

Date

Dear

Recognizing and respecting our abilities as human beings to heal ourselves, we offer natural therapies that support the body's inherent healing abilities. We embrace the whole family: babies, children, adults, and seniors.

Your initial appointment has been scheduled on \_\_\_\_\_,  
\_\_\_\_\_ at \_\_\_\_\_.

Please arrive 10 minutes before your scheduled time to complete your paperwork. If you must cancel or change this appointment, please notify us at least two business days in advance.

Please complete the following forms and bring them with you to your appointment. Copies of relevant medical records and lab results would be appreciated.

Dr. Mitchell is a provider with Connecticut Anthem Blue Cross. Don't forget your insurance card. If you need a referral, please arrange that with your referring physician. Many other insurance companies cover naturopathic medical services. Call your insurance company. It may take persistence.

Feel free to call if you have any additional questions. We look forward to meeting you.

**Many of the people who come to our office have severe allergies.**  
**Please don't wear perfume, cologne or strong scents when you come.**  
**Thank you.**

**PATIENT INFORMATION** (Please Print)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Email \_\_\_\_\_ Cell # \_\_\_\_\_  
Name of Employer \_\_\_\_\_ SS# \_\_\_\_\_  
Work Address \_\_\_\_\_ Work # \_\_\_\_\_  
Name of spouse/ partner \_\_\_\_\_ Work # \_\_\_\_\_  
If minor, name of parent/guardian(s) \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_  
Emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_  
How did you find out about us? \_\_\_\_\_

**INSURANCE INFORMATION** for Anthem Blue Cross only

Please give us your insurance card to copy.

Name of Insurance Company \_\_\_\_\_  
ID # \_\_\_\_\_ Plan Name & # \_\_\_\_\_  
Name of Insured (if different from patient) \_\_\_\_\_  
Address of Insured \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Employer \_\_\_\_\_

I authorize any holder of medical information about me to release to HCFA and its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits payable for related services. I request that payment of authorized benefits be made on my behalf to Anne Mitchell, N.D. for any services furnished to me.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### Office Policy

Thank you for choosing naturopathic medicine and this office for your health care needs. We hope your time with us is all you wish it to be. We encourage comments, questions, and suggestions. Your health and well being are our prime considerations.

- **Office hours**

Office hours are Tuesday, Wednesday, Thursday and Friday.

- **Cancellation Policy**

Your appointment time is reserved for you so please notify us if you can't come.

We try to remind you by phone before your appointment. If you do not want us to call or leave a message for you please let us know.

We ask for a minimum of 48 hours notice for cancellations so we can give your time to someone else. You may be charged for a missed appointment.

- **Telephone calls**

The staff is knowledgeable and available to answer most of your questions. If we are busy with patients, the telephone will be answered by an automated system. Leave a message and your call will be returned as soon as possible. If you're ill or in pain, please say so at the time of your call so we can determine if you need to be seen immediately.

- **HIPAA**

This is a very small medical office. Your health care information is confidential and access is limited. We use your health care information about you for diagnosis and treatment, to consult with other health care practitioners when necessary and with your permission, to obtain payment for treatment, for administrative services, and to evaluate the quality of care you receive. We will not disclose health information for other reasons without your signed permission unless it is required by law. You have the right to examine your records and to have copies for a reasonable fee. You may request a change in your records if you believe they are incomplete or incorrect. If you are concerned we have violated your privacy rights you may complain to us or directly to the US Department of Health and Human Services. We are required by law to protect the privacy of your information and to provide you with this information. More complete rules and regulations are available on request.

I understand my rights under the Health Insurance Portability and Accountability Act of 1996.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Financial Policy**

We make every effort to keep down the cost of your health care. Payment is expected at the time of your visit. Any laboratory tests and medications from our dispensary that you and your doctor decide are necessary are in addition to your visit charge. They must be paid for when you receive them. We accept VISA, Master Card, and of course, cash and checks. There is a fee for returned checks. If we have to bill you, we will charge you \$5 each time we send you a bill. We reserve the right to seek outside counsel for any unpaid bills.

Many insurance companies cover naturopathic medical services. Read your policy. Submit your claims. Don't give up easily! If your policy covers out-of-plan providers, or is a point-of-service plan and allows you to choose your doctor, it's likely that you will be reimbursed by your insurance company when you send in your claims. Payment is required at the time of your visit. You may submit the receipt we give you for out-of-plan coverage as it provides all the information your insurance company needs. Dr. Mitchell's services are frequently covered in this way.

**Dr. Mitchell is a provider for CONNECTICUT ANTHEM BLUE CROSS.**

With Anthem policies, we will collect your co-payment. We will submit claims and accept the amount allowed by your insurance company for covered services. Some of the services may not be covered by your insurance company. These are procedures or treatments or testing that they do not recognize. If your insurance company does not cover these fees, you are responsible for them. As Anthem will pay for approximately 15 minutes of Dr. Mitchell's time with a new patient, you may be charged an additional fee at that visit. These charges will be discussed with you prior to treatment. You will need to contact your PCP for a referral if it is required by your health plan.

Unfortunately, MEDICARE does not cover naturopathic services. There is no coverage under Medicare through Anthem Blue Cross even with participating naturopathic physicians. Medicare is a federal program and the federal government does not recognize naturopathic physicians. We are required by law to submit claims to Medicare for denial, however, payment is due at the time of service. To our knowledge, Federal Blue Cross programs do not cover any naturopathic services. We do not accept Workers Compensation coverage, auto medical benefit coverage, Medicaid or Title 19.

**I have read and understood the information provided above. I hereby authorize Dr. Anne Mitchell and her designated assistants to examine and treat me. I understand and agree that I am responsible for payment in full on my account.**

Name of Patient \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Signature of Responsible Party \_\_\_\_\_

**SYMPTOM SURVEY**

**NAME** \_\_\_\_\_

**DATE** \_\_\_\_\_

What is your major complaint? \_\_\_\_\_  
 \_\_\_\_\_

Are you coming for any specific therapy? (i.e. homeopathy, acupuncture, nutritional counseling, physical medicine, "anything that works") \_\_\_\_\_  
 \_\_\_\_\_

This survey will help us to evaluate you more completely. Please place a check mark next to those symptoms which you NOW experience or have experienced in the PAST. Include all the complaints which are familiar to you. If there are one or more words in a line which describe your specific problem you may want to circle those words.

<b>NOW</b>	<b>PAST</b>	<b><u>GENERAL SYMPTOMS</u></b>	<b>NOW</b>	<b>PAST</b>	<b><u>EYES</u></b>
_____	_____	tired, weak, lack of energy	_____	_____	nearsightedness or farsightedness
_____	_____	depression, melancholy, moodiness	_____	_____	blurred or failing vision
_____	_____	worry, anxiety, nervousness, irritability	_____	_____	dry, burning or itching eyes
_____	_____	sleeplessness or sleep too much	_____	_____	eyes water excessively
_____	_____	frequent colds or other illness	_____	_____	eyes sensitive to light
_____	_____	headaches	_____	_____	night blindness
_____	_____	don't sweat enough	_____	_____	bloodshot or puffy eyes
_____	_____	sweat too much	_____	_____	other _____
_____	_____	night sweats			
_____	_____	dizziness, fainting, convulsions			
_____	_____	loss or gain of weight	<b>NOW</b>	<b>PAST</b>	<b><u>EARS</u></b>
_____	_____	other _____	_____	_____	earaches
			_____	_____	noises or ringing in ears
<b>NOW</b>	<b>PAST</b>	<b><u>SKIN AND HAIR</u></b>	_____	_____	ear discharges
_____	_____	acne or pimples	_____	_____	loss of hearing
_____	_____	skin rashes	_____	_____	lots of wax
_____	_____	hives	_____	_____	other _____
_____	_____	stretch marks			
_____	_____	skin ulcers or sores	<b>NOW</b>	<b>PAST</b>	<b><u>NOSE AND THROAT</u></b>
_____	_____	dryness, roughness or scaling skin,	_____	_____	hay fever, sinusitis, runny nose
		scalp, elbows, knees, feet,	_____	_____	dry mouth or nose
		around nose, ears, eyebrows, etc.	_____	_____	nosebleeds
_____	_____	hair loss or thinning	_____	_____	cracks in corners of mouth
_____	_____	dry, coarse hair or split ends	_____	_____	dry or chapped lips
_____	_____	bruise easily	_____	_____	sore throats or tonsillitis
_____	_____	nails weak, ridged or split easily	_____	_____	clear throat often
_____	_____	brown spots or bronzing on skin	_____	_____	sore, red or cracked tongue
_____	_____	moles, warts or skin tags	_____	_____	cold sores or herpes
_____	_____	sunburn easily	_____	_____	inability to smell or taste
_____	_____	cuts heal slowly or scar badly	_____	_____	lots of cavities
_____	_____	flush easily	_____	_____	bleeding gums
_____	_____	hands or feet numb or tingling	_____	_____	hoarseness
_____	_____	feet burn	_____	_____	other _____
_____	_____	athletes foot			
_____	_____	other _____	<b>NOW</b>	<b>PAST</b>	<b><u>MUSCULO-SKELETAL</u></b>
			_____	_____	muscle pain or stiffness
			_____	_____	where? _____
<b>NOW</b>	<b>PAST</b>	<b><u>RESPIRATORY</u></b>	_____	_____	swollen, painful or stiff joints
_____	_____	cough frequently	_____	_____	bone pains
_____	_____	spitting up mucus or blood	_____	_____	painful feet, ankles or calves
_____	_____	difficulty breathing	_____	_____	tremors or twitches
_____	_____	shortness of breath on exertion	_____	_____	loss of strength
_____	_____	chest pain	_____	_____	hernia
_____	_____	other _____	_____	_____	

\_\_\_\_\_ muscle wasting  
 \_\_\_\_\_ other \_\_\_\_\_

**NOW**    **PAST**    **GASTROINTESTINAL**  
 \_\_\_\_\_    \_\_\_\_\_    loss of appetite  
 \_\_\_\_\_    \_\_\_\_\_    gagging, difficulty swallowing  
 \_\_\_\_\_    \_\_\_\_\_    nausea or vomiting  
 \_\_\_\_\_    \_\_\_\_\_    bad breath  
 \_\_\_\_\_    \_\_\_\_\_    metallic or bitter taste in mouth  
 \_\_\_\_\_    \_\_\_\_\_    food cravings or strong desires  
 \_\_\_\_\_    \_\_\_\_\_    can't eat fats  
 \_\_\_\_\_    \_\_\_\_\_    heartburn  
 \_\_\_\_\_    \_\_\_\_\_    indigestion or distress  
 \_\_\_\_\_    \_\_\_\_\_    heaviness after eating  
 \_\_\_\_\_    \_\_\_\_\_    belching                    or gas  
 \_\_\_\_\_    \_\_\_\_\_    bloating  
 \_\_\_\_\_    \_\_\_\_\_    stomach or abdomen tender or painful  
 \_\_\_\_\_    \_\_\_\_\_    symptoms relieved by eating  
 \_\_\_\_\_    \_\_\_\_\_    symptoms worse after eating  
 \_\_\_\_\_    \_\_\_\_\_    avoid certain foods  
 \_\_\_\_\_    \_\_\_\_\_    headache, dizziness or irritability if  
                                  skip meal  
 \_\_\_\_\_    \_\_\_\_\_    diarrhea or loose stools  
 \_\_\_\_\_    \_\_\_\_\_    constipation  
 \_\_\_\_\_    \_\_\_\_\_    change in bowel movements  
 \_\_\_\_\_    \_\_\_\_\_    light colored or greasy stools  
 \_\_\_\_\_    \_\_\_\_\_    dark stools or blood in stool  
 \_\_\_\_\_    \_\_\_\_\_    feeling of incomplete evacuation  
 \_\_\_\_\_    \_\_\_\_\_    undigested food in stool  
 \_\_\_\_\_    \_\_\_\_\_    foul odor of stool or gas  
 \_\_\_\_\_    \_\_\_\_\_    hemorrhoids  
 \_\_\_\_\_    \_\_\_\_\_    other \_\_\_\_\_

**NOW**    **PAST**    **CARDIOVASCULAR**  
 \_\_\_\_\_    \_\_\_\_\_    heart beats fast or irregularly  
 \_\_\_\_\_    \_\_\_\_\_    tightness in chest  
 \_\_\_\_\_    \_\_\_\_\_    discomfort at high altitude  
 \_\_\_\_\_    \_\_\_\_\_    dizzy or weak upon standing up  
 \_\_\_\_\_    \_\_\_\_\_    swollen feet, ankles or legs  
 \_\_\_\_\_    \_\_\_\_\_    cold hands or feet  
 \_\_\_\_\_    \_\_\_\_\_    hands or feet turn blue  
 \_\_\_\_\_    \_\_\_\_\_    blue fingernails  
 \_\_\_\_\_    \_\_\_\_\_    leg pains when walking  
 \_\_\_\_\_    \_\_\_\_\_    varicose veins  
 \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_                    tendency to anemia  
 \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_                    high blood pressure  
 \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_                    low blood pressure  
 \_\_\_\_\_    \_\_\_\_\_    other \_\_\_\_\_

**NOW**    **PAST**    **URINARY**  
 \_\_\_\_\_    \_\_\_\_\_    difficulty urinating  
 \_\_\_\_\_    \_\_\_\_\_    urinate frequently at night  
 \_\_\_\_\_    \_\_\_\_\_    bedwetting  
 \_\_\_\_\_    \_\_\_\_\_    incomplete urination or dribbling  
 \_\_\_\_\_    \_\_\_\_\_    pain when urinating  
 \_\_\_\_\_    \_\_\_\_\_    bladder infections  
 \_\_\_\_\_    \_\_\_\_\_    kidney infections  
 \_\_\_\_\_    \_\_\_\_\_    kidney stones  
 \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_                    lower back pain  
 \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_                    other \_\_\_\_\_

**NOW**    **PAST**    **MALE**  
 \_\_\_\_\_    \_\_\_\_\_    prostate problems  
 \_\_\_\_\_    \_\_\_\_\_    difficult or unusual urination  
 \_\_\_\_\_    \_\_\_\_\_    discomfort or pain in genital area  
 \_\_\_\_\_    \_\_\_\_\_    other \_\_\_\_\_

**NOW**    **PAST**    **MALE**  
 \_\_\_\_\_    \_\_\_\_\_    diminished sexual desire  
 \_\_\_\_\_    \_\_\_\_\_    excessive sexual desire  
 \_\_\_\_\_    \_\_\_\_\_    difficulty maintaining an erection

**NOW**    **PAST**    **FEMALE**  
 \_\_\_\_\_    \_\_\_\_\_    irregular menstruation  
 \_\_\_\_\_    \_\_\_\_\_    pain prior to or with periods  
 \_\_\_\_\_    \_\_\_\_\_    depressed, tense or irritable around periods  
 \_\_\_\_\_    \_\_\_\_\_    painful or swollen breasts  
 \_\_\_\_\_    \_\_\_\_\_    lumps in breasts  
 \_\_\_\_\_    \_\_\_\_\_    discharge from breasts  
 \_\_\_\_\_    \_\_\_\_\_    symptoms occur in monthly pattern  
 \_\_\_\_\_    \_\_\_\_\_    pain, discomfort or itching in genital area  
 \_\_\_\_\_    \_\_\_\_\_    vaginal discharge

**NOW**    **PAST**    **FEMALE**  
 \_\_\_\_\_    \_\_\_\_\_    hot flashes  
 \_\_\_\_\_    \_\_\_\_\_    diminished sexual desire  
 \_\_\_\_\_    \_\_\_\_\_    excessive sexual desire  
 \_\_\_\_\_    \_\_\_\_\_    difficulty having orgasm  
 \_\_\_\_\_    \_\_\_\_\_    inability to conceive  
 \_\_\_\_\_    \_\_\_\_\_    other symptoms \_\_\_\_\_

Date of last period \_\_\_\_\_ # of days \_\_\_\_\_ length of cycle \_\_\_\_\_  
 Date of last PAP smear \_\_\_\_\_ Have you ever had an abnormal PAP? \_\_\_\_\_  
 Present type of birth control \_\_\_\_\_ Have you ever used birth control pills or an IUD? \_\_\_\_\_  
 What type and for how long? \_\_\_\_\_  
 Pregnancies? \_\_\_\_\_ Number of children? \_\_\_\_\_ Miscarriages or abortions? \_\_\_\_\_

**Is your diet?**

typical American  
 vegetarian  
 vegan  
 macrobiotic  
 Kosher  
 fast food  
 low fat  
 other

**Do you get regular exercise?**

what? \_\_\_\_\_  
 how often? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Do you use any of the following?**

cigarettes or tobacco  
 coffee or black tea  
 marijuana or other drugs  
 \_\_\_\_\_ packs per day  
 \_\_\_\_\_ cups per day  
 \_\_\_\_\_ times per week

**Are you allergic to anything?** Include food, plants

medications, pollens, insects, MSG, chemicals, etc.  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please list any vitamins or medication which you are taking.** Use the back of the page if necessary

**VITAMINS OR MINERALS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PRESCRIPTION MEDICINES**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**HERBS OR FOOD SUPPLEMENTS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**OVER-THE-COUNTER MEDICATIONS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Have you ever been hospitalized or had surgery, a serious illness or accident?**

what \_\_\_\_\_ when \_\_\_\_\_ where \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Have you or any of your family members had any of the problems in this chart?** Please indicate who has had which problems by checking the appropriate space.

	Thyroid problems	Diabetes	Tuberculosis	Hypoglycemia	Stroke	Heart Attack	Epilepsy	Cancer	Asthma	Allergies	Anemia	Migraines	Hepatitis	Heart disease	Birth Defects	High Blood Pressure	Gall Bladder Disease	Arthritis	Alcoholism/addictio
Self																			
Children																			
Mother																			
Father																			
Sister(s)																			
Brother(s)																			
Grandparents																			
Others																			

Thank you for taking the time to fill out this questionnaire. For additional comments use the other side.