CYPRESS
NATURAL MEDICINE

Name:_____ Gender: M / F

Date of Birth:_____

Circle One: Minor Single Married/Partnered Divorced Widowed

Address:_____

City:_____ State:_____ Zip Code: _____

Home Phone: ( )_____Cell Phone:( ) _____

Name of Parent/Guardian (if minor): _____

Patient or Parent's Employer:_____

E-mail Address:_____

Emergency Contact:_____ Phone:( )_____

Would you be interested in signing up for our health blog? **Yes / No**

Would you prefer appointment reminders by email versus phone? **Yes / No**

How did you hear about our clinic?

- ☐ Internet Search – Which site or search engine?_____
- ☐ Bay Area Naturally
- ☐ Referred by a friend or acquaintance: _____
- ☐ Referred by another health care practitioner:_____
- ☐ Health Food Store – Which one?_____
- ☐ Bay Area Birth Information
- ☐ Blossom Birth Services
- ☐ Other?_____

***Please ask a staff member if you would like a copy of our privacy policies

Comprehensive Health History Questionnaire (Confidential)

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, please include them. The completed form will greatly assist us in providing a thorough evaluation of your health.

Name:_____ Gender: M / F Date of Birth:_____ Date:_____
Blood Type:_____

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 allergy attack to medication?_____

Hospitalizations & Surgeries (include plastic surgery procedures), 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:

Are you currently (please circle): ☐Married ☐Divorced ☐Single ☐Long-Term Relationship ☐Widowed

Number of children:_____ Ages?_____

Date of last physical exam: _____Date of last blood work?_____

Men: Date of last prostate exam:_____ **Women:** Date of last pelvic exam:_____

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

Health Habits Assessment	Yes	No	If "Yes", how long or how much per week
Do you exercise?			
Do you smoke tobacco currently or in the past?			
Do you drink alcohol currently or in the past?			
Do you use recreational drugs currently or in the past?			
Do you drink "diet" sodas or eat "diet" foods?			
Do you follow any dietary modifications / restrictions?			
Do you have any sleep difficulties?			Average hours per night:

Food or Environmental Allergies: *List any known allergens here.*

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

ENVIRONMENTAL EXPOSURE ASSESSMENT	Yes, Current	Yes, Past	No
Have you ever worked around known toxic chemicals?			
Have you ever been exposed to chemical solvents?			
Do you use oil paints?			
Do you have mercury amalgam fillings?			
Have you ever been excessively exposed to toxic fumes?			
Is there any known exposure to any heavy metals?			
Are you a gardener?			
Do you eat fish or shellfish?			
Do you have difficulty sleeping if you consume caffeine in the afternoon?			
Are you overly sensitive to alcohol consumption?			
Are you sensitive to any chemicals?			

Past Medical History: *Below, please check the appropriate box that applies to you.*

Illness	Current	Past	Illness	Current	Past
Allergies			Gout		
ADD/ADHD			Headaches / Migraine		
Alcoholism			Heart Attack		
Anemia			Hemorrhoids		
Anxiety/Depression			High Blood Pressure		
Arthritis			HIV / AIDS		
Asthma			Hyperthyroid		
Bleeding Disorder			Hypothyroid		
Bloody Stools			Injury (Serious)		
Blurred Vision			Kidney Disease		
Cancer			Low Blood Sugar		
Candida (Yeast)			Numbness / Tingling		
Chemical Sensitivity			Obesity		
Chronic Fatigue Syndrome			Other: Please specify		
Colitis			Ovarian Cysts		
Diabetes			Pneumonia		
Dizziness/Vertigo			Post Traumatic Stress Disorder		
Eczema / Rash / Hives			Recreational Drug Use		
Emphysema			Rheumatoid Arthritis		
Fainting			Schizophrenia		
Fibromyalgia			Seizure / Epilepsy		
Genital Herpes			Stroke		
Gastrointestinal Ulcers			Syphilis		
Glaucoma			Tuberculosis		

Family Medical History	Mother	Father	Brother(s)	Sister(s)	Maternal Grandparents	Paternal Grandparents
Age if living (or death)						
Cause of death						
Alcoholism / Addiction						
Alzheimer's Disease						
Anemia						
Asthma / Allergies / Hives						
Autoimmune Disease						
Blood Disorders						
Cancer: Type?						
Depression / Suicide						
Diabetes						
Epilepsy						
Gastrointestinal Disease						
Glaucoma						
Heart Disease						
High Blood Pressure						
HIV / AIDS						
Mental Illness						
Obesity						
Parkinson's Disease						
Syphilis						
Tuberculosis						

Review of Systems: *Below, please check the appropriate box.*

GENERAL SYMPTOMS:	**Yes, Currently**	**Yes, Past**	**Never**
Feel tired or worn out?			
Low blood sugar?			
Increased thirst?			
Weight gain or loss recently?			
Perspire a lot?			
Heat intolerance?			
Cold intolerance?			
SKIN / HAIR / NAILS:			
Changes in the color of your skin?			
Skin rashes, itching, hives, or eczema?			
Unusually dry skin?			
Growths on your skin?			
Sores or wounds that do not seem to heal?			
Warts?			
Peeling, cracking, or weakness of your fingernails?			
Discoloration of your fingernails or toenails?			
Irregular hair loss or growth?			
EYES:			
Eye pain?			
Blurry vision?			
Nearsighted or Farsighted? (circle one)			
Changes in your vision?			
Eye itching or watering?			
Redness or burning?			
Halos around lights?			
EARS / NOSE / THROAT:			
Difficulty hearing?			
Buzzing or ringing in your ears?			
Earaches or discharge from your ears?			
Nasal stuffiness or sinusitis?			
Post-nasal drip or frequent desire to clear the throat?			
Frequent or severe nose bleeds?			
Difficulty swallowing or choking on food?			
Constriction in the throat?			
Soreness of the tongue or mouth?			
Chancre sores?			
Excess saliva or drooling?			
Bad breath?			
Nasal congestion?			
RESPIRATORY:			
Frequent chest colds?			
Constant or bothersome cough?			
Coughing up blood?			
Difficulty breathing?			
Wheezing or whistling on inhaling or exhaling?			
Shortness of breath			

CARDIOVASCULAR:	**Yes, Currently**	**Yes, Past**	**Never**
High blood pressure?			
Pain, tightness, or pressure in front or back of your chest?			
If yes, is it when walking fast, working hard, or when excited?			
Have you ever had a abnormal EKG?			
Swelling of your feet and ankles?			
Cramps in the calf muscles when you walk?			
Awaken at night with difficulty breathing or suffocation?			
Need to sleep on more than one pillow?			
Fast or irregular heartbeat such as palpitations?			
Do your fingers or toes ever get cold, become numb, or turn bluish?			
Low blood pressure?			
GASTROINTESTINAL:			
Recent change in your eating habits?			
Are there any foods that upset your stomach or cause pain?			
Frequently experience nausea or vomiting?			
Excessive gas, bloating, belching or flatulence?			
Have you ever vomited blood?			
Frequent indigestion, heartburn, or reflux?			
Frequent constipation?			
Frequent diarrhea?			
Poor appetite or easily satiated?			
Blood in the stools?			
Hemorrhoids?			
Frequent use of laxatives?			
Bloating or fatigue after meals?			
Abdominal pain or cramping?			
Does stool or flatulence have an abnormally offensive odor?			
GENITOURINARY:			
Burning or pain on urination?			
Urinary frequency or urgency?			
Urinary incontinence?			
Do you have to wake frequently at night to urinate?			
Frequent bladder or kidney infections?			
Men, any prostate trouble?			
Men, any erectile dysfunction?			
Dribbling urine?			
Frequent yeast infections or “jock itch”?			
MUSCULOSKELETAL:			
Frequent or chronic back pain?			
Pain in the legs or feet?			
Scoliosis?			
Joint pain or stiffness?			
Trouble walking or weakness?			
Do you experience regular pain in your body?			
Physical Trauma or injury?			
Concussion or head trauma?			

CENTRAL NERVOUS SYSTEM:	Yes, Currently	Yes, Past	Never
Frequent of severe headaches?			
Dizzy spells, fainting, or lightheadedness?			
Loss of concentration?			
Disorientation?			
Have you ever lost the ability to speak?			
Have you ever lost consciousness or suffered a concussion?			
Seizures or convulsions?			
Insomnia?			
PSYCHOLOGICAL / MENTAL/ EMOTIONAL			
Nervousness?			
Anxiety or panic attacks?			
Sadness or depression?			
Poor memory?			
Moodiness, irritability, or anger?			
Restlessness?			
Hospitalized for a psychological condition?			
Have you ever attempted suicide?			
Suicidal thoughts?			
Have you been diagnosed with a psychological condition?			

WOMEN ONLY - GYNECOLOGY & PREGNANCY:

Please specify the number of: Births_____ Miscarriages_____ Abortions_____

Age at first period:_____Age at menopause:_____Menopausal symptoms:_____

Regular or Irregular cycles? (circle one) Duration of flow (days):_____ Time between cycles (days):_____

Flow (Check one): ☐ Excessive ☐ Moderate ☐ Scanty

PMS (Check one): ☐ Severe ☐ Moderate ☐ Mild ☐ Never
Symptoms:_____

Cramping (Check one): □ Severe □ Moderate □ Mild □ Never

Date of last period:_____Method of birth control:_____

Gynecological History: Below, please check those that apply:

☐ Breast lumps	☐ Breast tenderness	☐ History of genital warts	☐ Painful orgasm
☐ Vaginal discharge	☐ Nipple discharge	☐ Painful intercourse	☐ Mother/Sister breast cancer
☐ Vaginal dryness	☐ Vaginal itching	☐ Water retention	☐ IUD
☐ Infertility issues	☐ Abnormal PAP	☐ Spotting between periods	☐ Hysterectomy

Clinic Fees and Payment Policies

We make every effort to minimize the cost of your medical care. Full payment is required at the time of service. We accept payment by cash, check or credit card (Visa, Mastercard, American Express). Payment plans are available in cases of financial hardship. Checks or charges that are denied for lack of funds will incur a fee of $35.00 per transaction. Slight fee increases will occur in January of each year to accommodate increases in expenses. We are committed to providing economical, quality health care. Thank you for your patronage.

Cypress Natural Medicine Fee Schedule

Naturopathic Medicine / Bio-Communication Appointments with Dr. Destia Skinner / Dr. Bryan Skinner	
First Office Visit	$390
Return Office Visit	$195
Naturopathic Medicine / Bio-Communication Appointments with Dr. Raquel Espinol	
First Office Visit	$330
Return Office Visit	$165
Craniosacral Therapy Appointments	
First Office Visit for Adult	$390
First Office Visit for Child	$300
Return Office Visit for Adult	$195
Return Office Visit for Child	$145
Return Office Visit for Craniosacral + Naturopathic	$350
Osteopathic Appointments with Dr. Jennifer Logan	
First Office Visit for Adult	$400
Return Office Visit	$225
Mind / Body Healing with Dr. Marie Rodriguez	$335

***All Intravenous Therapy and Aesthetic procedures are individually priced based on the needs of the patient. Please contact the clinic more details**.

Telephone Consultations

Telephone consultations are available for new and existing patients. All telephone consultations are billed at the same rate as in-person visits.

Cancellation Policies

Appointments cancelled with greater than 48 hours notice will incur no charge. A full office visit fee will be charged for failure to provide 48 hours notice of cancellation.

I agree to payment according to the policies provided above.

_____ _____

Patient / Guardian Signature **Date**

_____

Patient / Guardian Printed Name

Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for Cypress Natural Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

With this consent, Cypress Natural Medicine may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Cypress Natural Medicine may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Cypress Natural Medicine may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Cypress Natural Medicine restrict how it uses or discloses my PHI to carry out TPO. The practice is 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 allow Cypress Natural Medicine to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Cypress Natural Medicine may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name **Date**

_____

Print Legal Guardian's Name (if applicable)

Cypress Natural Medicine Email Policy Agreement

On the occasion that I may wish to communicate with any employee or practitioner at the office of Cypress Natural Medicine by email:

1. I am aware that email communication is not 100% reliable or secure, but I acknowledge that the doctors and their staff assured me that they make every effort to protect my privacy. Please be aware that email communication is not a substitute for an in-person office visit with a doctor.

2. I am aware and agree that a hard copy of pertinent correspondence will be filed in my medical chart.

3. I agree to include my name and telephone number in the body of all email I send to my doctors' office to ensure that they have an alternate means of contacting me.

4. I will limit my email to: Clarifying a current treatment plan or symptoms relating to current treatment plan, ask routine, non-urgent medical questions; or I will make an appointment. (Some questions require an office visit depending on the length and complexity of the question.)

5. We do not accept prescription medication refill requests by email

6. New health complaints will require an office visit.

7. I will not email my doctor regarding emergencies, and I am aware that time-sensitive matters are not appropriate for email communication.

8. I acknowledge that it could take up 72 hours to receive a response. However, there is no way to guarantee that this will occur, for a variety of legitimate reasons (misaddressed email, server down, electric power failure, etc.). If I do not get a response to my email within 72 hours, I will contact the doctors or their staff via other means.

9. I understand the policies and agree to abide by them in full.

10. I agree to pay the doctor's fees for email communication if applicable. If we are on vacation, you will receive an automated reply with further instructions to contact the office by telephone.

_____ _____

Patient / Guardian signature **Date**