INTEGRATIVE MEDICINE &
HOLISTIC WELLNESS CENTER

NUTRITIONAL HOLISTIC HEALTH ASSESSMENT

Date:

Name: _____ **Signature:** _____

Sex: ❑ Male ❑ Female ❑ Other _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Partnership

Age: _____ **Height:** _____ **Weight:** Past: _____ Current: _____

Occupation: _____

Address: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Please describe your present health concerns and their duration.

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Disclosure Statement and Informed Consent

Dr. Jose M. Fernandez & Nutrition Coaches

I,_____(client name) request, authorize and consent to a program of holistic health education services, which includes consultation and recommendation, to be performed by Jose Fernandez, D.C.

I understand that the holistic health education services to be performed does not constitute as medical care and/or medical treatment which may only be provided in the state of Massachusetts by licensed medical providers. It is expressly understood that Dr. Fernandez does not diagnose and/or treat any disease and/or condition I have or may have under holistic health education services, but rather the consultation services to be provided by Dr. Fernandez offer an alternative approach for the condition(s) presented to him at the time of service.

It is understood that the holistic health education services provided by Dr. Fernandez are not to act as a replacement or substitute for proper medical care by licensed medical providers and that it is the responsibility of the client to obtain such treatment by primary care physicians and/or specialists and to obtain all appropriate diagnostic tests and evaluations. It is also understood that it is my responsibility, as the patient, to inform my primary care physician and/or other medical providers and to keep them regularly informed of the program recommended by Dr. Fernandez.

Notice to Pregnant Women: All female clients must alert Dr. Fernandez if they know or suspect they are pregnant or trying to become pregnant as some of the recommended therapies could present a risk to the pregnancy. It is further understood that the ultimate responsibility for my health is my own and that it is my responsibility to inform Dr. Fernandez of my complete medical and family history and of all other relevant factors concerning my condition(s) and to keep him advised of any prescription or over the counter medications including natural medicines that are utilized.

I understand, acknowledge and accept that a holistic educational program is not an exact science and that I have received no guarantees by Dr. Fernandez or any of his personnel and associates regarding complete resolution or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation at any time. I understand that my health record is confidential and that I may look at my health record at any time and can request a copy of it by giving appropriate and reasonable notice.

I understand that it is not being recommended to me to discontinue any other treatment or care being provided by any other licensed health care professional. I understand that Dr. Fernandez does not function as a primary care physician in the State of Massachusetts when he is providing holistic health education consultation services only, and that he offers his services in addition to the other services I receive elsewhere. I understand that he does not replace the service I receive from my primary care provider or other specialist(s).

It is also understood that there may be alternative programs; including alternative forms of medical treatment and that such medical alternatives are to be explained to me by the appropriate licensed medical provider(s). It is also understood that there are risks attendant to the services provided by Dr. Fernandez, including, but not limited to, unforeseen adverse or allergic reactions to recommended herbs and supplements, side effects of natural medications, or inconvenience of lifestyle changes.

I acknowledge and understand this entire document and have been given the opportunity to ask questions and those questions have been answered to my satisfaction. I choose to undergo holistic health education consultation and services and do so willingly as my freedom of choice for my healthcare and current medical condition.

_____ _____

Date Patient Signature

INTEGRATIVE MEDICINE &
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677 West Main Street, Hyannis, MA 02601
PHONE: (508) 790-0606 FAX: 508-790-0808

Informed Consent for Health Consultation: I herby authorize my practitioner to advise the use of the following therapies.

Nutritional Supplementation: concentrated dosages of vitamins, minerals, and other substances of naturally occurring foods.

Botanical medicine: concentrated or un-concentrated dosages of herbs, plants, and/or their constituents. Botanical substances may be prescribed as granules, teas, alcoholic tinctures, glycerite tinctures, capsules, tablets, creams, plasters or suppositories.

Homeopathic remedies: highly dilute quantities of a plant, animal, and mineral substances delivered on sucrose pellets or in 25% alcohol liquid preparations.

Psychological: stress reduction techniques.

I recognize the potential risks and benefits of these therapies as described below.

Potential risks: allergic reactions to prescribe herbs and supplements, side effects of natural medications, an inconvenience in lifestyle changes.

I understand the U.S. Food and Drug Administration has not evaluated or approved nutritional/herbal supplements or homeopathic remedies. I understand that, as with drugs, nutritional/herbal supplements and homeopathic remedies may cause some side effects in certain sensitive individuals, may interact with certain prescription medications or lab tests, or cause symptoms due to certain pre-existing disease conditions.

I do not expect my Practitioner to be able to anticipate and explain all risk potential complications. I wish to rely on my practitioner to exercise judgement in recommending therapies they feel are in my best interest, based on available knowledge. I have the opportunity to ask questions and discuss with my practitioner; 1) my condition 2)the nature, purpose and potential benefit of the proposed therapies 3) the material risks inherent in therapies 4) the probability of those risks occurring 5) the likelihood of success 6) reasonably available alternatives to the proposed therapies 7) the material risks inherent in such alternatives and the probability of such risks occurring 8)the possibility of consequences if advice is not followed and/or no therapies are undertaken.

Notice to Pregnant Woman: All female patients must alert the practitioner if they know or suspect that they are pregnant, as some of the therapies used could present risk to pregnancy.

With this knowledge, I voluntarily consent to the above therapies, realizing, that no guarantees have been made to me by the practitioner or any of his personnel, regarding prevention, treatment or cure of my condition or any condition. I understand that is my free will to withdraw my consent and discontinue participation in these therapies at any time. **I understand that it is not being recommended for me to discontinue any other treatment or care that is being provided by any other health care professional.**

I understand this practitioner does not function as a primary care physician, and that he offers services in addition to other services I receive. I understand the practitioner does not replace a specialist. I will discuss all my prescription medication questions and changes with my primary care or specialist. I understand that naturopathic therapies do not replace conventional medical advice or care.

Patient Printed Name_____ Patient Signature_____ Date_____

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PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the discloser of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of IM&HWC
or have been offered a copy and declined to take it: *Notices of Privacy Practices for Protection of Health Information.*

_____	_____/_____/_____	_____
Patient Name Printed	Date	Patient Signature
_____	_____	_____
Authorized Provider Rep.	Patient Representative Printed Relationship to Patient:	Patient Representative Signature

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Appointment Reminders and Health Care Information Authority

Your health care provider and members of the practice staff may need to use your name, address, phone numbers and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information. If you do not wish us to contact you by phone please note this by putting your initials here. **Initial here:** _____

You may restrict the individuals or organization to which your health care information is released or you may revoke your authorization to us at anytime: however, your revocation must be in writing and mailed to us, to our office address, as stated above. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. In addition, if we required your authorization to bill your insurance, we will need to continue to use that information to process your claim. The insurance company may have a right to your health information if they decide to contact us for further information or to process any of your claims.

Occasionally, an attorney or health related agency may require us to send them information on your behalf. It is our policy that a separate signed authorization to release information must be attached to any outside request for information. You have the right to refuse to give us authorization. If you do not give us authorization, it will not affect the treatment we provide or the methods we use to give you the necessary health care you need.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of ____/____/____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have been offered a copy of this authorization, which I may or may not have chosen to take.

_____	_____/_____/_____	_____
Patient Name Printed	Date	Patient Signature
_____	_____	_____
Authorized Provider Rep.	Patient Representative Printed Relationship to Patient:	Patient Representative Signature

Are you currently under the care of a family physician or any other health professional?

❑ Yes ❑ No

If yes, please explain: _____

Are you currently taking any medications and/or receiving any medical treatment for your health condition? If so, please list all medications/treatments and their dosage.

Are you allergic to any substances? Please specify: food, pollen, dust, etc., and any other allergic reactions?

Do you have any past medical history? If yes, please specify the age of occurrence, duration, and its treatment.

HEALTH AS A CHILD

❑ Good ❑ Fair ❑ Poor

How would you rate your usual energy level?

❑ Very high ❑ High ❑ Moderate ❑ Low ❑ Very low

DIGESTION

Do you experience any of the following?

❑ Gas ❑ Heartburn ❑ Low appetite
❑ Bloating ❑ Sour burps ❑ Nausea
❑ Constipation ❑ Diarrhea ❑ Heavy feeling in stomach

BOWEL MOVEMENTS

❑ Once every 2–3 days ❑ Once daily ❑ 2–3 times per day
❑ First thing in the morning ❑ Late in daytime ❑ Immediately after meals
❑ Immediately after dinner ❑ Need laxative daily ❑ Other, please specify: _____

Bowel nature:

❑ Soft ❑ Medium ❑ Hard

Bowel movement associated with:

❑ Pain ❑ Gas ❑ Blood ❑ Mucous
❑ Foul smell ❑ Other: _____

URINATION

Do you have any of the following urinary problems?

❑ Pain ❑ Burning sensation ❑ Discoloration ❑ Frequent urination during the day
❑ Urination several times during the night ❑ Other: _____

NATURAL URGES

Do you delay or suppress any of the following?

❑ Bowel movements ❑ Gas ❑ Urination ❑ Sleep ❑ Yawning ❑ Burping
❑ Breathing ❑ Sneezing ❑ Hunger ❑ Thirst ❑ Semen ❑ Cry, tears

SLEEPING

What time do you go to sleep? _____ **What time do you wake up?** _____

Do you sleep during the day?

❑ Yes ❑ No

How do you generally feel when you wake up in the morning?

❑ Fresh and rested ❑ Little tired ❑ Very tired

How is your sleep?

❑ Sound, normal duration
❑ Too heavy and or too long
❑ Wake up too early
❑ Light, interrupted
❑ Difficulty falling asleep
❑ Frequent nightmares
❑ Too little sleep
❑ Difficulty waking up

EMOTIONS

What is your present state of mind and emotions?

❑ Good ❑ Fair ❑ Poor

Do you often experience any of the following?

❑ Worry ❑ Anxiety ❑ Fear or panic ❑ Loneliness ❑ Depression
❑ High stress level ❑ Lack of memory ❑ Light-headedness ❑ Lack of energy
❑ Anger ❑ Irritation

How are your family relationships?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

How is your social life?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

How is your mental status?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

How is your career?

❑ Love it ❑ Like it ❑ Dislike it

How purposeful is your life?

❑ Completely ❑ Neutral ❑ Not happy

Rate your spiritual life:

❑ Satisfying ❑ Neutral ❑ Empty

DAILY ROUTINE

How regular is your daily routine?
(for example, do you go to bed early, eat your meals on time, exercise regularly, etc.?)

❑ Very regular ❑ Somewhat regular ❑ Irregular

Do you practice any type of meditation? Please explain.

Do you practice any yoga techniques? Please explain.

Do you travel a lot?

❑ Yes ❑ No

How often do you smoke cigarettes?

❑ Never ❑ Less than once a week ❑ About once a week ❑ Several times a week
❑ More than once a day

How often do you drink alcohol?

❑ Never ❑ Less than once a week ❑ About once a week ❑ Several times a week
❑ More than once a day

How often do you drink caffeinated beverages (coffee, tea, etc.)?

❑ Never ❑ One cup daily ❑ 2–3 cups daily ❑ 4–5 cups daily

Which type of weather makes you feel most uncomfortable? (Choose one)

❑ Cold ❑ Hot ❑ Cool and damp

PHYSICAL BODY

What is your body build?

❑ Thin ❑ Large ❑ Average ❑ Muscular

Are you overweight?

❑ Yes ❑ No

If so, by how much?

❑ Less than 15 pounds ❑ 15–30 pounds ❑ 30–50 pounds ❑ More than 50 pounds

How often do you exercise?

❑ Once a week ❑ Twice a week ❑ 3–4 days a week ❑ 5–6 days a week
❑ Every day ❑ Not at all

How long do you exercise? _____ **What type of exercise?** _____

Is your exercise: (choose one)

❑ Vigorous ❑ Moderate ❑ Light

FOOD PRACTICES

Food Groups	Daily	Weekly	Monthly	Never
Grains / Cereals				
Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meat				
Seafood				
Sugar / Honey				
Desserts				
Juices				
Other				

Please explain what you typically eat for meals.

Breakfast

Lunch

Dinner

Snacks

Do you eat between meals?

❑ Yes ❑ No

Do you eat your meals at the same times daily?

❑ Yes ❑ No

Which is your main meal?

❑ Breakfast ❑ Lunch ❑ Dinner

Rate your digestion:

❑ Good ❑ Fair ❑ Poor

How much water you drink per day?

❑ Never ❑ 1–2 glasses ❑ 3–4 glasses ❑ 5–6 glasses ❑ 7 glasses or more

My eating habits include:

❑ Eat with full attention on food ❑ Talk or converse a lot while eating ❑ Eat very fast
❑ Watch television while eating ❑ Never sit to eat

Describe your diet:

❑ Vegan ❑ Lacto-vegetarian ❑ Ova-lacto-vegetarian
❑ Other, please specify: _____

Non-vegetarian:

❑ Beef ❑ Pork ❑ Chicken ❑ Turkey ❑ Seafood ❑ Eggs
❑ Other, please specify: _____

What taste(s) do you like or crave?

❑ Sweet ❑ Salty ❑ Bitter ❑ Sour ❑ Hot/Spicy ❑ Starches ❑ Oily

Are there any particular foods that create discomfort when you eat them?

❑ Sweet ❑ Sour ❑ Oily/fatty ❑ Hot ❑ Salty ❑ Bitter ❑ Astringent
❑ Dairy products ❑ Other: _____

FOR WOMEN

Age menses began: _____

Which of the following describes your menstruation? (You may choose more than one)

❑ Regular ❑ Irregular ❑ Too frequent ❑ Absent ❑ Ceased due to menopause

How many days does your menstrual period last?

❑ 0–4 days ❑ 5–7 days ❑ More than 7 days ❑ Spotty or irregular throughout the month
❑ Other, please explain: _____

How is your menstrual flow?

❑ Heavy ❑ Light ❑ Normal

Associated symptoms (before or during menstruation):

❑ Food Cravings ❑ Cramping ❑ Fluid retention ❑ Migraine ❑ Depression ❑ Acne
❑ Tension ❑ Anger ❑ Frustration ❑ Breast tenderness ❑ Nightmares
❑ Other, please specify: _____

Do you experience pain during intercourse?

❑ Yes ❑ No

Do you have any sexual difficulties?

❑ Yes ❑ No If yes, please explain: _____

Are you pregnant now?

❑ Yes ❑ No ❑ Don't know

Do you take contraceptive pills or use other forms of birth control?

❑ Yes ❑ No If yes, please explain: _____

Number of previous pregnancies: _____ **How many children do you have?** _____

Do you do breast self-exams regularly?

❑ Yes ❑ No

Do you experience any problems in your breasts?

❑ Lumps ❑ Pain or tenderness ❑ Nipple discharge ❑ Other: _____

DETERMINING YOUR CURRENT STATE OF BEING USING AYURVEDA:

When answering the following questions, evaluate your current state of being. Circle one description for each row, or two if the answers are close.

Mental Profile

	Vata		Pitta		Kapha	
Mental activity	Quick, active, restless		Sharp, critical, aggressive		Calm, steady, slow, stable	
Memory	Short term		Generally good		Good long term	
Concentration	Weak		Generally good		Very good	
Ability to learn	Quick to grasp concepts		Moderate ability to grasp new information		Slow to grasp new information	

Dreams	Fearful, very active, flying,		Aggressive, fiery, adventurous		Watery, romance, relationships	
Sleep	Light, interrupted		Sound, medium		Sound, heavy, long	
Speech	Quick, can miss words		Sharp, direct, strong		Slower, clear, melodious	
Voice	High pitched		Medium pitched		Low pitched	
Sub-total						

Behavioral Profile

	Vata		Pitta		Kapha	
Eating speed	Fast		Medium		Slow	
Hunger level	Irregular		Sharp, can be strong		Can easily miss meals	
Food/Drink	Prefers warm		Prefers cold		Prefers dry and warm	
Achieving goals	Easily distracted		Focused and driven		Slow and steady	
Giving/donations	Gives small amounts		Gives nothing or large amounts infrequently		Gives regularly and generously	
Relationships	Many casual		Intense		Long and deep	
Sex drive	Variable, low		Moderate		Strong	
Works best	Supervised		Alone		In groups	
Weather preference	Warm and moist		Cool and dry		Warm and dry	
Reaction to stress	Excites quickly		Medium		Slow to get excited	
Financial	Doesn't save, spends quickly		Saves but big spender		Saves regularly, accumulates wealth	
Routine	Dislikes routine		Likes planning and organizing		Works well with routine	
Sub-total						

Emotional Profile

	Vata		Pitta		Kapha	
Moods	Changes quickly		Changes slowly		Steady, unchanging	
Reacts to stress with	Fear		Anger		Indifference	
More sensitive to	Own feelings		Not sensitive		Others feelings	
When threatened tends to	Run		Fight		Make peace	
Relations with spouse/partner	Clingy		Jealous		Secure	
Expresses affections	With words		With gifts		With touch	
When feeling hurt	Cries		Argues		Withdraws	
Emotional trauma causes	Anxiety		Denial		Depression	
Confidence level	Timid		Outwardly self-confident		Inner confidence	
Sub-total						

Physical Profile

	Vata		Pitta		Kapha	
Amount of hair	Average		Thinning		Thick	
Hair type	Dry, frizzy, thin, dark		Straight, fine, premature graying		Oily, wavy, thick	
Hair color	Light brown, blond		Auburn, reddish		Dark brown, black	
Skin	Dry, rough or both, dark/sallow, tans easily, cold		Soft, normal to oily, light, sunburns easily, warm		Oily, moist, fair, thic, cool	
Complexion	Darker		Pink, red		Pale/white	
Eyes	Small, brown, gray, violet, unusual color		Medium, green, hazel, almond-shaped		Large, dark, blue	
Whites of eyes	Blue/brown		Yellow or red		Glossy/white	

Teeth	Very large or very small		Small -medium		Medium-large	
Weight	Thin, hard to gain		Medium		Heavy, easy to gain	
Elimination	Dry, hard, thin, easily constipated		Many during day, soft to normal		Heavy, slow, thick, regular	
Sweat	Scanty		Profuse		Moderate	
Sub-total						

Total	Vata		Pitta		Kapha	

STATEMENT OF UNDERSTANDING AND DISCLOSURE AUTHORIZATION FORM

I understand that the role of Deborah Hoxie, as an Ayurvedic Health Counselor, is to serve as an educator. She is not a medical doctor or licensed medical practitioner, and does not diagnose, treat, or prescribe remedies for diseases, disorders, or other pathological conditions.

If I have any active health concerns or issues, I understand that Deborah Hoxie encourages me to have a regular medical checkup with a licensed medical professional of my choice, especially if the concern has taken the form of a disease or pathology. Furthermore, I understand that any medication that I am now taking or may take in the future is strictly based upon the directions of the my prescribing physician, and that only a licensed physician can advise a patient on medication dosages or the choice to discontinue or resume taking medication.

As part of my Ayurvedic Health Counsultation, I may be asked to answer questions or complete written forms that disclose private health information (PHI). I understand that these forms and the PHI they contain are to be used only by Deborah Hoxie of Ayurveda Cape Cod. All forms containing PHI are kept in a locked file cabinet.

I sign below to indicate that I have carefully read and understand the above terms, which I accept in their entirety and without reservation, and to authorize the disclosure of my private and protected health information to Deborah Hoxie, Ayurveda Cape Cod, for purposes of an Ayurvedic Health Counsultation as stated. These terms and the authorization to disclose can be revoked at any time by delivering a written revocation to Deborah Hoxie.

Signature: _____ Date: _____

Print Name: _____