WELCOME!

We are a 501(c)(3) NON-PROFIT Integrative Health Wellness Center. Your patronage directly contributes to providing Integrative health services to low-income, underserved, and needy populations throughout San Diego County each week.

Our sliding scale prices include GRATUITY. You may leave something additional for your clinician if you wish, but it is neither expected nor necessary.

WE LOOK FORWARD TO BEING YOUR PARTNERS IN HEALTH & WELLNESS!

Adams Avenue Integrative Health
3239 Adams Avenue
San Diego, CA 92116
619-546-4806 (Phone) · 619-546-5326 (Fax)
www.althealnet.org

This is a CONFIDENTIAL questionnaire to determine the most appropriate treatment plan for you.

Name: ______________________________ Date:__________________

Home Address: ______________________________City:________________ State: ______________

Zip: ___________ Email Address: ______________________________

Phone: ______________________ Secondary Phone: ____________________ Ok to leave messages? ☐Y ☐N

Emergency Contact: _______________ Emergency Phone: ___________________Occupation: _______________

Sex ☐ M ☐ F ☐Other Height: ______ Weight: ______ Birth Date: ____________ Do you have Medicare? ☐Y ☐N

How did you hear about Adams Avenue Integrative Health?

☐ Google
☐ Website
☐ Facebook
☐ Twitter
☐ Flyer
☐ Groupon/Living Social
☐ Alternative Happy Hour
☐ Healing Arts Festival
☐ SD Reader
☐ Doctor Referral
☐ Another AAIH Patient (please list):___________________________
☐ Other (please list):___________________________

Have you previously had acupuncture?
☐ Yes ☐ No

Have you previously had chiropractic?
☐ Yes ☐ No

Have you had previous massage therapy?
☐ Yes ☐ No

Adams Avenue Integrative Health offers a sliding scale for most services, based on self-reported income. Please indicate your ANNUAL income below:

☐ Below $25,000
☐ $25,001-35,000
☐ $35,001-45,000
☐ Above $45,000

Please check the reason for coming to Adams Avenue Integrative Health (check all that apply):

☐ Pain Management (headache, back pain, etc)
☐ Mental Health (depression, anxiety, anger, etc)
☐ Hormonal Imbalances (fertility, menses, etc)
☐ Digestive Problems
☐ Allergies
☐ Insomnia
☐ Weight Loss
☐ Wellness Care/Prevention/Relaxation
☐ Addiction (substance abuse, alcohol, food, etc)
☐ Smoking Cessation
☐ Injury (sports, automobile, fall, etc)
☐ Other:_____________________________________

I understand that the majority of the work done at Adams Avenue Integrative Health is considered Wellness Care and is therefore not covered under most insurance policies. Adams Avenue Integrative Health accepts insurance payments only when eligibility has been confirmed prior to the beginning of your treatment. You may request a 'Superbill' during your visit to submit to your insurance company for possible reimbursement. If requesting a Superbill for a treatment after the day it was performed, there is a 7 day processing period. Adams Avenue Integrative health does not guarantee you will receive reimbursement for any payments made for services or products.

All payments for services rendered are due at the time of service, unless previous arrangements have been made.

Patient Signature (Guarantor): ______________________________________ Date:__________________

Why are you seeking care?	When did this first become an issue?	What do you think caused this?	How severe is it on a scale of 1-10? (1 = mild; 10=very severe)	What makes it better? What makes it worse?	What have you tried so far for relief?

1. Past Medical History including accidents, surgeries (including cosmetic), and hospitalizations:
   ____ Date: ____________
   ____ Date: ____________
   ____ Date: ____________
   ____ Date: ____________

2. Please list if you are taking any medications, herbs, supplements, sleep aids or over-the-counter drugs (and please check 'advised' if you have been advised to take the following, but chose not to):

What are you taking?	Dosage	Reason	How long?	Prescribed by	Advised to take (but not)

3. Please list all Allergies: ____
   Food Cravings: ____
   Food Sensitivities: ____
   Special Diets (Vegan, Vegetarian, Gluten Free, etc): ______________________________

4. Please indicate any illnesses you or a blood relative (parent, grandparent, or sibling) have had:

	You	Relative	Who?		You	Relative	Who?
Cancer	☐	☐	____________	Diabetes	☐	☐	____________
Hepatitis	☐	☐	____________	Heart Disease	☐	☐	____________
High Blood Pressure	☐	☐	____________	Seizures	☐	☐	____________
Mental Illness	☐	☐	____________	Tuberculosis	☐	☐	____________
Depression/Anxiety	☐	☐	____________	Arthritis	☐	☐	____________
Alcoholism	☐	☐	____________	High Cholesterol	☐	☐	____________
Stroke	☐	☐	____________	Auto-immune disease	☐	☐	____________
Osteoporosis	☐	☐	____________	Allergies	☐	☐	____________
Thyroid Dysfunction	☐	☐	____________	Asthma	☐	☐	____________

Sexually Transmitted Diseases: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes

5. How would you rate these significant stressors?

	Extremely Stressful	Moderately Stressful	Not Stressful at All
Work/School	☐	☐	☐
Family Matters	☐	☐	☐
Moving	☐	☐	☐
Relationship/Marriage	☐	☐	☐
Finances	☐	☐	☐
Health Status	☐	☐	☐
Other (please list): ____________________	☐	☐	☐

6. What do you do to manage your stress or health condition now (check all that apply)?

Exercise	☐	Herbs	☐
Yoga/Meditate	☐	Supplements	☐
Massage	☐	Friends	☐
Family time	☐	TV/Media	☐
Personal Time/Rest	☐	Alcohol/Drugs	☐
Medication	☐	Other (please list)	☐ ____

7. What is your current level of physical activity?

Not physically active	☐	Less than 1 hour/week	☐
Less than 30 minutes/day	☐	30 minutes-1 hour/day	☐
More than 1 hour/day	☐		

8. What type of physical activity do you do? ____

____

9. What are your sleep patterns? Regular ☐ Irregular ☐

10. How many hours of sleep do you get per night?

Less than 5 hours per night	☐	5-6 hours per night	☐
6-7 hours per night	☐	7-8 hours per night	☐
8-10 hours per night	☐	More than 10 hours per night	☐

11. Please indicate the use and frequency of the following:

Coffee/Black Tea: _____________ Tobacco: _____________ Daily Water Intake: _____________

Recreational Drugs: _____________ Alcohol: _____________ Soft Drinks: _____________

12. Do you drink alcohol? Yes ☐ No ☐

How much? Daily ☐ Weekly ☐ Monthly ☐

13. Do you smoke cigarettes? Yes ☐ No ☐ Used to ☐ when did you quit? ____________________

How much do you currently smoke? __________ If you quit, how much did you used to smoke? ____________

For Women

Age of 1st period: ___________ Are you pregnant? ☐ Y ☐ N # of pregnancies/abortions: ___________________________

Age of last period: __________ # of live births: _________________ # of miscarriages: ___________________________________

Number of days between periods: ____________________ Have you ever had an abnormal pap smear? _____________________________

Number of days of flow: ______________ Color of flow: ________________ Blood Clots? ☐ Y ☐ N

How many tampons/pads do you use per day? Day 1:_____ Day 2:_____ Day 3: _____ Day 4: _____ Day 5: _____ Day 6: _____ Day 7: _____

Ever been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID ☐ Other: ________________________

Location of menstrual pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other: ____

Nature of Pain (Please indicate before, during or after menses)

Cramping:_________________ Stabbing: __________________

Burning: __________________ Aching: ____________________

Dull: _____________________ Bloating: ___________________

Consistent: ________________ Intermittent: ________________

Bearing down sensation: ____

Other symptoms related to menses:

☐ Discharge ☐ Vaginal dryness ☐ Headache

☐ Nausea ☐ Constipation ☐ Diarrhea

☐ Swollen Breasts ☐ Mood Swings ☐ Ravenous Appetite

☐ Poor Appetite ☐ Hot Flashes ☐ Night Sweats

☐ Increased libido ☐ Decreased libido ☐ Insomnia

For Men

Date of last prostate checkup: ______________________ PSA Results: ____

Lab Results: _________________________ Frequency of urination: daytime _______________________ nighttime ________________________

Color of urine: ☐ Clear ☐ Murky Urine Odor: ____

Symptoms related to prostate

☐ Prostate problems ☐ Delayed stream ☐ Dribbling ☐ Incontinence ☐ Retention of urine

☐ Rectal dysfunction ☐ Increased libido ☐ Decreased libido ☐ Premature ejaculation ☐ Impotence

☐ Back pain ☐ Groin pain ☐ Testicular pain ☐ Other: ____

Symptom Survey (for everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

NO MARK = never experience CHECK MARK √ = sometimes experience PLUS SIGN + = frequently experience

___________ Lack of appetite
___________ Excessive appetite
___________ Loose stool or diarrhea
___________ Indigestion
___________ Vomiting
___________ Belching, burping
___________ Heartburn/acid reflux
___________ Feeling the retention of food in the stomach
___________ Tendency to become obsessive in work, relationships…

___________ Difficulty sleeping
___________ Heart palpitations
___________ Cold hands and feet
___________ Nightmares
___________ Mentally restless
___________ Laughing for no apparent reason
___________ Angina pains
___________ Abdominal pain
___________ Chest pain
___________ Sciatic pain
___________ Headaches
___________ Pain or coldness in the genital area

___________ Cough
___________ Shortness of breath
___________ Decreased sense of smell or taste
___________ Nasal problems
___________ Skin problems
___________ Feeling of claustrophobia
___________ Bronchitis
___________ Colitis or diverticulitis
___________ Constipation
___________ Hemorrhoids
___________ Recent antibiotic use

___________ Eye problems
___________ Jaundice (yellowish eyes or skin)
___________ Difficulty digesting oily foods
___________ Gall stones
___________ Light colored stool
___________ Soft or brittle nails
___________ Easily angered or agitated
___________ Difficulty in making plans or decisions easily
___________ Spasms or twitching of muscles

___________ Low back pain
___________ Knee problems
___________ Ear ringing
___________ Kidney stones or infection
___________ Decreased sex drive
___________ Hair loss
___________ Urinary problems
___________ Fatigue
___________ Edema
___________ Blood in stool
___________ Black tarry stool
___________ Easily bruised
___________ Difficult to stop bleeding
___________ Asthma
___________ Tendency to catch colds easily
___________ Intolerance to weather changes
___________ Allergies
___________ Hay fever
___________ Dizziness
___________ Tendency to faint easily
___________ High cholesterol levels
___________ Sudden weight loss

Naturopathic Medicine Supplemental Intake Form

Only required for Naturopathic Medical Appointments

Dr. Shannyn Fowl, Naturopathic Doctor

1. What time do you generally go to bed? _____________; get up? ______________
2. Do you wake up during the night? Yes ☐ No ☐ how many times? _____________
3. How long does it take to get back to sleep? _____________
4. Do you wake rested? _____________
5. What is your energy level?

	Morning	Midday	Evening	after Meals
Very Low	☐	☐	☐	☐
Low	☐	☐	☐	☐
Medium	☐	☐	☐	☐
High	☐	☐	☐	☐
Very High	☐	☐	☐	☐

6. Please indicate **(P)** of you've experienced this in your past (include age at onset and resolve) or **(C)** current:

General

(P)	**(C)**	
☐	☐	Fatigue
☐	☐	Frequent colds
☐	☐	Venereal Disease/STD
☐	☐	Bed-wetting
☐	☐	Alcoholism
☐	☐	Night sweats
☐	☐	Weight gain (rapid)
☐	☐	Weight loss (rapid)
☐	☐	Chills

Head/Eyes/Ears/Nose/Throat

☐	☐	Headache
☐	☐	Ear noises/ringing
☐	☐	Dizziness
☐	☐	Sinus infection
☐	☐	Ear infections
☐	☐	Post nasal drip
☐	☐	Loss of smell or taste
☐	☐	Eye Dryness
☐	☐	Goiter
☐	☐	Swollen lymph nodes

Dental

☐	☐	Canker/cold sores
☐	☐	Number of silver fillings________
		Number removed_________
☐	☐	Root Canals
☐	☐	Bleeding
☐	☐	Gums/Gingivitis
☐	☐	Grinding Teeth

Chest/heart/lungs

(P)	**(C)**	
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Rapid heart beat
☐	☐	Chest pain
☐	☐	Difficulty breathing
☐	☐	Coughs
☐	☐	Excessive phlegm/mucus
☐	☐	Palpitations
☐	☐	Irregular heart rhythms
☐	☐	Pneumonia
☐	☐	Bronchitis
☐	☐	Asthma

Gastro-intestinal

☐	☐	Bad breath
☐	☐	Nausea
☐	☐	Heart burn
☐	☐	Belching
☐	☐	Flatus
☐	☐	Nervous stomach
☐	☐	Bloat
☐	☐	Ulcers
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Stools color not brown
☐	☐	Gallbladder problems
☐	☐	Unformed stools
☐	☐	Undigested food in stool
☐	☐	Hemorrhoids
☐	☐	Rectal itching
☐	☐	Blood in stools

Kidney/bladder

(P)	(C)	
☐	☐	Bladder infections
☐	☐	Frequent urination
☐	☐	Kidney infection or stones
☐	☐	Frequency/urgency/discomfort
☐	☐	Waking to urinate
☐	☐	Excessive thirst

Skin/Hair/Nails

☐ ☐ Bruise easily
☐ ☐ Dry skin
☐ ☐ Acne
☐ ☐ Itching
☐ ☐ Rash
☐ ☐ Cancer/growths
☐ ☐ Eczema
☐ ☐ Psoriasis
☐ ☐ Loss of hair
☐ ☐ Thinning eyebrows
☐ ☐ Herpes type II/genital
☐ ☐ Yeast skin/nails

Musculo-skeletal/extremities

☐ ☐ Cold hands/feet
☐ ☐ Muscle cramps
☐ ☐ Neck pain or stiffness
☐ ☐ Low back pain
☐ ☐ Sciatica
☐ ☐ Swelling of the ankles
☐ ☐ Varicose veins
☐ ☐ Pain/numbness/tingling in:
- ☐ ☐ Arm(s)/Shoulders
- ☐ ☐ Elbow(s)
- ☐ ☐ Wrist/hand
- ☐ ☐ Leg(s)
- ☐ ☐ Hips
- ☐ ☐ Knees
- ☐ ☐ Ankles
- ☐ ☐ Feet

☐ ☐ Arthritis/ bursitis/tendonitis
- ☐ ☐ Arm(s)/Shoulders
- ☐ ☐ Elbow(s)
- ☐ ☐ Wrist/hand
- ☐ ☐ Leg(s)
- ☐ ☐ Hips
- ☐ ☐ Knees

Reproductive:

Women

(P) (C)

☐ ☐ Hysterectomy
☐ ☐ Cramps or pain w/menses
☐ ☐ PMS
☐ ☐ Breast tenderness
☐ ☐ Bloating
☐ ☐ Hot flashes
☐ ☐ Irregular cycles
☐ ☐ Excessive menstrual flow
☐ ☐ Lumps cysts in breast
☐ ☐ Uterine fibroids
☐ ☐ Endometriosis
☐ ☐ Ovarian cysts
☐ ☐ Yeast infections
☐ ☐ Painful intercourse
☐ ☐ Low libido (sex drive)

Men

☐ ☐ Prostate trouble
☐ ☐ Dribbling
☐ ☐ Difficult urination
☐ ☐ Testicular pain
☐ ☐ Erectile dysfunction
☐ ☐ Low libido (sex drive)
☐ ☐ Hernias

3 Day Diet Recall

	Day 1	**Day 2**	**Day 3**
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Dessert			
Beverages			
Alcohol			
Coffee/Tea			
Nicotine			
Other			

Cancellations and Rescheduling

1 Part of our mission is to make *Integrative Healthcare* available and affordable to everyone. We value your time and hold your appointment time specifically for you. If for any reason you need to cancel or reschedule an appointment, **we require 24 hours notice** or you may be charged a cancellation fee for each scheduled service, payable prior to your next appointment. If treatments have been purchased in a package, the missed appointment may be deducted from the number remaining. We understand that situations arise and you must cancel or reschedule with less than a 24 hour notice. If you call to explain the situation, we may allow you a one time “free pass” for last minute-cancellation.

I have read and understood the Cancellation and Rescheduling Policy ____________
Initials

Privacy and Confidentiality

2 Your confidentiality is important to us. None of your personal information is shared or disclosed outside of our clinical team without your express written permission.

3 Since several people are being treated in the same room at once, it is vital that we work together to respect your privacy and the privacy of others. Your intake will be done in a soft voice and there will be ambient music in the background to drown out the discussion of any sensitive issues. Let us know if there are certain topics that need extra discretion and/or if you prefer to do your intake in a more private setting.

4 If you happen to overhear someone else’s private information, do not share this information with others. We ask that you show the same respect for others as you would expect for yourself.

I have read and understood the Privacy and Confidentiality Policy ____________
Initials

Insurance and Financial Responsibility

5 We are a community based Integrative Health Center operating under a 501(c)(3) Nonprofit. Our goal is to make the highest quality natural healthcare readily available at the most affordable prices. ***We accept insurance for Acupuncture only when it has been pre-approved through American Specialty Health PRIOR to the beginning of your treatment.*** All other services are considered fee-for-service and payment is due at the time of service. Some insurance coverage and flex spending accounts allow for patient reimbursement for qualifying services (chiropractic, acupuncture, massage, etc). Your clinician will provide you with a ‘Superbill’ and Adams Avenue Integrative Health will provide proof of payment to submit to your insurance company for reimbursement, however, full payment is due at the time of service. Reimbursement from any insurance company for services received from our center is not guaranteed and is the responsibility of the patient to coordinate.

6 All services, nutritional and herbal products, orthotics and other items are non-refundable.

7 Fees for all services, nutritional and herbal products, orthotics and other items are due and payable at the time items are received and/or services are rendered.

8 Fees will be assessed on checks returned for any reason at the maximum amount allowed by the State.

9 By signing this agreement you agree to accept full financial responsible for any and all charges incurred at *Adams Avenue Integrative Health.*

10 Please understand that we cannot guarantee any level of success of treatment administered, nor is the result or outcome of treatment related to your obligation to pay for same.

I have read and understood the Insurance and Financial Responsibility Policy ____________
Initials

I have read, or have had read to me, the above terms of Policies and Responsibilities Agreement. I have had the opportunity to have any questions answered to my satisfaction. I agree to and accept fully these terms of agreement.

Patient (Guarantor) Signature ____Date: _______________