Dr. Kelly Austin, ND
www.atmyprime.com
RB: 858-705-1727
SB: 858-792-7995

NEW PATIENT INTAKE FORM

CONTACT INFORMATION

LAST NAME	FIRST NAME		TODAY'S DATE MM DD YY
HOME ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS
Permission to leave messages: ☐ Y ☐ N	DATE OF BIRTH MM DD YY	GENDER ☐FEMALE ☐MALE	AGE / MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP
OCCUPATION	EMPLOYER	EMERGENCY CONTACT NAME	PHONE
How did you hear about our clinic?	PRIMARY MEDICAL PHYSICIAN NAME		PHONE

PAST TREATMENT

Do you regularly have physical exams? ☐Y ☐N	DATE OF LAST EXAM MM DD YY	Exams normally include: ☐Prostate exams ☐Blood work	☐Pap smears ☐Breast exams	☐Mammograms ☐Breast thermography
WOMEN Last gynecological exam	DATE MM DD YY	RESULTS ☐Normal Other:		
MEN Last prostate exam	DATE MM DD YY	RESULTS ☐Normal Other:		
Other providers seen currently or in past year	☐Medical doctor ☐Chiropractor	☐Physical therapist ☐Psychiatrist	☐Naturopathic doctor ☐Massage therapist	☐Nutritionist ☐Personal trainer
Other treatments currently followed:		Any contagious disease at this time? ☐ Y ☐ N	→ If yes, what?	

CURRENT STATUS

MOST IMPORTANT HEALTH CONCERNS, STARTING WITH THE MOST IMMEDIATE

1	4
2	5
3	6

USUAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR — Time of highest energy during day: ☐MORNING ☐AFTERNOON ☐EVENING

ENERGY: ☐GOOD ☐FAIR ☐POOR ☐VARIES — Time of lowest energy during day: ☐MORNING ☐AFTERNOON ☐EVENING

WEIGHT:	CURRENT: lbs	MAXIMUM: lbs	IDEAL: lbs	1 yr ago: lbs

Have you recently ☐GAINED or ☐LOST weight? — REASON for gain or loss: ☐Unexplained Other:

Current **MEDICATIONS** used more than just occasionally:

☐Laxatives	☐ Cortisone (inhalers, cream, oral)	☐Nasal decongestants	☐Diuretics
☐Tranquilizers	☐Antibiotics	☐Antacids	☐Blood thinners (coumadin, warfarin, heparin)
☐Pain relievers	☐Hormones	☐Sleeping pills	☐Appetite suppressants
☐Thyroid medication		☐Birth control pills	

List other prescription, over-the-counter **MEDICATIONS** and **SUPPLEMENTS** you take regularly

NAME	REASON	DOSE	START DATE	SIDE EFFECTS

HEALTH HISTORY

Have you had all standard vaccinations? ☐Y ☐ N	**CHILDHOOD ILLNESSES**:	☐Measles ☐Whooping cough	☐Rheumatic fever ☐Scarlet fever	☐Polio ☐Asthma	☐Roseola ☐Chickenpox	☐Rubella *Others:*

ALLERGIES:	☐Drugs / medications ☐Food / beverages	☐Chemical / environmental	☐ Airborne including pollen, molds, dust	*Others:*
How were hypersensitivities or allergies tested?	☐None ☐Scratch	☐Kinesiology ☐Intradermal	☐Food reintroduction ☐Electroacupuncture	☐Blood IGG ☐Blood IGE
What happens when you have an allergic reaction?				

Do you currently or have you ever had dental amalgams (silver fillings)? ☐Y ☐ N → If yes, how many? _ _ _	If they were removed, what do you have in their place?	Did the dentist take special precautions ☐Y ☐ N

Have you ever had your heavy metals tested? ☐Y ☐ N → If yes, how? ☐Urine ☐Hair ☐Blood

Please list all hospitalization, surgeries and major injuries:

LIFESTYLE

PHYSICAL ACTIVITIES	FREQUENCY	DURATION

SUBSTANCES CONSUMED	TYPE	AMOUNT		TYPE	AMOUNT
☐RECREATIONAL DRUGS			☐CAFFEINE		
☐NICOTINE / TOBACCO			☐SODA		
☐EAT EXCESSIVE SUGAR			☐ALCOHOL		
☐EAT OUT OFTEN					

SLEEP	Go to bed at:		Do you wake rested?	Sleep quality:
Hours per night:	Wake at:		☐Y ☐N	☐POOR ☐FAIR ☐GOOD ☐DEPENDS

STRESS Current level of stress in your life (0-10, with 10 being the most ever):

Major Stressors:	☐Divorce	☐Loss of job	☐Physical abuse	☐Alcohol / drug addiction (you or loved one)
☐Illness in someone close	☐A move	☐Change of workplace	☐Emotional abuse	*Other:*
☐Loss of someone close	☐Pregnancy			

DIET & DIGESTION

TYPICAL FOOD INTAKE

BREAKFAST	LUNCH	DINNER	SNACKS	FLUIDS

Are you following any special diets?	Any food cravings?

☐Change in thirst ☐Excessive thirst	☐Change in appetite ☐Excessive appetite ☐Poor appetite	☐Eating disorder → If yes, specify:

URINATION FREQUENCY	Daytime	_ _ _ _ times	Urine color:	☐ CLEAR ☐ MURKY	Strong odor?	☐Y ☐ N	**BOWEL MOVEMENT FREQUENCY**	_ _ _ _ times
	Nighttime	_ _ _ _ times						

REPRODUCTIVE

Are you and your partner trying to conceive? ☐Y ☐ N → If yes, for how long: _ _ _ _ _ _ _

WOMEN

Age of first menses:	Age of menopause: (if applicable)	Check if currently pregnant: ☐	→ If yes, how many months? _ _ _ _ _
No. of children:	No. of pregnancies:	No. of live births:	No. of miscarriages:
On hormone replacement therapy? ☐Y ☐ N		On oral contraceptives? ☐Y ☐ N	
Date of last menstrual period (first day of cycle): | MM | DD | YY |	Average # days of flow _ _ _ _	Average length of cycle (days) _ _ _ _	Regular menstrual cycle? ☐Y ☐ N / Bleeding between periods? ☐Y ☐ N

Menstrual Pain Type: (if applicable)	**Menstrual pain location:**	**Other Menses symptoms:**			**Previously diagnosed with:**
☐Cramping	☐Lower abdomen	☐Heavy flow	☐Poor appetite	☐Hot flashes	☐PID
☐Burning	☐Lower back	☐Scanty flow	☐Ravenous appetite	☐Decreased libido	☐Fibroids
☐Dull/aching	☐Thighs	☐Spotting mid-cycle	☐Vaginal dryness	☐Headache	☐Fibrocystic breasts
☐Consistent	*Other:*	☐Clotting	☐Night sweats	☐PMS	☐Endometriosis
☐Bearing down		☐Vaginal discharge	☐Constipation	☐Nausea	☐Ovarian cysts
☐Intermittent stabbing		☐Uterine prolapse	☐Diarrhea	☐Swollen breast	
		☐Bloating	☐Mood swings		

MEN

☐Prostate problems ☐Erectile dysfunction ☐Premature ejaculation ☐Impotence ☐Testicular pain ☐Lumps in testicles ☐Feeling of cold or numbness in genitals

FAMILY HEALTH HISTORY

	AGE (IF LIVING)	HEALTH STATUS (IF NOT HEALTHY)	AGE AT DEATH	CAUSE OF DEATH
Mother				
Father				
Sisters				
Brothers				

Indicate those applicable: **M** Mother **F** Father **S** Sibling **G** Grandparent

[ ] Anemia	[ ] Glaucoma	[ ] Mental illness	[ ] Emotional disorders	[ ] Cancer
[ ] Arthritis	[ ] Heart disease	[ ] Seizures / epilepsy	[ ] Tuberculosis	*types:* _____
[ ] Asthma / hayfever	[ ] High blood pressure	[ ] Thyroid problems	[ ] Substance abuse	_____
[ ] Allergies	[ ] High cholesterol	[ ] Hemophilia	[ ] Eating disorders	[ ] Hepatitis
[ ] Alzheimer's	[ ] Kidney disease	[ ] HIV/AIDS	[ ] Parkinson's disease	*type:* _____
[ ] Diabetes	[ ] Liver disease	[ ] Stroke		

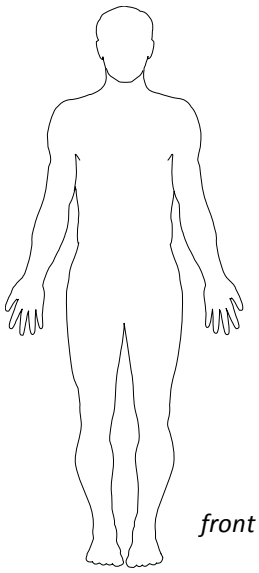
EXPERIENCING PHYSICAL PAIN

Do you have any prosthetic devices, pacemakers, metal pins, etc. in your body? ☐Y ☐ N → If yes, where?

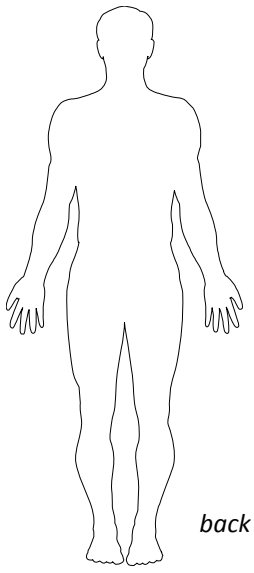
If currently experiencing pain or discomfort, please indicate where by marking the illustration using the letters that best describe the pain and/or sensations that you are experiencing.

If the pain radiates or moves, please indicate using arrows the direction.

P Pain
F Fixed
D Dull
A Aching
S Sharp / Stabbing
N Numb
C Cramping
B Burning
***** Scarring



front



back

CURRENT SYMPTOMS

For the following please write:

✓ if you currently have the symptom
P if you had the symptom before to a significant degree
LEAVE BLANK if you never had the symptom

EMOTIONAL
[ ] Anxiety / nervousness
[ ] Mood swings
[ ] Treated emotional issues
[ ] Considered suicide
[ ] Excessive worry
[ ] Easily stressed
[ ] Depression
[ ] Seasonal depression
[ ] Panic attacks
[ ] Tension
[ ] Insomnia
[ ] Dreams/ nightmares
[ ] Irritability
[ ] Mood swings
[ ] PTSD
[ ] Fatigue
[ ] Poor memory
[ ] Decreased libido
[ ] Increased libido

HEAD
[ ] Headaches / migraines
[ ] Head injury

NECK
[ ] Lumps
[ ] Goiter
[ ] Swollen glands
[ ] Pain or stiffness

EARS
[ ] Pain in ear
[ ] Earache
[ ] Infections
[ ] Discharge from ears
[ ] Sensitivity to noise
[ ] Hearing loss
[ ] Hearing aids

EYES
[ ] Blurriness
[ ] Sensitivity to light
[ ] Impaired vision
[ ] Cataracts
[ ] Eye pain / strain
[ ] Tearing
[ ] Dryness
[ ] Glaucoma
[ ] Macular degeneration
[ ] Glasses / contact lenses
[ ] Poor night vision
[ ] Spots or floaters
[ ] Eye inflammation
[ ] Double vision

NOSE & SINUSES
[ ] Nasal congestion
[ ] Sinus problems / sinusitis
[ ] Nose bleeds
[ ] Hay fever/ allergies
[ ] Loss of smell

MOUTH & THROAT
[ ] Frequent sore throats
[ ] Teeth grinding
[ ] Bleeding gums
[ ] Speech difficulties
[ ] Copious saliva
[ ] Mouth & tongue ulcers
[ ] Hoarseness
[ ] Loss of voice
[ ] Difficulty swallowing
[ ] Thirst/dry mouth
[ ] Jaw/TMJ problems
[ ] Gum problems

CARDIOVASCULAR
[ ] Heart disease
[ ] Low blood pressure
[ ] High blood pressure
[ ] Blood clots
[ ] Phlebitis
[ ] Rheumatic fever
[ ] Swollen ankles
[ ] Angina
[ ] Fainting
[ ] Palpitations
[ ] Chest pain
[ ] Heart murmurs
[ ] Stroke
[ ] Chest pain or tightness
[ ] Rapid heart beat
[ ] Irregular heart beat
[ ] Poor circulation

RESPIRATORY
[ ] Cough
[ ] Spitting up blood
[ ] Asthma
[ ] Pneumonia
[ ] Emphysema
[ ] Pain upon breathing
[ ] Tuberculosis
[ ] Night sweats
[ ] Coughing up phlegm
[ ] Wheezing
[ ] Bronchitis
[ ] Pleurisy
[ ] Difficulty breathing
[ ] Shortness of breath
  └[ ] While lying down
  └[ ] At night

IMMUNE
[ ] Chills
[ ] Fever
[ ] Frequently catch cold/flu
[ ] Chronic fatigue syndrome
[ ] Chronically swollen glands
[ ] Reactions to vaccinations
[ ] Chronic infections
[ ] Slow wound healing

GASTROINTESTINAL
[ ] Trouble swallowing
[ ] Hiccups
[ ] Heartburn
[ ] Nausea
[ ] Bad breath
[ ] Bad taste in mouth
[ ] Vomiting
[ ] Vomiting blood
[ ] Blood in stool
[ ] Black stool
[ ] Mucus in stool
[ ] Laxative use
[ ] Constipation
[ ] Diarrhea
[ ] Bloating
[ ] Indigestion
[ ] Pain or cramps
[ ] Belching
[ ] Passing gas
[ ] Ulcers
[ ] Hemorrhoids
[ ] Liver disease
[ ] Gallbladder disease
[ ] Distress from eating fats
[ ] Jaundice

URINARY
[ ] Pain on urination
[ ] Wake to urinate
[ ] Many urinary infections
[ ] Blood in urine
[ ] Frequent urination
[ ] Incontinence
[ ] Problem starting urination
[ ] Kidney stones
[ ] Urgent urination
[ ] Incomplete urination
[ ] Bedwetting
[ ] Pain/itching of genitalia
[ ] Nocturnal emission
[ ] Delayed stream
[ ] Dribbling
[ ] Hernia
[ ] Retention of urine
[ ] Groin pain

BLOOD / PERIPHERAL VASCULAR
[ ] Easy bleeding / bruising
[ ] Deep leg pain
[ ] Varicose veins
[ ] Anemia
[ ] Cold hands / feet
[ ] Thrombophlebitis
[ ] Fluid retention

ENDOCRINE
[ ] Hypothyroid
[ ] Hypoglycemia
[ ] Heat/cold intolerance
[ ] Diabetes

SKIN
[ ] Rashes
[ ] Acne/boils
[ ] Color changes
[ ] Changes in moles, lumps
[ ] Eczema/ psoriasis
[ ] Itching
[ ] Hair loss
[ ] Warts
[ ] Hives
[ ] Night sweating
[ ] Excess sweating
[ ] Dry skin
[ ] Easy bruising
[ ] Fungal infection
[ ] Burns
[ ] Dermatitis
[ ] Impetigo
[ ] Scars
[ ] Bad body odor

NEUROLOGICAL
[ ] Seizures / epilepsy
[ ] Vertigo or dizziness
[ ] Paralysis
[ ] Numbness or tingling
[ ] Loss of balance
[ ] Tremors
[ ] Poor coordination

MUSCULOSKELETAL
[ ] Joint pain or stiffness
[ ] Broken bones
[ ] Muscle soreness, spasms, cramps
[ ] Arthritis
[ ] Muscle weakness
[ ] Back pain
[ ] Difficulty walking
[ ] Rib pain
[ ] Limited range of motion
[ ] Artificial joint(s)
[ ] Bursitis
[ ] Carpal tunnel syndrome
[ ] Muscular dystrophy
[ ] Plantar fasciitis
[ ] Tendonitis
[ ] Whiplash
[ ] Other (describe)

INFECTION SCREENING
[ ] HIV risks: self or partner
[ ] TB: self or household
[ ] Hepatitis risk
[ ] Gonorrhea
[ ] Chlamydia
[ ] Syphilis
[ ] Genital warts
[ ] Herpes: oral/ genital
[ ] Other (describe)

DECLARATION AND CONSENT TO TREAT

Name: _____ Date: MM DD YY

please print

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, and treat the cause of the illness by taking into consideration physical, mental, and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

It is very important therefore, that you provide such information as any medications or over the counter drugs you are currently taking, disease processes you are currently suffering from or if you suspect that you are pregnant.

This is to acknowledge that I have been informed and I understand that:

1. I have read all the foregoing information and that I understand that the ultimate responsibility for my health is my own.
2. I am receiving treatment from a Naturopathic Doctor, not a Medical Doctor.
3. All treatments offered are within the Naturopathic scope of practice.
4. Any treatment or advice given to me as a patient is not mutually exclusive from any treatment or advice that I may receive now, or in the future, from another licensed health care provider.
5. I am at liberty to seek or continue medical care from a physician, surgeon or other health care provider.
6. I accept full responsibility for any fees incurred during care and treatment. I agree to fully discharge this responsibility at the time of the visit unless prior arrangements have been made.
7. There are some slight health risks to treatment by Naturopathic medicine. These include, but are not limited to:
    - Allergic reactions to supplements or herbs
    - Side effects of medications (eg. Hormone Therapy, Antibiotics)
    - Pain, bruising, infection or injury from injections

PLEASE NOTE: There is a 24-hour cancellation policy at the clinic. If you are unable to make your appointment, please notify the clinic at least 24 hours in advance to ensure you are not charged the initial visit fee. _____ ← *please initial here*

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Signature / Signature of Guardian _____

PRESCRIPTION REFILL POLICY

Name: _____ Date: MM DD YY

please print

Patients are required to book an appointment at least two weeks before needing a prescription refill. Appointments can be conveniently booked by calling the office or online. Follow-up appointments are required every two to three months. We will not write a prescription for a longer duration.

Appointments are needed to review and properly document how well you are doing with your prescriptions and lifestyle changes. At this time, the Naturopathic Doctor will have the opportunity to review your blood work, symptoms, questions, concerns and general progress.

Please make sure to allow at least two weeks, as it takes time to do a follow up and for the pharmacy to mail you your prescription medications on time. This will ensure continuation of your treatment protocol without interruption. If you are unable to come into the office for an appointment and your prescription is going to run out, please let us know two weeks prior and we will be happy to offer you a phone consult. If you are financially unable to do a visit, we will accept post-dated checks and arrange a payment plan for you so this does not stand in the way of your treatment protocol.

Please do not email the office with health updates, as e-mail is not a secure way to transmit information. Sometimes we will not have access to your file when answering emails, so we cannot record your progress in your file. However, please feel free to e-mail the office with any questions you have about your treatment protocol.

In the event you just need a refill called in for a pharmaceutical you have been on for years, and we have deemed you stable, we will call in the refill for a $10 admin fee.

I understand the above,

Patient Signature / Signature of Guardian _____

PRIME WELLNESS

Dr. Kelly Austin, ND
www.atmyprime.com

OFFICE POLICIES

Hours Rancho Bernardo
Monday- Friday 9am-5pm

Hours Solana Beach
Monday- Thurs 9am-5:30pm
Friday 9am-1:00pm

Office visits are by appointment only.
B12 walk-ins welcomed!

Fees
$250 Initial and 1st follow-up
(55 min RN/MD/ND)
$350 Initial (55 min-Dr. Austin)
$110 follow-up (25 min-Dr. Austin)
$90 follow-up (25 min-RN/MD/ND)
$60 follow-up (15 min-RN/MD/ND)

Payment
- Payment is due at the time of service. Please discuss any fee questions with the doctor before your visit so you can know what to expect.
- We accept cash, check or credit cards.
- Lab testing is not included in the fee. If you have a PPO, we will use a lab facility that is covered by your insurance company. If you have a HMO, we can ask your HMO MD to run the labs we need.
- Fee schedules can be arranged with the doctor prior to a visit if you are in financial need.

Insurance
- Insurance does not directly cover naturopathic doctors.
- However, we can provide you with a superbill after every visit which you may submit to your insurance company to request out-of-network reimbursement. Some services may not be covered by certain health insurance plans.
- It is your responsibility to know what your insurance plan covers.
- We are not responsible for unpaid claims by your insurance company for services we provide.

Phone Consults
- We will call you for your scheduled appointment. Please allow a 5 to 10 minute window of buffered time.
- All appointments are scheduled for the Pacific Standard Time.

Cancellations
- As a courtesy, our office will e-mail or call you to confirm your appointment 1 business day in advance.
- If you cannot keep a scheduled appointment, please notify us at least 24 hours prior to your scheduled time.
- If you miss your appointment without cancelling, you will be charged for the missed appointment.

Appointments
- First appointment: Please fill in the new patient forms prior to your appointment. You may bring them with you to your appointment or fax them in.
- Please arrive 15 minutes before your scheduled appointment.
- Please do not wear any scented products, as many of our patients are chemically sensitive. These include lotions, perfumes, cologne and hair spray.
- Follow-up consults may be scheduled in 15, 30, 45, or 60 minute blocks, depending on your needs.
- All consultations are charged for the time used, not the time blocked.
- Research requested by the patient is a billable service and will be charged at the hourly rate.
- Follow-up visits: We generally recommend that all patients have a follow-up every 3 months at minimum.

Prescriptions
- Prescriptions need to be obtained at your appointment. We do not mail prescriptions or lab orders.
- We require 24-hour notice for refills.
- Hormone prescriptions are done on a 3 month basis, and require a follow up to renew them.
- Please come to all appointments prepared with a complete medication list and let us know which require refills.
- No prescription dose change will be made without an appointment.
- If you are sick or have side effects, please contact us immediately.
- The doctor cannot prescribe medications to those who are not his or her patient.

Tests
- If you misplace an order for testing, we require 24-hour notice to rewrite the order. You can pick it up at the office or we can e-mail it to you.
- Tests will not be discussed via phone unless it is a phone consult.
- Results are only discussed at appointments and not outside the office to prevent unsafe disclosure of the confidential health information.

Medical Letters
- Medical letters (for schools, insurance companies, etc) can be provided. The charge for generating these will be billed at the doctor's hourly rate.

Follow-Up Questions
- You can contact the doctor with follow-up questions, but please keep these brief. If a question is more involved, a consult may be required.

General
- Please keep all health concern discussions to office visits.
- Please avoid discussing other people's health concerns at the visit. You have limited time with the doctor and we want to make sure you get the time and attention needed to make you feel better.

The policies listed above have been established to ensure quality care for our patients. Should you have any questions, please contact our office.

[redacted]

I acknowledge the by electing to receive my health information via email in an unsecure manner, that the information will not be encrypted, and that it could be intercepted and viewed by a third party. Prime Wellness is not responsible for unauthorized access of your health information while in transmission to the email address you designated above.

[redacted] _____

[redacted] _____ [redacted] _____

If signed by other than patient, indicate relationship: _____

Witness: _____

Cancellation Policy/No Show Policy for Appointments

1. *Cancellation/ No Show Policy for Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged the full price for your service.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment and you will be charged the full price for your service.

3. Account Balances

We do require that patients to pay their account balances to zero prior to receiving further services by our practice. Patients who have questions about their bills may call and ask to speak to a business office representative

_____	_____	___/___/___
Print Name	Signature Patient/Guardian	Date