Pathway to Wellness LLC
315 Mount Zion Dr
Ripon, WI 54971

Date : _____

PATIENT INFORMATION:

Sex : Male Female

Height : _____ Weight : _____

First Name : _____ DOB : _____

Middle Name _____ Last Name _____

Address : _____ City : _____ State: _____ Zip : _____

Marital Status : _____ Spouse Name : _____ Number of Children : _____

Home Phone: _____ Cell Phone : _____

Email : _____

Emergency Contact Name & Number: _____

** Please include any labs with in last year**

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Complete the form below

What is the reason for your visit? List 3-5 your health goals

Please list top concerns/symptoms that keep you from feeling as well as you'd like:

List any diagnoses below:

Have you ever been hospitalized? If yes, when & why?

Are you currently taking any prescriptions, medications, or supplements? (if yes, please list them all below:

Please list any known allergies to foods, medications, and environment below:

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Complete the form below

Diet Questions:

How much water do you typically drink in a day?

In your opinion what are the least 3 healthiest things you eat on a weekly basis? (list below)

In your opinion what are the 3 healthiest things you eat on a weekly basis? (list below)

How often do you eat out weekly (list a percent below) ex: 50%

Please briefly describe typical eating habits below: (please mention if you are currently following any diets).

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Complete the form below

General Questions:
Please circle Y (for yes), or N (for no), with a brief description for "yes" answers, if it makes sense too:

Y	N	**Do you have Fatigue more than average for your activity level?**
Y	N	**Do you have anxiety?**
Y	N	**Are you sensitive to the heat or cold?**
Y	N	**Do you commonly have cold hands and or feet?**
Y	N	**Do you feel pain in any part of your body commonly?**
Y	N	**Do you have skin or hair changes including rashes?**
Y	N	**Do you have difficulty with memory?**
Y	N	**Have you experienced fainting, dizziness or difficulty at rest or with exertion?**
Y	N	**Do you have numbness or unusual sensations in your body?**
Y	N	**Do you have a history of pneumonia, emphysema, or other lung problems?**
Y	N	**Do you have history of antibiotic use?**
Y	N	**Do you have chest pain at rest or with activity?**
Y	N	**Do you have swelling in your ankles, feet, or other parts of your body?**
Y	N	**Do you have palpitations, heart racing, and or skipping beats?**
Y	N	**Do you have gas, bloating, diarrhea, constipation, or abdominal pain ?**
Y	N	**Do you have pain or stiffness in your muscles, bones, and or joints?**

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Complete the form below

General Questions:
Please circle Y (for yes), or N (for no), with a brief description for "yes" answers, if it makes sense too:

Y	N	**Feel tired after eating? (if yes, do you ever notice this happening after eating certain foods?)**
Y	N	**Do you have hemorrhoids?**
Y	N	**Do you have frequent urination?**
Y	N	**Do you have apin or burning during urination?**
Y	N	**Do you have a history of UTIs (Urinary Tract Infections)?**
Y	N	**Have you experienced a change in libido (increase/decrease sexual desire?)**
Y	N	**WOMEN: Do you have any menstrual or reproductive difficulties?**
Y	N	**Do you or did you smoke? (if yes please write below how much & for how long)**
Y	N	**Currently drink alcohol? If yes, please write below how much weekly:**
Y	N	**Do drugs, recreationally or otherwise?**
Y	N	**Difficulty falling alseep?**
Y	N	**Silver fillings (amalgams)?**
Y	N	**Have you ever had root canals? (if yes, write below how many & when)**

Is there anything else you'd like us to know?

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Complete the form below

Women Specific:

Check the box if yes and provide a number.

☐ **Pregnancies** ____ ☐ Miscarriage ____ ☐ Living Children ____ ☐ **Abortion** ____ ☐ **Cesarean** ____

☐ **Vaginal Delivery** ____ ☐ Postpartum Depression ____ ☐ Toxemia ____ ☐ **Baby Over 8 Pounds** ____

☐ **Gestational Diabetes** ____

Menstrual History

Age At 1st Period ____ **Menses Frequency** _____ **Length** _____

Painful? ◯ Yes ◯ No **Clotting?** ◯ Yes ◯ No **Have you ever missed your period?** ◯ Yes ◯ No

For How Long? _____ **Are you menopausal?** ◯ Yes ◯ No **Age At Menopause** _____

Last Menstrual Period _____

Do you take any hormone contraception? ☐ Birth Control Pill ☐ Patch ☐ Nuva Ring

Hormonal issues:

IDENTIFICATION OF PERSONS WITH AUTHORIZATION OF ACCESS TO PATIENT HEALTH INFORMATION

Those individuals or parties that could have access to Patient Health Information include but may not be limited to the staff and contractors of Pathway to Wellness LLC; Nutrition. Please provide the necessary health care providers or persons who may need to be consulted if related to the client's condition. They include:

1. _____
2. _____
3. _____
4. _____

Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease." A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or other Natural Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, or Herb may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body. I have read and understand the above information:

_____ _____

Signature of Client/Guardian of Client if a Child **Date**

GUIDE AND CASH PRACTICE AGREEMENT

PATHWAY
TO WELLNESS LLC

Will there be a potential for lab work and if so, how are labs billed?
Lab work results are very important will typically assist the practitioner in determining the plan of care. If prior lab work has not been completed, we may recommend lab testing at your first appointment. This typically involves blood work or test kits.

Initial _____

Will I need supplements, and if so, how long will I have to be on these supplements?
Most patients with nutritional health concerns will have supplements recommended. Each supplement is chosen for the results of nay lab testing. We will discuss into further detail about supplements for you at your second appointment.
The intent is always for the patient to eventually lessen the number and/or dosage of supplements, but the timeline for this is different for each patient and is based upon the improvement of the patient's condition over time. Often improvements are seen by 3-6 months and again at 9-12 months, however, results may take longer if patient fails to implement the dietary recommendations. Due to quality control, all supplements are non-refundable.

Initial _____

What happens after initial appointment?
After we receive your test results, we will contact you to set up your next appointment. At this appointment the practitioner will go over your test results, your plan of care, and give you can estimate for length of care. Charge of $275 ROF(report of findings)

Initial _____

Appointment Cancellation Policy Agreement
Pathway to Wellness is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. Please call us ..... Two days prior to you rescheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday. If prior notification is not given, you will be charged $100 for the missed appointment.

Initial _____

Cash Practice Agreement
Pathway to Wellness is a 100% cash-based practice. We do not accept any insurances for various reasons. Types of payment we accept include cash, check, credit card, and HSA (health savings account). *You have read the prices of all services as well

Initial _____

_____ _____

Signature of Client/Guardian of Client if a Child **Date**

HIPPA & NOTICE OF PRIVACY PRACTICE

PATHWAY
TO WELLNESS LLC

PATIENT DETAILS

First Name* **Middle Name** **Last Name ***

Date of Birth *

Gender ◯**Male** ◯**Female** **Marital Status** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

WE CONSIDER THE PRIVACY OF YOUR HEALTH INFORMATION OF PARAMOUNT IMPORTANCE.

OUR LEGAL DUTY

As a recipient of health care services, you have certain rights. To learn more about these rights, we suggest you visit: https://www.hhs.gov/hipaa/for-individuals/index.html. We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We will follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will make commercially reasonable efforts to change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

OUR USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you only as necessary for treatment, payment, and our healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

HIPPA & NOTICE OF PRIVACY PRACTICE

PATHWAY
TO WELLNESS LLC

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations including without limitation, quality assessment and improvement activities, reviewing the competence or qualifications of Health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us a written authorization, you may revoke it in writing at any time, although such revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or intentionally disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree in writing that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, concerning your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will (1) disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care and (2) use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing third parties to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

***By signing below, I acknowledge that I have read and understand this practices Notice of Privacy Practices**

Patient Signature: _____x Date: ___/___/_____