

IN: DOB:



Natural Remedies
 Dr. Borislava Johnson, B.C.N.D.
 11078 Regency Green
 Cypress, TX 77429
 832-588-8863
 www.naturalremedies.com

New Client Information Packet

Full Legal Name: _____ Date: _____
 Preferred Name: _____ Email Address: _____
 Gender: Female Male Marital Status: _____ Date of Birth: _____
 Home Phone: _____ Cellular: _____ Work Phone: _____
 Address: _____ Apt. Number: _____
 City: _____ State: _____ Zip: _____
 Client's Occupation: _____
 Emergency Contact's Name: _____
 Phone Number: _____ Relation to Client: _____
 How did you hear about us? _____
 • Google Ad • Web Search • NextDoor App • Yelp • Siri/Alexa • Friend or Family

Due to the possibility of interactions among medications and/or supplements, please list **ALL** medications and vitamins/supplements (prescribed and over the counter) you are **CURRENTLY** taking:

Prescribed Medications	Dose	Last Taken
1.		
2.		
3.		
4.		
5.		
Over-the-counter Medications	Dose	Last Taken
1.		
2.		
3.		
4.		
Nutritional Supplements	Dose	Last Taken
Examples: Vitamins, minerals, probiotics, herbal & homeopathic remedies		
1.		
2.		
3.		
4.		
5.		

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Name any allergies (medicines, environment, food, etc.) you have, if any?

1. _____ 3. _____
2. _____ 4. _____

Have you tested positive for COVID-19? **Y / N** If so, when, what were your symptoms, and how severe were the symptoms?

Have you had a COVID-19 vaccine? **Y / N**

- Johnson & Johnson 1st Dose _____
 Moderna 1st Dose _____ 2nd Dose _____
 Pfizer 1st Dose _____ 2nd Dose _____
 Other _____ 1st Dose _____ 2nd Dose _____
 Booster Vaccine Name: _____ Date of Dose: _____

Please list current/recent physicians you are seeing:

Name of Physician	Specialty	Phone Number	Last Seen

List **CURRENT** medical conditions and concerns:

1. _____
2. _____
3. _____
4. _____

In the last year, what other conditions (not mentioned above) have you been treated for by a physician?

Please list any other past health problems/hospitalizations: _____

What are your specific goals for today's consultation? _____

Females Only:

What was the date of your last menstrual cycle? _____ Are you currently pregnant? **Y / N**

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Of bowel movements per day: _____ Do you experience gas or bloating on a regular basis? **Y / N**

Do you frequently use any of the following? (Check **ALL** that apply to you)

Aspirin Laxatives Antacids Diet pills Birth control pills/implants/injections

Alcohol – type _____ and amount: per day _____ per week _____

Tobacco (including vaping) – type _____ and amount: per day _____ per week _____

Caffeine – type _____ and amount: per day _____ per week _____

Recreational drugs (including vaping – type _____ and frequency _____

Do you get regular screening test done by another doctor (pap, blood test, etc.)? **Y / N**

How many hours of sleep do you get at night? _____

Do you wake during the night? **Y / N** If yes, how often and reason? _____

Do you exercise regularly? **Y / N** If yes, what form of exercise, how often, and at what intensity? _____

How would you describe the emotional climate of your home? _____

How stressful is your work, and other aspects of your life? _____

Your stress levels? (Please check one) **Low** **Medium** **High**

How well do you handle these stresses? _____

Are you regularly exposed to toxins and other hazards (work, home, hobbies, etc.)? Please describe. _____

Diet: Vegan Vegetarian Flexitarian Paleo Keto Other _____

Do you eat at home cooked meals? **Y / N** # of times per week do you eat out: _____

Please list what you eat on a typical day:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Do you have any dietary restrictions? _____

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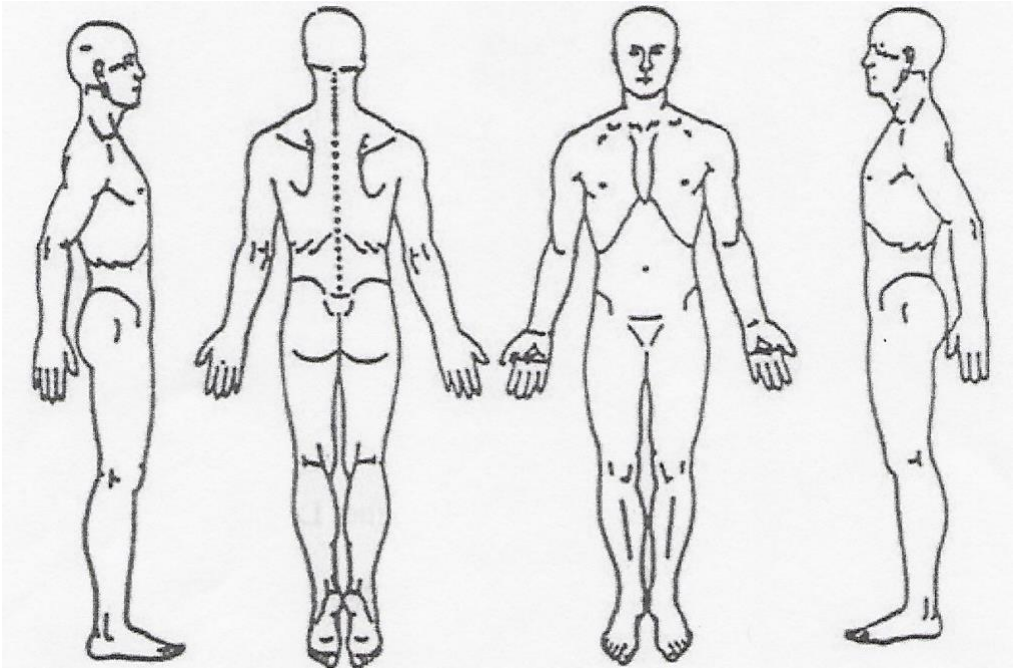
Check the following conditions that apply to you, past and present.

<p>Full Body</p> <p><input type="checkbox"/> Weight change</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Bleed/ Bruise easily</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Fever/ Chills</p> <p><input type="checkbox"/> Sweats/ Night sweats</p> <p><input type="checkbox"/> Change in sleep</p> <p><input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Change in appetite</p> <p><input type="checkbox"/> Hot Flashes</p> <p><input type="checkbox"/> Other _____</p>	<p>Cardiovascular</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Edema (Swelling)</p> <p><input type="checkbox"/> Arrhythmias</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Low Blood Pressure</p> <p><input type="checkbox"/> Heart Palpitations</p> <p><input type="checkbox"/> Other _____</p>	<p>Gastrointestinal (Continued)</p> <p><input type="checkbox"/> Other _____</p> <p>Genitourinary (Genital & Urinary)</p> <p><input type="checkbox"/> Painful Urination</p> <p><input type="checkbox"/> Frequent Urinations</p> <p><input type="checkbox"/> Night Urinations</p> <p><input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Other _____</p>
<p>Eyes</p> <p><input type="checkbox"/> Vision Glasses</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Blurring</p> <p><input type="checkbox"/> Dryness</p> <p><input type="checkbox"/> Styes</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Dark under eyelid</p> <p><input type="checkbox"/> Other _____</p>	<p>Respiratory</p> <p><input type="checkbox"/> Dyspnea (breathlessness)</p> <p><input type="checkbox"/> Sputum (cough)</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> TB</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Other _____</p>	<p>Musculoskeletal</p> <p><input type="checkbox"/> Trauma</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Other _____</p>
<p>Ears, Nose, Mouth, Throat</p> <p><input type="checkbox"/> Tinnitus (ringing)</p> <p><input type="checkbox"/> Bleeding</p> <p><input type="checkbox"/> Teeth Problem</p> <p><input type="checkbox"/> Nasal Polyps</p> <p><input type="checkbox"/> Diminishing Hearing</p> <p><input type="checkbox"/> Obstruction</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Sore Throat</p> <p><input type="checkbox"/> Postnasal Drip</p> <p><input type="checkbox"/> Mouth Sores</p> <p><input type="checkbox"/> Taste Problem</p> <p><input type="checkbox"/> Gum Disease</p> <p><input type="checkbox"/> Other _____</p>	<p>Gastrointestinal</p> <p><input type="checkbox"/> Appetite</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Difficulty Swallowing</p> <p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Blood in Stool</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Anal Discomfort</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Gall Bladder Disease</p> <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Infrequent/ Inconsistent Bowels</p>	<p>Neurological</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Coordination</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Convulsions</p> <p><input type="checkbox"/> Speech</p> <p><input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> Sensations</p> <p><input type="checkbox"/> Carpal Tunnel</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Other _____</p>
<p>Neck</p> <p><input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Swollen Glands</p> <p><input type="checkbox"/> Other _____</p>		<p>Psychiatric</p> <p><input type="checkbox"/> Memory Loss</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Drug/ Alcohol Abuse</p> <p><input type="checkbox"/> Mood Swings</p> <p><input type="checkbox"/> Suicidal</p> <p><input type="checkbox"/> Sleep Pattern</p> <p><input type="checkbox"/> Phobia</p> <p><input type="checkbox"/> Anger/ Irritability</p> <p><input type="checkbox"/> Other _____</p> <p>Endocrine</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Heat/ Cold Intolerance</p>

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Endocrine (Continued) <input type="checkbox"/> Tremor <input type="checkbox"/> Hormone Therapy <input type="checkbox"/> Other _____	Head (Continued) <input type="checkbox"/> Other _____	STI (Continued) <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Herpes <input type="checkbox"/> Sores/Discharge <input type="checkbox"/> Other _____
Hematological/ Lymphatic <input type="checkbox"/> Anemia <input type="checkbox"/> Enlarged Lymph Nodes <input type="checkbox"/> Bleeding Tendency <input type="checkbox"/> Transfusion <input type="checkbox"/> Other _____	Skin <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Psoriasis/Eczema <input type="checkbox"/> Cancer <input type="checkbox"/> Color Change <input type="checkbox"/> Lump <input type="checkbox"/> Wart/Moles <input type="checkbox"/> Dry Skin <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Other _____	Female <input type="checkbox"/> Breast Masses <input type="checkbox"/> Menstrual Cramping <input type="checkbox"/> Dexa Scan <input type="checkbox"/> Vaginitis <input type="checkbox"/> Irregular Periods <input type="checkbox"/> Breast Pain <input type="checkbox"/> Any abnormal Pap Smears <input type="checkbox"/> Heavy Menstrual Bleeding <input type="checkbox"/> Pain with Intercourse <input type="checkbox"/> Uterine Fibroids <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Dry Vagina <input type="checkbox"/> Menstrual Pain <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Ovarian Cysts <input type="checkbox"/> Other _____
Allergic/ Immunological <input type="checkbox"/> Hives <input type="checkbox"/> Hay Fever <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Other _____	Male <input type="checkbox"/> Testicular Pain/ Swelling <input type="checkbox"/> Hernia <input type="checkbox"/> Prostate Disease/ Symptoms <input type="checkbox"/> Discharge <input type="checkbox"/> Other _____	
Head <input type="checkbox"/> Headaches <input type="checkbox"/> Trauma/ Head Injury <input type="checkbox"/> Migraine <input type="checkbox"/> Hair Loss <input type="checkbox"/> Dandruff <input type="checkbox"/> Oily	STI <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia	

Please circle the number below, which indicates the level of pain:



(No Symptoms) 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 (Extreme Symptoms)

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Family History:

Indicate if a close relative (parent/ child/ sibling) has had any of the following: Who?

Condition:	Who? (Example: parent, child, sibbing, etc.)	Condition:	Who? (Example: parent, child, sibbing, etc.)
Allergies		Arthritis	
Asthma		Heart Disease	
Cancer		Diabetes	
High Blood Pressure		Thyroid Condition	
Kidney Disease		Depression	
Other Mental illness		Other	
Drug/alcohol abuse		Other	

Is there anything that you feel is important that has not been covered? _____

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Health Saving and Flexible Spending Accounts Disclaimer

The state of Texas does not allow ND's (naturopathic doctors) to prescribe pharmaceutical medications at this time, although it is legal in other states. In Texas, naturopathic doctors cannot legally "diagnose" or "treat" illness. We can, however, work with you to enhance your overall health and well-being. Due to the lack of licensure in Texas for naturopaths, most health insurances do not cover naturopathic/holistic services, homeopathic medications, and/or supplements. Please be aware if you choose to use a Flexible Spending Account or Health Savings Account, we are not responsible if they choose not to cover for naturopathic/holistic services, homeopathic medications, and/or supplements.

I, _____, understand that I cannot hold Natural Remedes accountable if I pay using my HSA or FSA for any services rendered and/or any purchases made at Natural Remedes.

Supplement Pick-Up Authorization

In order to protect the privacy of our clients, Natural Remedes will only release supplements to relatives, partners, or friends with your signed consent. If you wish to authorize someone to pick your supplements for any future date, please fill out the information below for our records.

Please list below the name of any individual(s) you wish to authorize to pick-up any supplement(s) recommended by Dr. Johnson:

1. _____
2. _____
3. _____
4. _____
5. _____

Please note: This permission form only authorizes the release of supplements to another individual(s), not the release of your health information.

Client/ Legal Guardian Signature

Date

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice is effective as of August 19, 2020.

Please be aware: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

Since 1996 certain laws have been enforced regarding medical record privacy (Health Insurance Portability and Accountability Act) or HIPAA. Under the law, we are now required to notify you of this, so here is a short version of these regulations for you, for your convenience. The privacy notice is available for you to read.

This Notice of Privacy Practices describes the ways we are allowed by law to use your protected health information (medical records) or PHI as we work with you to enhance your overall health and well-being, payment, and other health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. We are required to abide by these privacy rules.

According to privacy laws, your doctor or health care provider will your use your PHI as he/she has always done to work with you to enhance your overall health and well-being, payment, or other health care operations. In addition, we may also disclose your PHI from time to time to other physicians or health care providers who become involved in taking care of you. Your PHI will be used, as needed, in order for us to obtain payments for our services. Should front desk sign in sheets be used where you will be asked to sign your name and we will call you by your name in the waiting room when your doctor is ready to see you. We may also use your PHI when necessary to contact you concerning your appointment. We will share your PHI with business associates who perform services for us. There could include billing services or transcribing services. They are also required to maintain confidentiality.

Your PHI could be used to provide you with information about alternative ways to improve your health or other health related benefits and services that may be of interest to you. Other used or disclosures will be made only with your written authorization, unless otherwise allowed or required by law. You may revoke this authorization at any time, in writing.

Unless you object, we may reveal (with your signed consent) to a member of your family, close friend, or other person you choose parts of your PHI that relate to that person's involvement in your health care. If you are unable to agree or object to this, as an emergency, your doctor will try to obtain your consent as soon as possible. Your PHI may be disclosed by us in order to comply with workman's compensation laws. If you are an inmate, we may disclose necessary information to the staff of the institution.

You have the right to inspect and copy your PHI except for certain federal law limitations. You may also ask us not to disclose your PHI or reason for seeing Dr. Johnson, payment, or health care operations, also that it not be disclosed to family members. This must be specific and in

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writing. However, your doctor is not required to agree to such restrictions if he/she believes it is not in your best interest. You may ask for your PHI to be amended. You also have the right to know to whom we have revealed your information if it is other than for the care, payment, or health care operations.

You have the right to a paper copy of this notice upon request. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against your filing such a complaint.

I HAVE READ AND UNDERSTOOD THE PRIVACY NOTICE

Client Full Legal Name (Printed)

Client/ Legal Guardian Signature Date

INDIVIDUAL/INDIVIDUALS LIST BELOW ARE AUTHORIZED TO RECEIVE MEDICAL INFORMATION CONCERNING THE ABOVE CLIENT:

Spouse: _____

Son / Daughter: _____

Mother / Father: _____

Other: _____

Client/Legal Guardian Signature Date

Client Full Legal Name (Printed)

IN: DOB:

Client Health Information Consent Form

We want you to know how your Protected Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Protected Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing the consent.

1. The client understands and agrees to allow Natural Remedes to use their Protected Health Information (PHI) for the purpose of care, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this naturopathic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that Natural Remedes will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The client has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The client may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A client's written consent need only be obtained one time for all subsequent care given the client in this office.
4. The client may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of client record privacy, and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Clients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the client refuses to sign this consent for the purpose of care, payment and health care operations, Natural Remedes has the right to refuse to give care.
8. From time to time we may send you birthday cards or letters, use your name on a birthday list or use your name on a referral board in our office. By your signature below, you have given us permission to do so.
9. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

I have read and understand how my Protected Health Information will be used and I agree to these policies and procedures.

Client/Legal Guardian Signature

Date

Client Full Legal Name (Printed)