Mind Body Spirit Center

Patient Information
Sherry Tackett W.H.C.N.P.

Date_____

Name_____Age_____Birthdate_____Blood Type_____

Address_____City_____State_____Zip_____

Email Address_____Phone_____Cell_____
Would you like to receive our email newsletter? ☐ Yes ☐No

Occupation_____Full Time/Part Time

Employer_____

Nearest Relative_____Relationship_____Phone_____

Emergency Contact_____Relationship_____Phone_____

Last Physician_____Phone_____

Who referred you to our office_____

Pharmacy preference _____Phone _____

We ask that you provide your insurance information in case lab work is needed, many labs will bill insurance.
We do not bill insurance at this time.

Insurance Co._____Policy No._____Group No._____

1702 E Bethany Home Rd. Phoenix, AZ 85016 602-277-1477

Patient Name_____Date of Birth_____

What is the main reason for your visit?_____

Describe in detail_____

When was the first time you noticed your condition_____

How long has this problem been troubling you_____

What therapies have you tried and what were the results_____

Any Allergies?_____

Health History

Current medications (prescription or over-the-counter):

_____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications if any and dates:

Year	Operation, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence or finances, legal problems): _____

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right ☐ your weight today_____

☐ Unintentional weight loss or gain of 10 pounds or more in the last three months

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)

_____ _____

☐Corrective lenses ☐Dentures ☐Hearing aid ☐Medical devices/ prosthetics/implants, describe_____

Recent changes in your ability to: ☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations

☐Move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Strong dislike for any one of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Do you: □Prefer warmth (i.e., food, drinks, weather, etc.) □Prefer cold (i.e., food, drinks, weather, etc.)

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

□7 am – 9am □9am – 11am □11am – 1pm
□1pm – 3pm □3pm – 5pm □5pm – 7pm
□7pm – 9pm □9pm – 11pm □11pm – 1am
□1am – 3am □3am - 5am □5am – 7am

Time of day you feel the worst or your symptoms are aggravated:

□7am – 9am □9am – 11am □11am – 1pm
□1pm – 3pm □3pm – 5pm □5pm – 7pm
□7pm – 9pm □9pm – 11pm □11pm – 1am
□1am – 3am □3am – 5am □5am – 7am

Do you experience any of these general symptoms EVERYDAY?

□ Debilitating fatigue □ Shortness of breath □ Insomnia □ Constipation □ Chronic pain/inflammation
□ Depression □ Panic attacks □ Nausea □ Fecal Incontinence □ Bleeding
□ Disinterest in sex □ Headaches □ Vomiting □ Urinary Incontinence □ Discharge
□ Disinterest in eating □ Dizziness □ Diarrhea □ Low grade fever □ Itching/rash

Medical History

□ Arthritis
□ Allergies/hay fever
□ Asthma
□ Alcoholism
□ Alzheimer's disease
□ Autoimmune disease
□ Blood pressure problems
□ Bronchitis
□ Cancer
□ Chronic fatigue syndrome
□ Carpal tunnel syndrome
□ Cholesterol, elevated
□ Circulatory problems
□ Colitis
□ Dental problems
□ Depression
□ Diabetes
□ Diverticular disease
□ Drug addiction
□ Eating disorder
□ Epilepsy
□ Emphysema
□ Eyes, ears, nose, throat problems
□ Environmental sensitivities
□ Fibromyalgia
□ Food intolerance
□ Gastroesophageal reflux disease
□ Genetic disorder
□ Glaucoma
□ Gout
□ Heart disease
□ Infection, chronic
□ Inflammatory bowel disease
□ Irritable bowel syndrome
□ Kidney or bladder disease
□ Learning disabilities
□ liver or gallbladder disease(stones)
□ Mental illness
□ Mental retardation
□ Migraine headaches
□ Neurological problems (Parkinson's, paralysis)
□ Sinus problems
□ Stroke
□ Thyroid trouble
□ Obesity
□ Osteoporosis
□ Pneumonia
□ Sexually transmitted disease
□ Seasonal affective disorder
□ Skin problems
□ Tuberculosis
□ Ulcer
□ Urinary tract infection
□ Varicose veins
□ Other_____
_____

Medical (Men)

□ BPH
□ Prostate cancer
□ Decreased sex drive
□ Infertility
□ STD
Other_____

Medical (Women)

□ Menstrual irregularities
□ Endometriosis
□ Infertility
□ Fibrocystic breasts
□ Fibroids/ovarian cysts
□ PMS
□ Breast cancer
□ Pelvic inflammatory disease
□ Vaginal infections
□ Decreased sex drive
□ STD
Other_____
Age of first period_____
Last gynecological exam_____
Mammogram □ + □-
PAP □+ □-
Form of birth control
# of children_____
# of pregnancies_____
□ C-section
□ Surgical menopause
□ Menopause
Date of last menstrual cycle Length of cycle _____days
Days between cycles_____
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)_____

Family Health History (parents and siblings)

- ☐ Arthritis, rheumatoid
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other_____

Health Habits

- ☐ Tobacco:

Cigarettes: #/day_____
Cigars: #/day_____

- ☐ Alcohol:

Wine: glasses/d or wk _____
Liquor: ounces/d or wk _____
Beer: glasses/d or wk_____

- ☐ Caffeine:

Coffee: #6 oz cups/d_____
Tea: #6 oz cups/d_____
Soda w/caffeine: #cans/d_____
Other sources_____

- ☐ Water: # glasses/d_____

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk
- ☐ Run
- ☐ Jump rope
- ☐ Weight lift
- ☐ Swim
- ☐ Box
- ☐ Yoga

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable source)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific rood restrictions:
☐dairy ☐wheat ☐eggs
☐soy ☐ corn ☐all gluten
Other_____

Food Frequency

Servings per day:
Fruits (citrus, melons, etc.)_____
Dark green or deep yellow/orange vegetables_____
Grains unprocessed _____
Beans, peas, legumes_____
Dairy, eggs_____
Meat, poultry, fish_____

Eating Habits

- ☐ Skip breakfast
- ☐ Two meals/day
- ☐ One meal/day
- ☐ Graze(small frequent meals)
- ☐ Food rotation
- ☐ Eat constantly whether hungry or not
- ☐ Generally eat on the run
- ☐ Add salt to food

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source_____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe_____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveritrol, etc.)
- ☐ Herbs – teas
- ☐ Herbs – extracts
- ☐ Chinese herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach towers
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals (e.g., Ensure)

Other_____

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get less colds and flues
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.

Payment Agreement & Cancellation Policy

Payment is always due at the time of service.
We accept the following forms of payment: Cash, Check, Debit Card, Visa, Mastercard, and American Express

Many insurance plans may reimburse for all or part of your services provided at the center; however, you are still expected to pay same day for services. Claims submission is also your responsibility; we are pleased to provide you with a pre-printed standard claim form to facilitate your claim submission. We can never guarantee that your insurance company will reimburse you for your visits or cover the cost of your labs and imaging studies. You are ultimately responsible for the cost of your care at our office.

I,_____ hereby agree to pay at **time of service** for all services, Int._____
labs and/or supplements provided to me by Sherry Tackett, WHCNP, unless otherwise agreed upon.

I understand that Sherry Tackett will not submit claims to Medicare or any other insurance Int._____
providers for services and/or supplements regardless of covered benefits. I understand that I may choose to submit to my carrier.

I understand that appointments need to be cancelled 24 hours in advance or a charge may incur. Int._____
If I am late for an appointment by 15 minutes or more, I understand that a charge may incur as well as a longer wait time to see Sherry

By signing this agreement, I acknowledge that payment for services rendered will be required at the time of treatment and claims will not be submitted to my insurance provider. I understand that I may choose to submit to my carrier.

_____ _____

Patient signature Date

_____ _____

Witness Date

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
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. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before January 1, 2008.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name_____

Signature_____Date_____