VITACORE

An AK-Based Vitalistic Wellness Center

ADULT

Confidential Patient Health History Form

Patient Information

Last Name:_____ First:_____ Middle: _____ Date:_____

Address:_____ City: _____ State: _____ Zip: _____

Phone Number:_____ (cell/home) E-mail Address:_____

Birth Date_____ Sex: Male or Female Marital Status:_____ # of Children _____

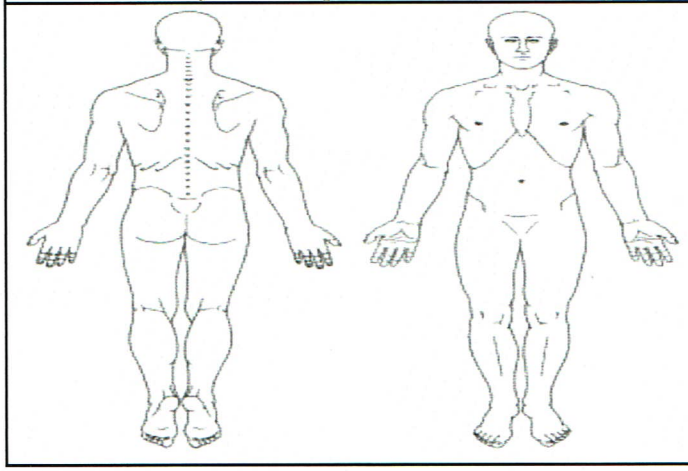
Occupation:_____ Employer:_____

Parent/Guardian (if minor):_____ How did you hear about us?:_____

Emergency Contact:_____ Relationship:_____ Phone Number:_____

Primary Care Physician:_____ May we contact them? Yes/No Phone Number:_____

Please **circle** any areas of pain/discomfort on the graph below **AND describe** the pain in detail:



Head	
Neck	
Shoulders	
Back	
Arms	
Elbows	
Wrists	
Hands	
Hips	
Legs	
Knees	
Feet	

How long have you had this condition?_____ What seemed to be the cause?_____

How often does this issue bother you? _____ Is it getting worse? Yes / No

What **treatments** have you already received for this condition? _____

Have you seen a Chiropractor or Naturopathic Doctor for this condition? If yes, name of practitioner and when:

_____

What is your **energy level** on a scale from 0-10 (10 being highest): _____/10

Have you ever:	**Yes**	**No**	**If yes, please explain:**
Had broken bones, strains or sprains?			
Used a cane, crutch or other support?			
Been struck unconscious?			
Had major dental work? (Root Canal, Extractions, etc.)			
Had any surgeries?			

How much water do you drink daily?	What time do you generally fall asleep/wake up?
Do you have difficulty getting to sleep?	How many times do you awake in middle of night?

Put an X next to any health conditions you have experienced **in your lifetime**
Circle any you have experienced **in the past few months**

MEN ONLY
- Erectile Dysfunction
- Prostate Dysfunction

WOMEN ONLY
- Breast Pain or Lumps
- Endometriosis
- Fibroids (Uterine/Ovarian)
- Heavy Periods
- Irregular Cycle
- PMS/Cramps
- Hot Flashes
- Menopause
- Miscarriage: #_____
- Pregnant: # of months

Eye/Ear/Nose/Throat
- Blurred or Double Vision
- Eye Pain
- Vision Loss
- Far/Near Sightedness
- Deafness/Hearing Loss
- Ear Ache/Infection
- Ear Discharge
- Ringing/Noise in Ears
- Redness in Ears
- Nasal Obstruction
- Nose Bleeds
- Sinus Infection/Pain
- Enlarged Glands/Goiter
- Hoarseness
- Sore Throat
- Thyroid Disorder
- Tonsilitis

Cardiovascular
- Ankle Swelling
- Blood Pressure: High/Low
- Bloody Nose
- Chest Pain/Angina
- Hardening/Thickening of Arteries
- Heart Disease
- Irregular Heartbeat
- Pacemaker
- Palpitations
- Poor Circulation

Respiratory
- Asthma
- Coughing/Wheezing
- Collapsed Lung
- Difficulty Breathing
- Emphysema
- Pleurisy
- Pneumonia
- Spitting Up Blood
- Spitting Up Phlegm

Muscle/Joint
- Arthritis
- Back Pain (Lower/Mid/Upper)
- Difficulty w/ Stairs or Walking
- Foot Trouble
- Hernia
- Neck Pain, Stiffness
- Morning Stiffness
- Muscle Aches
- Pain Between Shoulders
- Sciatica
- Swollen Joints

Skin
- Bruise Easily
- Dryness
- Eczema
- Hives or Allergy
- Itching
- Skin Eruptions (Rash or Boils)
- Tattoos
- Varicose Veins

Gastrointestinal
- Belching or gas
- Colon Trouble
- Crohn's Disease
- Constipation
- Diarrhea
- Difficult Digestion
- Bloated Abdomen
- Blood in Stool
- Excessive Hunger
- Gallbladder Trouble
- Heartburn/GERD
- Hemorrhoids
- Intestinal Worms
- Irritable Bowel Syndrome
- Jaundice
- Nausea
- Pain Over Stomach
- Poor Appetite
- Skipping Meals
- Ulcerative Colitis
- Vomitting/Vomit Blood

Genitourinary
- Bladder Infection
- Bed-wetting
- Blood in Urine
- Discolored Urine
- Frequent Urination
- Painful Urination
- Kidney Stones
- Lack of Kidney Control
- Kidney Infection

General
- Anxiety/Nervousness
- Chills
- Colds
- Convulsions
- Dental Decay
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Gum Trouble
- Headaches/Migraines
- Influenza (Flu)
- Numbness
- Scoliosis/Spine Curvature
- Sweats
- Tremors/Chorea
- Weight Gain or Loss

Other
- Anemia
- Appendicitis
- Cancer: Type? _____
- Chicken Pox
- Cold Sores/Fever Blisters
- Cysts
- Diabetes
- Diphtheria
- Edema
- Epilepsy
- Gout
- Herpes
- Loss of Libido
- Malaria
- Measles or Mumps
- Multiple Sclerosis
- Polio
- Rheumatic Fever
- Sexually Active
- Scarlet Fever
- Small Pox
- Stroke
- Tuberculosis
- Typhoid Fever
- Ulcers
- Venereal Disease
- Whooping Cough

Immunizations / What Year?	
Tetanus	
Hepatitis	
Pneumonia	
Flu	
COVID	

List year of most recent exam (if they apply):

Testicle		CT-Scan	
Prostate/Rectal		MRI	
Pelvic		X-Ray	
Breast		Mammogram	
Pap Smear		Thermogram	
Colonoscopy		Blood Test	

Any History Of:	Yes/No	Type & How often:
Smoking?		
Alcohol Use?		
Caffeine?		
Recreational drug use?		

Please rate the following areas of potential stress by circling the number describing your stress level:

	Low				High
Financial/Money Matters	1	2	3	4	5
Relationship/Family	1	2	3	4	5
Job/Career/Education	1	2	3	4	5
Current Level of Health	1	2	3	4	5
Spiritual/Religious	1	2	3	4	5
Ethical/Moral	1	2	3	4	5
Overall level of life stress	1	2	3	4	5

Please check all of the following events that you currently (or previously) experience stress with:

□ Betrayal	□ Loss of Job/Layoff	□ Diagnosis of a Fatal Condition
□ Marriage	□ Colleagues	□ Death of a Pet/Pet Health
□ Divorce	□ Financial Disruptions	□ College
□ Abortion/Miscarriages	□ Moving/Traveling	□ Fights
□ Infertility	□ Accidents	□ School/Teachers
□ Dating	□ Illness of a Loved One	□ Bullying
□ Friends	□ Illness/Operations	□ Onset of Puberty
□ Birth of Siblings	□ Death of a Loved One	□ Other: _____

Please list any allergies in regards to medications, supplements or foods that you may have:

Name	Symptoms

Were you previously prescribed any medications to treat a condition that you're not currently taking?

Name	For what condition?

Please list all medications and/or supplements that you are currently taking:

Name	Dosage	Date Started	Reason

VITA**CORE**

Summary of Privacy Practices

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. The full length Notice is available at the front desk of all locations.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting this information. As our patient, we create medical records about your health, our care for you, and services we provide to you as our patient. By law, we are required to make sure that your Protected Health Information (PHI) is kept private and confidential.

How will we use or disclose your information? Here are a few examples:

*For medical treatment
*For appointment and patient recall reminders
*To obtain payment for our services
*For research
*In emergency situations
*In response to requests arising out of a lawsuit

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

*The right to inspect and copy
*The right to request confidential communications
*The right to an accounting of disclosures
*The right to request restrictions
*The right to a paper copy of this notice
*The right to ammend

The Practice may phone, email or send a text to you to confirm appointments. We may also leave a message by voicemail on your cell phone or at your home if you have an answering machine or service, unless otherwise requested in writing.

For more information about these rights, please see the full notice posted in the office or request the detailed Notice of Privacy Practices from the front desk. This notice applies to all clinics and providers of VitaCore Holistic.

_____
Print Patient's Name

_____
Signature of Patient or Representative

_____
Print Name of Representative (if applicable)

_____
Date

I hereby grant permission to disclose my health information to the following individual(s). I may revoke permission at any time by notifying the practice in writing of my intent to do so.
Individual's Name/Relationship to Patient:
Individual's Name/Relationship to Patient:

VITACORE
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Informed Consent

I, _____, a mature adult of sound mind, come to S. Raheel Haque ND for Naturopathic healthcare for either myself or as a guardian of _____.

I understand that Dr. S. Raheel Haque attended and graduated from the National University of Health Sciences, a 4 year accredited Naturopathic and Chiropractic Medical school, with Doctorate of Naturopathic and Chiropractic Medicine degrees.

I understand that any herbs, nutritional supplements, essential oils, adjustments and homeopathic remedies that may be recommended are not a treatment for any health condition - rather natural substances that support my body systems. I agree to inform Dr. S. Raheel Haque immediately of any adverse reactions while I am using these substances.

I understand that should I continue to consult with my primary and specialty care physicians in regard to any medical concerns that I may have. I understand that Dr. S. Raheel Haque cannot and will not advise on the discontinuation of any pharmaceutical medications prescribed by a physician, and that discontinuation of such medications must be directed by the prescribing physician. I agree to take responsibility for following up on any referrals for medical care when necessary.

Dr. S. Raheel Haque realizes that privacy and communication with patients are very important. Dr. S. Raheel Haque will hold my records and information in strict confidentiality. However, I understand that communication modalities used in consulting with VitaCore Holistic, including but not limited to phone, email and video chat may or may not be HIPPA compliant. I accept all risks if I choose to communicate by these methods.

Dr. S. Raheel Haque recommends supplements from companies that he trusts. I understand that supplements are an unregulated industry and that the brands Dr. S. Raheel Haque uses are of a higher quality that have been clinically proven by his mentors over the years of research and practice. Therefore, if I choose to purchase supplements from other sources, Dr. S. Raheel Haque cannot place reliance on these supplements.

I understand that many interactions between herbs themselves, and between herbs and medications my physicians may prescribe, may not be well known. While unlikely, I could have an adverse reaction or experience a reduction or increase in effect of the medications. I understand that I should inform my physicians of all supplements I am taking. I also agree to inform Dr. S. Raheel Haque of all medications and supplements I am taking.

All female patients must inform Dr. S. Raheel Haque if they know or suspect that they may be pregnant or are trying to conceive as some of the supplements used could present a risk.

For any new concern, a visit must be scheduled so that it can be properly evaluated. Email or waiting to hear back for a visit is never appropriate for urgent or emergency problems. Please go to Urgent Care or the ER for emergencies.

Signature of Patient or Guardian: _____ **Date:** _____