be repaired.

We have a wonderful referral network. Your doctor will inform you of alternatives to the above-mentioned therapies. Your health/ well-being is our first concern. Please inform your doctor of any medication change, new allergies or if there is a possibility of pregnancy at any time during your treatment.

PATIENT RIGHTS

- You have the right to be treated with courtesy, respect and dignity.
- You have the right to know the process through which services are offered, including the general course of treatment, and with whom you will be working.
- You have the right to full confidentiality. All transactions and records within this office are kept strictly confidential. Your records may be released to other parties only when requested in writing by you, or when required by law.
- You have access and may request copies of your information at any time.
- You have the right to know and understand the practitioner's assessments and recommendations. These will be given to you at each visit including therapeutic goals, success of treatment, and proposed duration of treatment. If this is unclear please ask.
- If a medication is prescribed, or any other specific treatment is recommended, you have the right to know what the medication or treatment is, why it is being prescribed, what is the expected outcome, and general side effects which might be reasonably expected. Please ask your physician to explain prior to treatment.
- You have the right to access other community services and also the right to select and change practitioners. If you are interested in other practitioners or therapeutic modalities, please ask.
- You have the right to refuse service.
- You have the right to opt-out of newsletter service.
- You have the right to assert your rights as described within this document at any time without retaliation or fear of negative consequence.
- You as a patient have the right to full knowledge of fees.
- You have the right to know of any changes to services or charges and you will be notified.

HORMONE REPLACEMENT THERAPY

All medical treatments have potential side effects. The most common side effects are generally mild and temporary, and may include: overproduction of red blood cells, decreased testosterone and/or sperm production and testicular shrinkage, fluid retention, acne and hair thinning.

I acknowledge, understand and agree that testosterone is intended to lessen or eliminate the signs and symptoms of low testosterone, and to lessen the risk of diseases associated with testosterone deficiency. I acknowledge, understand and agree that testosterone therapy is not accompanied by any guarantees, promises or warrantees.

I hereby consent to get a full physical exam including PSA lab testing, digital rectal exam, PAP, mammogram, complete wellness panel as my doctor recommends.

I acknowledge and understand that hormone replacement therapy, specifically testosterone, is DEA schedule III controlled substance and will require a follow up with my physician and follow up with my physician every 6 months to continue the prescription.

I have read this document and understand it. The staff has answered all of my questions. I consent to use controlled substances and I understand that my treatment with them will be carried out in accordance with the conditions stated above. I understand that if I do not follow the conditions of this consent that I can endanger my health as well as my life.

INTRAVENOUS THERAPY

Informed consent for intravenous nutrition therapy with or without chelating agents for heavy metal toxicity. Informed consent for intravenous treatment for arteriosclerosis disease and/or for prevention of disease. Informed consent for intravenous treatment of flu/colds, cancer, chronic fatigue syndrome, immune system support, multiple sclerosis, auto immune diseases, endocrine dysfunction, fibromyalgia, gulf war illness, scleroderma, revitalization after chemo, chronic Lyme disease, shingles, Epstein-Barr, cardiovascular disease, infections, Alzheimer, hepatitis C and AIDS, heavy metal contamination, allergies and others.

I give consent to the doctors and staff at Health Matters to perform intravenous nutrient therapy, intravenous chelation therapy, intravenous arteriosclerosis therapy and/or any other intravenous therapy deemed by my Health Matters doctor to be beneficial to my care. I understand that the intravenous treatment may contain vitamins, minerals, amino acids, chelating agents (such as DMPS and/or EDTA), glutathione, N-Acetyl-Cysteine, DMSO, procaine, H2o2, alpha lipoic acid, preservative agents, and/or other ingredients as deemed beneficial by my doctor. I understand that any or all of these ingredients may or may not be FDA approved for use intravenously or otherwise.

I have been informed of possible risks and side effects of intravenous therapy including but not limited to severe allergic reactions, discomfort at the injection site, painful and long lasting inflammation of the vein (thrombophlebitis), muscle aches or cramps, bone pain, body odor, low blood calcium, transient dizziness, hypoglycemia, mineral loss, skin rash, kidney irritation and inflammation, nephrotoxicity, congestive heart failure and liver disease. I have disclosed to my physician any known significant clinical conditions including liver, kidney, heart disease, allergies or current pregnancy. I understand that it is my responsibility to report to my treating physician any adverse reactions to the treatment and any changes in my health condition.

I understand that the benefits of intravenous therapy are greater if I eat a healthy diet, drink plenty of water, take extra fiber, get appropriate exercise, get proper sleep and do not smoke. I have not been guaranteed any specific outcome. I understand that I am free to discontinue therapy at any time. I am aware that conventional medicine has other drugs and treatments used for my condition that may differ from the approach I am choosing to use at Health Matters. I understand that I am free to consult with other health care providers at any time regarding my condition. I have not been asked to discontinue care with any other physician or specialist.

I have read this consent and have had the chance to have my questions answered to my full satisfaction regarding the prescribed treatment. I have considered the information given to me in this document, verbally by my provider and Health Matters staff, that which I may have researched outside of this office, including on the Internet and I understand the risks of intravenous and/or chelation therapy. I desire to undergo intravenous and/or chelation therapy as prescribed by my Health Matters provider.
I feel that I fully understand what I am signing and I hereby request and consent to receive intravenous and/or chelation treatments at Health Matters. This signed consent is to remain in effect indefinitely unless revoked by me in writing.

CONSENT FOR USE OF CONTROLLED MEDICATIONS

Health Matters is a primary care facility that occasionally finds it necessary to prescribe medications deemed “controlled” by the Drug Enforcement Agency (DEA). They have been given this designation because of their risk for causing dependency. For your own protection, it is important that you understand that these types of medicines can be used safely and can help to improve your ability to complete your daily activities; however, all medications have possible side effects. Please be sure to understand these potential side effects before starting any medication but especially any controlled substance.

The potential side effects of controlled medications include the following:

- Tolerance – you need more of the medication to get the same effect
- Physical dependence – abrupt stopping of the medication can trigger “withdrawal” syndrome (also, physical dependence in newborns of mother taking opioids while pregnant)
- Psychological dependence – stopping the medications could cause you to miss/crave it

To be prescribed controlled medications, you must agree with the following statements:

- I will take medications only as prescribed by my Health Matters provider.
- I will not allow other individuals to take my medications.
- I will report all prescriptions for other medications (analgesics, antidepressants, etc.) to my Health Matters provider.
- I will inform Health Matters if I see another physician in an emergency or for any other medical reason when controlled substances are prescribed.
- I do NOT have a problem with substance abuse or dependence, including TOBACCO (i.e., I do not use addictive substances or tobacco).
- I am not involved in the sale, illegal possession, diversion, or transport of controlled substances.
- I will agree to participate in a program for chemical dependency should a problem be identified.
- If I am a female of childbearing age, I will inform Health Matters that I may be pregnant.

I understand that treatment with controlled substances WILL BE DISCONTINUED if any of the following occur:

- My physician feels that the controlled substance is no longer the correct medication for me.
- I give away or sell the medication.
- I lose/misplace the prescriptions or medications.
- I do not follow instructions and do not take the medications as prescribed.
- I obtain controlled medications from other sources.
- I abuse other substances (narcotics, alcohol, tobacco, cocaine, etc.).

ALL CONTROLLED MEDICATION REFILLS ARE BY APPOINTMENT ONLY. FAXES FROM PHARMACIES WILL NOT BE ACCEPTED. THIS REQUIRES THAT I PLAN AHEAD AND CALL AT LEAST ONE WEEK BEFORE I NEED MY PRESCRIPTION REFILLED. I MAY ALSO BE REQUIRED TO TAKE A RANDOM URINE TEST AS LONG AS I AM ON PRESCRIPTION MEDICATION.

I have read this document and understand it. The staff has answered all of my questions. I consent to use controlled substances and I understand that my treatment with them will be carried out in accordance with the conditions stated above. I understand that if I do not follow the conditions of this consent that I can endanger my health as well as my life.

Signed. . . . .

Date . . . . (Please give responsible guardian’s signature if patient is a minor)