



Health History (Adult)

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

- Musculo-Skeletal**
- Headaches
 - Joint stiffness/swelling
 - Spasms/cramps
 - Broken/fractured bones
 - Strains/sprains
 - Back, hip pain
 - Shoulder, neck, arm, hand pain
 - Leg, foot pain
 - Chest, ribs, abdominal pain
 - Problems walking
 - Jaw pain/TMJ
 - Tendinitis
 - Bursitis
 - Arthritis
 - Osteoporosis
 - Scoliosis
 - Bone or joint disease
 - Other: _____

- Circulatory and Respiratory**
- Dizziness
 - Shortness of breath
 - Fainting
 - Cold feet or hands
 - Cold sweats
 - Swollen ankles
 - Pressure sores
 - Varicose veins
 - Blood clots
 - Stroke
 - Heart condition
 - Allergies
 - Sinus problems
 - Asthma
 - High blood pressure
 - Low blood pressure
 - Lymphedema
 - Other: _____

- Skin**
- Rashes
 - Allergies
 - Athlete's Foot
 - Warts
 - Moles
 - Acne
 - Cosmetic surgery
 - Other: _____

- Digestive**
- Nervous stomach
 - Indigestion
 - Constipation
 - Intestinal gas/bloating
 - Diarrhea
 - Diverticulitis
 - Irritable bowel syndrome
 - Crohn's Disease
 - Colitis
 - Adaptive aids
 - Other: _____

- Nervous System**
- Numbness/tingling
 - Twitching of face
 - Fatigue
 - Chronic pain
 - Sleep disorders
 - Ulcers
 - Paralysis
 - Herpes/shingles
 - Cerebral Palsy
 - Epilepsy
 - Chronic Fatigue Syndrome
 - Multiple Sclerosis
 - Muscular Dystrophy
 - Parkinson's disease
 - Spinal cord injury
 - Other: _____

- Reproductive System**
- Pregnancy:
 - Current
 - Previous
 - PMS
 - Menopause
 - Pelvic Inflammatory Disease
 - Endometriosis
 - Hysterectomy
 - Fertility concerns
 - Prostate problems

- Other**
- Loss of appetite
 - Forgetfulness
 - Confusion
 - Depression
 - Difficulty concentrating
 - Drug use _____
 - Alcohol use _____
 - Nicotine use _____
 - Caffeine use _____
 - Hearing impaired
 - Visually impaired
 - Burning upon urination
 - Bladder infection
 - Eating disorder
 - Diabetes
 - Fibromyalgia
 - Cancer
 - Infectious disease (please list) _____
 - Other congenital or acquired disabilities (please list) _____
 - Surgeries _____
 - Other: _____

For clients who need mobility assistance, please give your height: _____ weight: _____

Please list any additional comments regarding your health and well-being: _____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: _____ Date: _____



Client Consent for the Purposes of Lifestyle Coaching, Payment, and Health Care Operations

Naturopathy is a philosophy of healthful living as well as a system of health care founded on trust in the natural order of life, in the self-healing ability of the body and the belief that disease results from living at odds with natural laws.

Naturopathic techniques involve use of naturally occurring substances such as herbs, food and nutritional supplements; detoxification; purification; light; air; color; water; movement and breathing practices; rest; and mental and spiritual techniques which address deep-seated causes of distress.

Naturopaths provide lifestyle choices which support the body's efforts to reach a state of disease resistance or illness prevention. Scientific findings, clinical results, theory and ongoing education of both client and practitioner are included. In illness, natural methods are employed before and alongside combative, symptom-directed treatment modalities such as surgery and pharmaceuticals.

Naturopathy encompasses a view of life, a purpose in human health and suffering and a model of living a full life which presents the potential for renaissance in the art and science of living.

I _____ give consent to Blue Rose Holistics, LLC for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing lifestyle coaching to me, receiving payment for services rendered to me and for general administrative operations of the practice.

I understand that I have the right to request restrictions on the use and disclosure of my PHI, but the practice is not required to agree to these restrictions. If the practice agrees with my restrictions, the restriction is binding on the practice.

You may contact me for appointment reminders, schedule changes, or other needs by the following methods (fill in only those methods by which you desire to be contacted):

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____ e-mail: _____

Home Address: _____ Work Address _____

City _____ City _____

State/Province _____ Postal code: _____ State/Province _____ Postal code: _____

Country _____ Country _____

Marketing: Occasionally we send out newsletters, announcements and special occasion cards. If you do not wish to receive these, please check here:



I have received a copy of the Privacy Policies Notice. I have read the Notice and understand this authorization form. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain lifestyle coaching, nor will it affect my eligibility for benefits. I also understand that I may revoke this authorization at any time by notifying the lifestyle coach in writing.

Signature Date

Print Name (Client or Personal Representative)_____

Relationship to Client and Description of Representative's Authority _____



Privacy Policies Notice

We are dedicated to providing top-quality service. Protecting your privacy is paramount and we have implemented procedures to safeguard the information included in your files. We have installed a firewall on our computer; computerized files can only be accessed with a password; and all paperwork is kept in a locked filing cabinet.

This notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please Review it Carefully.

Your Personal and Protected Health Information

We may gather personal and health information from you, other health care providers and third party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:

- * We may provide PHI about you to health care providers, other practice personnel, or third parties who are involved in the provision, management or coordination of your treatment care.
- * We may disclose your PHI to any third party you designate in writing.
- * We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
- * We may disclose your PHI if we ever sell or transfer our practice.
- * We may disclose your PHI if we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public.
- * We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or required by law.
- * We may disclose your PHI to a health oversight agency for activities authorized by law.
- * We may disclose your PHI as required by a court or administrative order, or under certain circumstances in response to a subpoena, discovery request or other legal process.
- * We may release your PHI as necessary to comply with laws relating to Workers' Compensation or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault.
- * We may disclose your PHI to a HIPAA certified Business Associate (a person or organization that performs a function or activity on behalf of the practice that involves the use or disclosure of PHI, such as a billing services company or another practitioner who is involved in your health care).
- * Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities.
- * We may use or disclose your PHI when required by law.
- * We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls, recall postcards, greeting cards, information about alternative therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.



Please note your rights regarding this information:

1. You are entitled to inspect and receive copies of your records.
2. You are entitled make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have the right to disagree with the practitioner's refusal of inclusion.
5. You have a right to receive all notices in writing.
6. You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.
7. You may complain to us or the Secretary for Health and Human Services if you feel that we have violated your privacy rights. There will be no retaliation for filing a complaint. Written comments should be addressed to our Privacy Officer at our office address or the Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.

Original Effective Date: September 1, 2008

This notice remains in effect until it is replaced or amended by changes in the law.