Harvest Healthcare MT, LLC
1601 2nd Ave N, Suite 520
Great Falls, MT 5905
Phone: 406-453-1254 / Fax: 406-743-1622

PLEASE BRING THESE FORMS FULLY COMPLETED TO YOUR FIRST APPOINTMENT

PLEASE KEEP PAGES 1 - 5 FOR YOUR RECORDS

Personalized Family Medicine: New Patient Information

Welcome to the Personalized Family Medicine Approach

Harvest Healthcare MT is delighted that you have chosen Personalized Medicine to be a part of your primary healthcare approach or to address your health concerns. This approach combines advanced laboratory diagnostics based on current scientific research with lifestyle medicine and ancient wisdom. Areas of focus include stress management, diet, nutrition, movement, breathing, quiet time, and the use of botanical and nutritional supplements. Our aim is to partner with you in your pursuit of true wellness.

Initial Appointment

Your first appointment is scheduled for 90 minutes. Please ensure that all new patient forms are fully completed and brought with you to this visit as well as any old labs or documents that you have (testing or procedures).

Consultation Overview

- Initial Consultation (90 minutes): The first hour consists of a comprehensive health history intake and a consultation, including a review of body systems and relevant functional medicine diagnostic labs. The final 15–20 minutes after the consultation we will discuss recommended tests or supplements. Payment for the consultation, labs, and any supplements is collected at this time.
- Second Consultation (45–60 minutes): This visit is dedicated to reviewing your lab results and your personalized treatment program. Payment for the follow-up and any supplements is due at this appointment.
- Ongoing Consultations (45–60 minutes): Follow-up sessions focus on evaluating your progress and updating your treatment plan as needed. Payment is required for each visit and for any additional supplements.

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PRACTICE POLICIES FOR PATIENTS

Our goal is to provide you with the highest level of personalized care possible. We are committed to helping you achieve true wellness. It is important to read all of the enclosed information carefully, complete all the forms, and bring it to your first appointment.

WEBSITE

Information about Harvest Healthcare MT and all relevant patient forms will be available through the website: www.harvesthealthcare.com.

SELF SCHEDULING OPTION

https://www.patientfusion.com/doctor/alicia-hamilton-pa-c-16686

DIRECT PRIMARY CARE MEMBERSHIP

Includes:

- A personalized relationship with your primary care provider.
- Same day or next day appointments for urgent visits.
- Extended access to your provider: in person, virtual, and text access.
- Preventative Care: wellness visits, annual labs, chronic health condition management.

DIRECT PRIMARY CARE MEMBERSHIP OPTIONS

- Individual: $75.00 per month per adult
    - $25,00 per child with adult membership
- Couples' Discount: $125.00/month
- Family Max out of pocket: $200.00/month
- Military and Emergency Response Personnel get 20% discount.

What if you are happy with your Primary Care Provider and only want testing and consultation for specialized testing?

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PERSONALIZED MEDICINE CONSULTATION FEES

- Initial Consultation with Alicia Hamilton: $250.00 (75 minutes)
- Second Consultation with Alicia Hamilton: $250 (60 min) or $175 (45 min)
- Ongoing Consultations with Dr. Jamie: $175 (45 min)

This can be easily scheduled online at:

https://harvesthealthcare.wellproz.com/patient/home

LAB TESTS

The personalized labs that we use do not accept insurance. Most of these lab tests may be done in the privacy of your own home and involve stool, urine, saliva, or bloodspot (skin prick) samples. Labs that require phlebotomy draws can be taken to Big Sky Laboratory for a small draw fee (approx. $25.00) and processing. They will call UPS for pickup at his location same day.

The personalized tests will be drop-shipped, or you will be given a kit from the office that has step-by-step instructions at the time of your consult, depending on the lab that we choose. Once all the final lab results are received, we will review them with you at your follow-up visits.

SUPPLEMENTS

Supplements that are recommended by Alicia Hamilton are available for purchase at a local medicinary, at local pharmacies (like Montana Apothecary) or from mail order through FullScript for your convenience. Supplements purchased online will be mailed directly to you. We will educate you and recommend foods and nutritional supplements as part of your treatment program, but you are under no obligation to purchase supplements from our office or website.

CREDIT CARDS

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We require a credit card number at the time of your first appointment. This credit card will be used to hold your appointment and will be kept on file to use for all appointments, labs and supplements unless otherwise specified by you at the time of check out.

CANCELLATION AND RESCHEDULING OF APPOINTMENTS

Your appointment must be cancelled or rescheduled at least 24 hours prior to your consultation time, or you will be charged a $50 cancellation fee. You may cancel your appointment by calling the office at 406-453-1254.

FOLLOW-UP APPOINTMENTS

At the time of check out you will be scheduled for a follow-up appointment.

PAYMENT OPTIONS

Cash, check, and credit card are accepted methods of payment for services. When you come to your initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment your initial fee will be due.

You will be charged the first consultation fee and if signing up for DPC you will be set up on a recurring fee schedule for the 1st or the 15th of the month (whichever is closest to the date of your appointment).

Over-the-phone or in-person consultations will be billed to your credit card on file unless you provide other payment information and instructions up to your appointment time. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to your account as agreed upon.

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INSURANCE INFORMATION

Medical insurance is not accepted by Harvest Healthcare MT and our office cannot assist you with claim resolution. If requested, we can provide you with an itemized receipt that you can submit to your insurance carrier. Harvest Healthcare does not submit medical notes to insurance companies.

We will use ICD-10 codes in our documentation and on orders to facilitate using your insurance for items such as outside testing (annual labs, imaging, procedures etc) and for referrals.

OFFICE HOURS

Monday: by phone only (in person for cancer patients only)

Tuesday, Wednesday and Friday: 0900-1200 and by appointment.

PHONE CALLS AND MESSAGES

To reach the office, please call 406-453-1254. If you call after hours, please leave a message and the office staff will return your call on the next business day. If you have a medical emergency, call 911 or go directly to the nearest ER.

When leaving a message, please be brief, speak slowly, and include the following information:

- Full name and date of birth
- Reason for call
- Phone number(s) - please repeat this twice

If you have a BRIEF medical question for Alicia Hamilton, PA-C please email her at manager@harvesthealthcare.org . Please note that it can take up to 3 business days to respond to emails, so please do not put any information in this format that is time sensitive.

Wishing you health and happiness, Alicia Hamilton, PA-C and the Harvest Healthcare MT team!

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HARVEST HEALTHCARE IMPORTANT PATIENT INFORMATION

APPOINTMENT TYPES

1. DIRECT PRIMARY CARE MEMBERSHIP
    - Individual: $75.00 per month per adult
        - $25,00 per child with adult membership
    - Couples' Discount: $125.00/month
    - Family Max out of pocket: $200.00/month
    - Military and Emergency Response Personnel get 20% discount.
2. CONSULTATIONS ONLY
    - Initial Consultation with Alicia Hamilton: $250.00 (75 minutes)
    - Second Consultation with Alicia Hamilton: $250 (60 min) or $175 (45 min)
    - Ongoing Consultations with Alicia Hamilton: $175 (45 min)
3. CANCELLATION POLICY
    - We reserve the right to charge your credit card $50 if the appointment is not canceled or rescheduled 24 hours prior to your appointment.
    - By signing below you agree to our cancelation policy and authorize Harvest Healthcare MT to charge your credit card on file for any missed visits.
4. RETURN CHECK FEE ● A $35 fee will be assessed for all checks returned for insufficient funds.

Patient signature:
_____

Date: _____

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INFORMED CONSENT REGARDING E-MAIL OR INTERNET USE OF PROTECTED PERSONAL INFORMATION

Harvest Healthcare MT offers patients the option to communicate via e-mail. Communicating confidential health information by e-mail may entail certain risks that should be considered before proceeding.

1. Risks:
    - General e-mail risks: E-mails can be widely distributed and received by both intended and unintended recipients; recipients may forward e-mails to others with or without authorization; there is potential for misaddressing messages; e-mails are susceptible to falsification more than handwritten or signed documents; backup copies of e-mails may remain even after deletion by senders or recipients.
    - Specific e-mail risks: E-mails containing diagnostic and/or treatment information are considered part of protected personal health information; all authorized personnel with access to the protected health information may access these e-mails; patients who use workplace e-mail accounts may have their correspondence accessed by their employer.
2. Harvest Healthcare MT maintains a policy wherein all e-mails related to diagnosis or treatment are integrated into the patient's protected personal health information. Such e-mails or internet communications receive the same confidentiality protections as other parts of the health record. Harvest Healthcare MT utilizes reasonable measures to maintain security and confidentiality of electronic communications but cannot guarantee absolute security due to the risks described.
3. Patients are required to provide informed consent for the use of e-mail to transmit confidential medical information, acknowledging the following conditions:
    - All patient e-mails regarding diagnosis and/or treatment will become part of the protected personal health information.
    - Other healthcare practitioners, insurance coordinators, and, with written authorization, additional providers and insurers may access these messages as permitted.

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- Harvest Healthcare MT practitioners may internally forward e-mails as necessary for care but will not distribute them externally without patient consent unless required by law.

4. While efforts are made to review e-mails promptly, immediate response cannot be assured. E-mail should not be used for medical emergencies. It is the sender's responsibility to confirm e-mail receipt and response time.
   - Due to sensitivity, e-mail should not be used for communication regarding diagnosis or treatment of HIV/AIDS, sexually transmitted or communicable diseases, behavioral or mental health concerns, developmental disabilities, or substance abuse.
   - Although privacy cannot be guaranteed, reasonable steps are taken to ensure e-mail confidentiality.
   - Patients must inform staff if they do not wish specific information to be sent by e-mail. They are also responsible for maintaining password security for their accounts. Harvest Healthcare MT is not liable for breaches of confidentiality resulting from actions by the patient. Any further patient-initiated correspondence discussing diagnosis or treatment constitutes ongoing informed consent.
   - Consent to e-mail use may be withdrawn at any time by e-mail or written notice to Harvest Healthcare MT at manager@harvesthealthcare.org.

I acknowledge that I have read and understood the above information and accept the associated risks and responsibilities of using e-mail for communication.

Name Printed:
_____

Signature:
_____

Date:_____

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GENERAL INFORMATION

Full Name:

_____
___

Date of Birth: _____Age: _____ Gender: __Male __Female

Social Security Number: _____

Primary Address, City, State, Zip:

_____
_____

Home Phone: _____

Work Phone: _____

E-mail: _____

What is your preferred contact method?

Cell phone: _____ Home phone: _____ Email: _____

Is it okay for us to email or text appointment reminders? Y / N

Education: ___High School___ Under-Graduate __Post-Graduate

Job Title:

_____
____ Nature of Current Occupation / Business:

_____
_____

Past Occupations and Occupational Exposures:

_____
_____

Military Service? (branch, deployments and years) THANK YOUYOU'RE YOUR SERVICE!

_____
_____
_____

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Emergency Contact, Relationship and Phone number:

_____
_____

Primary Provider's Name and Phone Number:__
_____

Who Referred you to Alicia Hamilton, PA-C/Harvest Healthcare MT?

_____
_____

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HARVEST HEALTHCARE MT FAMILY MEDICINE MEDICAL QUESTIONNAIRE

COMPLAINTS / CONCERNS

What do you hope that we can help you to achieve?

_____
_____
_____

If you had a magic wand and could erase three problems, what would they be?

1.
_____
_____

2.
_____
_____

3.
_____
_____

When was the last time you felt well?

_____
_____ Did something trigger your change in health?
_____
_____ What makes you feel worse?
_____
_____ What makes you feel better?
_____
_____

Please list top three current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe
Ex. headaches		X	

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Prior Treatment / Therapeutic Approach	Excellent	Good	Fair
Ex. Elimination Diet	X		

ALLERGIES

Medications / Supplement / Food and Reaction:

_____
_____
_____
_____

Environmental and Reaction:

_____
_____
_____

MEDICATIONS CURRENT

Current Medications				
Medication	**Dose**	**Frequency**	**Start date**	**Reason for Use**
Previous Medications				

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Supplements (vitamins/minerals/herbs/homeopathy)				

MEDICAL HISTORY - DISEASES / DIAGNOSIS / CONDITIONS

Check the box next to the conditions you have and provide date of onset

GASTROINTESTINAL

┼ Irritable Bowel Syndrome _____ ┼ Inflammatory Bowel Disease _____

┼ Crohn's Disease _____ ┼ Ulcerative Colitis _____

┼ Gastritis or Peptic Ulcer Disease _____ ┼ GERD (reflux) _____

┼ Celiac Disease _____ ┼ Constipation _____

┼ Loose Stools _____ ┼ Bloating _____

┼ Flatulence (gas) _____

┼ Other _____

CARDIOVASCULAR

┼ Heart Attack _____ ┼ Other Heart Disease _____

┼ Stroke _____ ┼ Elevated Cholesterol _____

┼ Arrythmia (irregular heart rate) _____ ┼ Hypertension (high blood pressure) _____

┼ Rheumatic Fever _____ ┼ Mitral Valve Prolapse _____

┼ Other _____ _____

METABOLIC / ENDOCRINE

┼ Type 1 Diabetes _____ ┼ Type 2 Diabetes _____

┼ Weight Gain _____ ┼ Weight Loss _____

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- Hypoglycemia _____
- Metabolic Syndrome _____
- Insulin Resistance or Pre-Diabetes _____
- Hypothyroidism (low thyroid) _____
- Hyperthyroidism (overactive thyroid) _____
- PCOS _____
- Infertility _____
- Frequent Weight Fluctuations _____

- Bulimia _____
- Anorexia _____
- Binge Eating Disorder _____
- Night Eating Syndrome _____
- Eating Disorder (non-specific) _____
- Other _____

CANCER

- Lung Cancer _____
- Breast Cancer _____
- Colon Cancer _____
- Ovarian Cancer _____
- Prostate Cancer _____
- Skin Cancer _____
- Other _____

GENITOURINARY

- Kidney Stones _____
- Gout _____
- Interstitial Cystitis _____
- Frequent Urinary Tract Infections _____
- Frequent Yeast Infections _____
- Erectile and/or Sexual Dysfunction _____
- Other _____

MUSCULOSKELETAL / PAIN

- Osteoarthritis _____
- Fibromyalgia _____
- Chronic Pain _____
- Other _____

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INFLAMMATORY / IMMUNE

┼ Chronic Fatigue Syndrome _____ ┼ Autoimmune Disease _____ ┼ Rheumatoid Arthritis _____ ┼ Lupus SLE _____ ┼ Immune Deficiency Disease _____ ┼ Herpes-Genital _____ ┼ Severe Infectious Disease ┼ Poor Immune Function _____ ┼ Food Allergies _____ ┼ Environmental Allergies _____ ┼ Multiple Chemical Sensitivities _____ ┼ Latex Allergy _____ ┼ Other _____

RESPIRATORY DISEASES

┼ Asthma _____ ┼ Chronic Sinusitis _____ ┼ Bronchitis _____ ┼ Emphysema _____┼ Pneumonia _____ ┼ Tuberculosis _____ ┼ Sleep Apnea _____ ┼ Other _____

SKIN DISEASES

┼ Eczema _____ ┼ Psoriasis _____ ┼ Acne _____ ┼ Melanoma _____ ┼ Skin Cancer _____ ┼ Other _____ _____

NEUROLOGIC / MOOD

┼ Depression _____ ┼ Anxiety _____ ┼ Bipolar Disorder _____ ┼ Headaches _____ ┼ Migraines _____ ┼ ADD/ADHD _____ ┼ Autism _____ ┼ Mild Cognitive Impairment _____ ┼ Memory Problems _____ ┼ Parkinson's Disease _____ ┼ Multiple Sclerosis _____ ┼ ALS _____ ┼ Seizures _____ ┼ Other _____

INJURIES

_____
_____

Circle if yes:

┼ Back Injury

┼ Head Injury

┼ Neck Injury

┼ Broken Bones

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SURGERIES Check box if yes and provide **date** of surgery

┼ Appendectomy _____ ┼ Hysterectomy +/- Ovaries _____ ┼ Gall Bladder _____ ┼ Hernia _____ ┼ Tonsillectomy _____ ┼ Dental Surgery _____ ┼ Joint Replacement –Knee/Hip _____ ┼ Spinal Surgery _____ ┼ Heart Surgery–Bypass Valve _____ ┼ Angioplasty or Stent _____ ┼ Pacemaker _____

┼ Other

_____
__

HOSPITALIZATIONS

┼ None

Date/Reason:

_____
_____
_____
_____
_____

GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY (Check box if yes and provide number)

┼ Pregnancies_____ ┼ Caesarean_____ ┼ Miscarriage_____ ┼ Postpartum Depression ┼ Baby Over 8 Pounds ┼ Abortion_____ ┼ Toxemia ┼ Vaginal deliveries_____ ┼ Living Children_____ ┼ Gestational Diabetes ┼ Breastfeeding For how long?_____

MENSTRUAL HISTORY

Age at First Period: _____ Menses Frequency: _____ Length: _____

Pain: ┼ Yes ┼ No Clotting: ┼ Yes ┼ No Cycle length _____

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Last Menstrual Period: _____

Use of hormonal contraception such as:

┼ Birth Control ┼ Pills ┼ Patch ┼ Nuva Ring

How long?_____

Do you use contraception?

┼ Yes ┼ No ┼ Condom ┼ Diaphragm ┼ IUD ┼ Partner Vasectomy

WOMEN'S DISORDERS / HORMONAL IMBALANCES (for women only)

┼ Fibrocystic ┼ Breasts ┼ Endometriosis ┼ Fibroids Infertility ┼ Painful Periods ┼ Heavy periods ┼ PMS

Last PAP Test: _____ ┼ Normal ┼ Abnormal

Are you in menopause? ┼ Yes ┼ No

Age at Menopause: _____

Symptoms:

┼ Hot Flashes ┼ Mood Swings ┼ Concentration / Memory Problems ┼ Vaginal Dryness ┼ Decreased Libido ┼ Heavy Bleeding ┼ Joint Pains ┼ Headaches ┼ Weight Gain ┼ Loss of Control of Urine ┼ Palpitations ┼

Use of hormone replacement therapy How long?_____

MEN'S HISTORY (for men only)

┼ Prostate Enlargement ┼ Prostate infection ┼ Change in Libido ┼ Impotence ┼ Difficulty Obtaining an Erection ┼ Difficulty Maintaining an Erection

┼ Nocturia (urination at night) How many times at night? _____

┼ Urgency/Hesitancy/Change in Urinary Stream ┼ Loss of Control of Urine

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GI HISTORY Foreign Travel? ┼ Yes ┼ No Where?

_____

Wilderness Camping? ┼ Yes ┼ No Where?

_____

Have you ever had severe: ┼ Gastroenteritis ┼ Diarrhea

Do you feel like you digest your food well? ┼ Yes ┼ No

Do you feel bloated after meals? ┼ Yes ┼ No

DENTAL HISTORY

Silver Mercury Fillings:

┼ Yes ┼ No How many? _____

┼ Gold Fillings

┼ Root Canals If yes, how many? _____

┼ Implants If yes, how many? _____

What material is the implant made of? _____

┼ Tooth Pain ┼ Bleeding Gums ┼ Gingivitis ┼

Problems with Chewing Do you floss regularly? ┼ Yes ┼ No

What type of toothpaste do you use?

_____

Have your medications or supplements ever caused you unusual side effects or problems? ┼ Yes ┼ No

Describe:

_____

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Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin?

┼ Yes ┼ No

Have you had prolonged or regular use of Tylenol?

┼ Yes ┼ No

Have you had prolonged or regular use of Acid Blockers (Tagamet, Zantac, Prilosec, etc.)

┼ Yes ┼ No

Frequent antibiotics (> 2 times/year)

┼ Yes ┼ No

Long term antibiotics ┼ Yes ┼ No

Use of steroids (prednisone, nasal allergy inhalers) in the past

┼ Yes ┼ No

NUTRITION HISTORY

Have you ever had a nutritional consultation? ┼ Yes ┼ No

Have you made any changes in your eating habits because of your health? ┼ Yes ┼ No Describe:

_____
____

Do you currently follow a special diet or nutritional program? ┼ Yes ┼ No

Check all that apply:

┼ Low Fat ┼ Low Carbohydrate ┼ High Protein ┼ Low Sodium ┼ Diabetic ┼ No Dairy ┼ No Wheat ┼ No Gluten ┼ Vegetarian ┼ Vegan

Specific Program for Weight Loss/Maintenance Type:

_____

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Other:
_____
_____

Height (feet/inches)_____ Current Weight _____

Usual Weight Range +/- 5 lbs _____

Desired Weight Range +/- 5 lbs _____

Highest adult weight _____

Lowest adult weight _____

Weight Fluctuations (> 10 lbs.) ┼ Yes ┼ No

Body Fat % _____

How often do you weigh yourself? ┼ Daily ┼ Weekly ┼ Monthly ┼ Rarely ┼ Never

Do you avoid any particular foods? ┼ Yes ┼ No

If yes, types and reason
_____
_____
_____
_____ Do you grocery shop? ┼ Yes ┼ No

If no, who does the
shopping?_____ Do
you read food labels? ┼ Yes ┼ No

Do you cook? ┼ Yes ┼ No

If no, who does the cooking?_____

How many meals do you eat out per week? ┼ 0-1 ┼ 1-3 ┼ 3-5 ┼ >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

┼ Fast eater ┼ Erratic eating pattern

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- Eat too much
- Late night eating
- Dislike healthy food
- Time constraints
- Eat more than 50% meals away from home
- Travel frequently
- Non-availability of healthy foods
- Do not plan meals or menus
- Reliance on convenience items
- Significant other or family members don't like healthy foods
- Significant other or family members have special dietary needs or food preferences
- Love to eat food
- Have a negative relationship with
- Struggle with eating issues
- Emotional eater (eat when sad, lonely depressed, bored)
- Eat too much under stress
- Eat too little under stress
- Don't care to cook
- Eating in the middle of the night
- Confused about nutrition advice

SMOKING

Currently Smoking? ┼ Yes ┼ No

How many years? _____ Packs per day: _____

Attempts to quit: _____

Previous Smoking: How many years? _____ Packs per day? _____

Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

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How many drinks do you currently have per week?

(1 drink = 5 ounces wine, 12 ounces beer, or 1.5 ounces spirits)

┼ None ┼ 1-3 ┼ 4-6 ┼ 7-10 ┼ >10

Previous alcohol intake?

┼ None ┼ Yes (┼ Mild ┼ Moderate ┼ High)

Have you ever been told you should cut down your alcohol intake? ┼ Yes ┼ No

Do you ever feel guilty about your alcohol consumption? ┼ Yes ┼ No

Do you notice a tolerance to alcohol (can you “hold” more than others)? ┼ Yes ┼ No

Have you ever backed out during drinking? ┼ Yes ┼ No

Do you get into arguments or physical fights when you have been drinking? ┼ Yes ┼ No

Have you ever been arrested or hospitalized because of drinking? ┼ Yes ┼ No

Have you ever thought about getting help to control or stop your drinking? ┼ Yes ┼ No

OTHER SUBSTANCES

Caffeine Intake: ┼ Yes ┼ No

Coffee cups/day: ┼ 1 ┼ 2-4 ┼ >4 | Tea cups/day: ┼ 1 ┼ 2-4 ┼ > 4

Caffeinated Sodas or Diet Sodas Intake: ┼ Yes ┼ No

12-ounce can/bottle ┼ 1 ┼ 2-4 ┼ >4 per day

Are you currently using any recreational drugs (marijuana, ecstasy, etc)? ┼ Yes ┼ No
Type_____
_____

Have you ever used IV recreational drugs? ┼ Yes ┼ No

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EXERCISE

Current Exercise Program: (List type of activity, number of sessions/week, and duration)

Activity Stretching Cardio / Aerobics Strength

Other Type Frequency per Week Duration in Minutes Sports or Leisure Activities (golf, tennis, rollerblading, etc)

Rate your level of motivation for including exercise in your life? ┼ Low ┼ Medium ┼ High

List problems that limit activity:

_____
_____
_____
_____ Do you feel unusually fatigued after exercise? ┼ Yes ┼ No If yes, please describe:

_____
_____
_____
_____

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ┼ Yes ┼ No

Are you happy? ┼ Yes ┼ No

Do you feel your life has meaning and purpose? ┼ Yes ┼ No

Do you have a religious preference?_____

Do you believe stress is presently reducing the quality of your life? ┼ Yes ┼ No

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Do you like the work you do? ┼ Yes ┼ No

Have you ever experienced major losses in your life? ┼ Yes ┼ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ┼ Yes ┼ No

Would you describe your experience as a child in your family as happy and secure?

┼ Yes ┼ No

STRESS/COPING

Have you ever sought counseling? ┼ Yes ┼ No

Are you currently in therapy? ┼ Yes ┼ No

Describe:

_____
_____

Do you feel you have an excessive amount of stress in your life? ┼ Yes ┼ No

Do you feel you can easily handle the stress in your life? ┼ Yes ┼ No

Daily Stressors: Rate on scale of 1-10 Work _____ Family _____ Social _____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation techniques? ┼ Yes ┼ No How often? _____ Check all that apply: ┼ Yoga ┼ Meditation ┼ Prayer ┼ Imagery ┼ Breathing ┼ Tai Chi Other:

_____
_____

Have you ever been abused, a victim of a crime, or experienced a significant trauma?

┼ Yes ┼ No

SLEEP / REST

Average number of hours you sleep per night: ┼ >10 ┼ 8-10 ┼ 6-8 ┼ < 6

Do you have trouble falling asleep? ┼ Yes ┼ No

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Do you feel rested upon awakening? ┼ Yes ┼ No

Do you have problems with insomnia? ┼ Yes ┼ No

Do you snore? ┼ Yes ┼ No

Do you use sleeping aids? ┼ Yes ┼ No

Explain:

_____
_____

ROLES / RELATIONSHIPS

Marital status: ┼ Single ┼ Married ┼ Divorced ┼ Long Term Partnership

┼ Widow

# of Children _____ Year of birth of Each Child:

_____

Who else is living in household?

_____

Under what circumstances? (ex: my mother - dementia)

_____
_____
_____

Resources for emotional support?

Check all that apply:

┼ Spouse ┼ Family ┼ Friends ┼Religious/Spiritual

┼ Pets ┼ Other: _____

Are you satisfied with your sex life? ┼ Yes ┼ No

How well have things been going for you?	Very Well	Fine	Poorly	N/A
Overall in your life				
At school				
In your job				

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In your social life				
With your friends				
With sex				
With your spouse/significant other				
With your children				
With your parents				
With having a positive attitude				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have adverse food reactions or sensitivities? ┼ Yes ┼ No

If yes, describe symptoms:

_____

Do you have any food allergies or sensitivities? ┼ Yes ┼ No

If yes, list all:

_____
_

Do you have an adverse reaction to caffeine? ┼ Yes ┼ No

When you drink caffeine do you feel: ┼ Irritable or wired ┼ Aches & Pains

Do you adversely react to any of the following:

┼ Monosodium glutamate (MSG) ┼ Aspartame (NutraSweet)

┼ Caffeine ┼ Garlic ┼ Onion ┼ Cheese

┼ Citrus Foods ┼ Chocolate ┼ Alcohol ┼ Red Wine

┼ Sulfite Containing Foods (wine, dried fruit, salad bars)

┼ Preservatives (ex. sodium benzoate) ┼ Cigarette Smoke ┼ Perfumes/Colognes

┼ Auto Exhaust Fumes ┼ Other: _____

In your work or home environment, are you exposed to:

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┼ Chemicals ┼ Electromagnetic Radiation ┼ Mold

Do you have a known history of significant exposure to any harmful chemicals such as the following: ┼ Herbicides

┼ Insecticides (frequent visits of exterminator) Pesticides Organic Solvents Heavy Metals Other_____

Do you dry clean your clothes frequently? Y┼ Yes ┼ No

Do you or have you lived or worked in a damp or moldy environment? ┼ Yes ┼ No

Do you have any pets or farm animals? ┼ Yes ┼ No

CURRENT SYMPTOM REVIEW

Please check all symptoms experienced within the past 6 months to the present.

GENERAL	HEAD, EYES & EARS	MUSCULOSKELETAL
__ Cold Hands & Feet	__ Conjunctivitis	__ Back Muscle Spasm
__ Cold Intolerance	__ Distorted Sense of Smell	__ Calf Cramps
__ Low Body Temperature	__ Distorted Taste	__ Chest Tightness
__ Low Blood Pressure	__ Ear Fullness	__ Foot Cramps
__ Daytime Sleepiness	__ Ear Pain	__ Joint Deformity
__ Difficulty Falling Asleep	__ Ear Ringing/Buzzing	__ Joint Pain
__ Early Waking	__ Eye Pain	__ Joint Redness
__ Fatigue	__ Hearing Problems	__ Joint Stiffness
__ Fever	__ Headache	__ Muscle Pain
__ Heat Intolerance	__ Migraine	__ Muscle Spasms
__ Night Waking	__ Sensitivity to Loud Noises	__ Muscle Stiffness
__ Nightmares	__ Vision problems (other than glasses)	__ Muscle Twitches - eyes
__ No Dream Recall	__ Macular Degeneration	__ Muscle Twitches - arms, legs
		__ Muscle Weakness
		__ Neck Muscle Spasm
		__ Tendonitis
		__ Tension Headache
		__ TMJ Problems

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MOOD / NERVES	DIGESTION	SKIN & HAIR PROBLEMS
__ Anxiety	__ Anal Spasms	__ Acne on Face
__ Blackout	__ Bad Teeth	__ Acne on Body
__ Depression	__ Bleeding Gums	__ Athlete's Foot
	__ Bloating	__ Bumps on Back of Upper Arms
Difficulty:	__ Bloating After Meals	__ Easy Bruising
__ Concentrating	__ Blood in Stools	__ Eczema
__ With Balance	__ Burping	__ Hair Loss
__ With Thinking	__ Canker Sores	__ Hives
__ With Speech	__ Cold Sores	__ Jock Itch
__ With Memory	__ Constipation	__ Oily Skin
__ Dizziness / Vertigo	__ Cramps	__ Pale Skin
__ Fainting	__ Diarrhea	__ Rash
__ Fearfulness	__ Alternating Diarrhea and Constipation	__ Red Face / Ears
__ Irritability	__ Difficulty Swallowing	__ Sensitivity to Insect Bites
__ Lightheadedness	__ Dry Mouth	__ Shingles
__ Numbness	__ Excess Flatulence/Gas	__ Strong Body Odor
__ Phobias:	__ Fissures	__ Sweating - Excessive
_____	__ Foods "Repeat" (Reflux)	__ Sweating - None
__ Panic Attacks	__ Gas	__ Vitiligo
__ Paranoia	__ Heartburn	
__ Seizures	__ Hemorrhoids	ITCHING SKIN
__ Suicidal Thoughts	__ Indigestion	__ Skin in General
__ Tremor/Trembling	__ Nausea	__ Anus
	__ Vomiting	__ Arms
EATING		__ Ear Canals
__ Binge Eating	Intolerance to:	__ Eyes
__ Bulimia	__ Lactose	__ Feet
__ Can't Gain Weight	__ All Dairy Products	__ Hands
__ Can't Lose Weight	__ Wheat	__ Legs
__ Can't Maintain Healthy Weight	__ Gluten (Wheat, Rye, Barley)	__ Nipples
__ Frequent Dieting	__ Corn	__ Nose
__ Poor Appetite	__ Eggs	__ Penis
__ Salt Cravings	__ Fatty Foods	__ Roof of Mouth
__ Carbohydrate Craving (breads, pastas)	__ Yeast	__ Scalp
__ Sweet Cravings (candy, cookies, cakes)	__ Liver Disease/Jaundice	__ Throat
__ Chocolate Cravings	__Lower Abdominal Pain	
__ Caffeine Dependency	__ Mucus in Stools	
	__ Periodontal Disease	
	__ Sore Tongue	
	__ Strong Stool Odor	
	__Undigested Food in Stools	

SKIN, DRYNESS OF	CARDIOVASCULAR	FEMALE REPRODUCTIVE
__ Eyes	__ Angina/chest pain	__ Breast Cysts

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__ Feet __ Hair __ Hands __ Mouth/Throat __ Scalp __ Skin In General LYMPH NODES __ Enlarged/neck __ Tender/neck __ Other Enlarged/Tender NAILS __ Bitten __ Brittle __ Fungus-Fingers __ Fungus-Toes __ Ridges __Soft Thickening of: __ Fingernails __ Toenails __ White Spots/Lines RESPIRATORY __ Bad Breath __ Cough-Dry __ Cough-Productive __ Hoarseness __ Sore Throat __ Hay Fever, seasonal __ Hay Fever, perennial (all year) __ Nasal Stuffiness __ Nose Bleeds __ Post Nasal Drip __ Sinus Fullness __ Sinus Infection __ Snoring __ Wheezing	__ Breathlessness __ Heart Murmur __ Irregular Pulse __ Palpitations __ Swollen Ankles/Feet __ Varicose Veins URINARY __ Bed Wetting __ Hesitancy (trouble getting started) __ Infection __ Kidney Disease __ Leaking/Incontinence __ Pain/Burning __ Prostate Infection __ Urgency MALE REPRODUCTIVE __ Discharge From Penis __ Ejaculation Problem __ Genital Pain __ Impotence __ Prostate or Urinary Infection __ Lumps In Testicles __ Poor Libido (Sex Drive)	__ Breast Lumps __ Breast Tenderness __ Ovarian Cyst __ Poor Libido (Sex Drive) __ Vaginal Discharge __ Vaginal Odor __ Vaginal Itch __ Vaginal Pain with Sex Premenstrual: __ Bloating __ Breast Tenderness __ Carbohydrate Cravings __ Chocolate Cravings __ Constipation __ Decreased Sleep __ Diarrhea __ Fatigue __ Increased Sleep __ Irritability Menstrual: __ Cramps __ Heavy Periods __ Irregular Periods __ No Periods __ Scanty Periods __ Spotting Between

READINESS ASSESSMENT

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Rate on a scale of 5 (very willing) to 1 (not willing): To improve your health, how willing are you to:

Significantly modify your diet..... ┼ 5 ┼ 4 ┼ 3 ┼ 2 ┼ 1
Take several nutritional supplements each day..... ┼ 5 ┼ 4 ┼ 3 ┼ 2 ┼ 1 Keep a record of everything you eat each day ..... ┼ 5 ┼ 4 ┼ 3 ┼ 2 ┼ 1 Modify your lifestyle (e.g., work demands, sleep habits) ..... ┼ 5 ┼ 4 ┼ 3 ┼ 2 ┼ 1 Practice a relaxation technique ..... ┼ 5 ┼ 4 ┼ 3 ┼ 2 ┼ 1 Engage in regular exercise ..... ┼ 5 ┼ 4 ┼ 3 ┼ 2 ┼ 1 Have periodic lab tests to assess your progress ..... ┼ 5 ┼ 4 ┼ 3 ┼ 2 ┼ 1 Comments
_____
_____
_____
_____
_____
_____

Rate on a scale of 5 (very confident) to 1 (not confident at all):
How confident are you of your ability to organize and follow through on the above health related Activities? ┼ 5 ┼ 4 ┼ 3 ┼ 2 ┼ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities

_____
_____
_____
_____
_____
_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? ┼ 5 ┼ 4 ┼ 3 ┼ 2 ┼ 1

Comments _____
_____
_____

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_____
_____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: □ MasterCard □ VISA □ Discover □ AMEX □ Other

_____

Cardholder Name (as shown on card):

_____

Full Card Number:

_____

Expiration Date (mm/yy): _____Security Code: _____

FULL Card billing address with zip:

_____
_____

I, _____, authorize Harvest Healthcare MT to charge

my credit card above for agreed upon services in the amount of _____.
This payment will/will not repeat each month on the 1st/15th of each month.

I understand that my information will be saved to file for future transactions on my account and that I may contact them at any time to cancel.

_____

Customer Signature

_____

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Date