DEB BOSSIO, ND
100B Danbury Rd, Suite 102, Ridgefield, CT 06877
203-431-4443, fax: 203-431-6664
office@drdebbossio.com

CONFIDENTIAL PATIENT INFORMATION

Name _____ Nickname _____ Today's Date _____

Date of Birth _____ Age _____ Sex M/F Single ___ Married ___Other_____

Home Address _____ Email_____

City _____ State _____ Zip Code _____ Main Phone _____ Cell Phone _____

Occupation _____ Employer _____ Work Phone _____

Work Address _____

Name of Parent/spouse/partner_____ Occupation _____ Phone _____

Type of Insurance _____ Policy Number _____ Group # _____

Emergency Contact Person _____ Relationship to patient _____Phone _____

Primary Physician _____ Phone _____

Previous naturopathic physician _____ When _____ Name of ND _____

How did you hear about us _____

HEALTH HISTORY QUESTIONNAIRE

Reason for Today's Visit _____

What are your most important health problems? List as many as you can in order of importance.

1)
2)
3)
4)

How does your condition affect you _____

What do you think is happening _____

What do you feel needs to happen for you to get better _____

How much change are you willing to make to improve your health? Minimal Some Complete

What are your goals for today's visit, long-term health goals, and expectations of me as your Naturopathic Doctor?

_____

_____

_____

PLEASE LIST ANY PRESCRIPTION AND OVER THE COUNTER MEDICATIONS, SUPPLEMENTS, AND VITAMINS

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8_____ 9. _____

PLEASE LIST ANY ALLERGIES TO THE FOLLOWING AND DESCRIBE REACTION:

Medications _____
Foods_____
Environmental _____

PLEASE LIST PRIOR HOSPITALIZATIONS, MAJOR ILLNESSES, OR SURGERIES WITH APPROXIMATE DATES:

_____
_____

MEDICAL DIAGNOSTIC EXAMS/LABS/SCREENINGS: PLEASE LIST APPROXIMATE DATES/RESULTS BELOW

PAP Smear:	Mammogram:	Bone Density Scan:
EKG / Stress Test:	Colonoscopy:	Urinalysis:
Blood Work:	X-ray/CT scan:	Ultrasound:

FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Spouse	Child
Age (or age at death)	_____	_____	_____	_____	_____	_____
Health (good, poor, deceased)	_____	_____	_____	_____	_____	_____
Check (√) those applicable						
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Cancer (type)	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Anxiety/Depression	_____	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____	_____
Asthma/Allergies	_____	_____	_____	_____	_____	_____
Anemia/Bleeding Tendency	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____	_____	_____

MARITAL HISTORY

Single _____ Married (how long?) _____ Widowed (when?) _____ Divorced (when?) _____ Other _____

Are you in a supportive relationship?

Children, if any: Names: _____Ages: _____

LIFESTYLE EXPERIENCE

Diet

Do you follow a special diet? _____ If yes, please describe: _____

How many times a week do you eat out? _____

How many meals do you eat a day? _____

How many glasses of water do you drink a day? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Habits

Do you exercise? Y/N If yes, what kind? _____How often? _____

Main Interests and hobbies: _____

What do you enjoy most in life? _____

Do you enjoy your job (describe)? _____ Hours of work/week ____

Alcohol? (please describe) _____

Nicotine? (please describe) _____

Coffee? (please describe) _____

Recreational Drugs? _____ Ever been treated for alcohol or drug dependence? Y N

Have a history of abuse? Y N Any major traumas? Y N

Sleep

What is your average # of hours of sleep per night? _____ Do you wake up feeling rested? Y N

Do you have trouble falling asleep? Y N Do you awaken frequently at night? Y N

Stress

Please list any chemicals, fumes, dust, pesticides, or other toxins to which you are exposed:

Please describe your main stressors in life and how you cope with them:

Are you frustrated by your present situation: Personal? _____ Relationship? _____ Family?_____Work?_____

SYMPTOMS CHECKLIST: FOR THE FOLLOWING, PLEASE CIRCLE

Y = a condition you have now **P** = had in the past **N** = never had

Mental/Emotional

Depression?	Y P N	Mood swings	Y P N
Anxiety?	Y P N	Considered/Attempted Suicide	Y P N
Seasonal Depression	Y P N	Poor concentration	Y P N

Endocrine

Hypothyroid	Y P N	Heat or cold intolerance	Y P N
Hypoglycemia	Y P N	Fatigue	Y P N
Diabetes	Y P N	Dry/brittle nails	Y P N

Weight

Significant weight gain/loss	Y P N	Emotional/stress eating	Y P N
Current Weight _____lbs		Max Weight _____ lbs	when _____
Ideal/goal weight _____lbs			

Immune

Frequent Infections	Y P N	Chronic Infections	Y P N
Cancer	Y P N	Slow wound healing	Y P N
Lyme Disease	Y P N		

Neurological

Seizures	Y P N	Memory Problems	Y P N
Muscle Weakness	Y P N	Numbness or tingling	Y P N
Vertigo or dizziness	Y P N	Paralysis	Y P N

Skin

Rashes	Y P N	Eczema	Y P N
Acne	Y P N	Hair loss	Y P N
Lumps	Y P N	Itching	Y P N
Dry skin	Y P N		

Head

Headaches	Y P N	Head injury	Y P N
Migraines	Y P N	TMJ problems/jaw clicks	Y P N

Eyes

Blurriness	Y P N	Eye pain/strain	Y P N
Tearing or dryness	Y P N	Glaucoma	Y P N
Double vision/spots in eyes	Y P N	Glasses/Contacts	Y P N

Ears

Impaired hearing	Y P N	Ringing	Y P N
Earaches	Y P N	Excessive ear wax	Y P N

Nose and Sinuses

Congestion/stuffiness	Y P N	Sinus problems	Y P N
Nose bleeds	Y P N	Hayfever/allergies	Y P N

Mouth and Throat

Frequent sore throat	Y P N	Hoarseness	Y P N
Gum problems	Y P N	Bad breath	Y P N

Neck

Lumps	Y P N	Swollen glands	Y P N
Goiter/enlarged thyroid	Y P N	Pain or stiffness	Y P N

Respiratory

Cough	Y P N	Sputum	Y P N
Spitting up blood	Y P N	Wheezing	Y P N
Asthma	Y P N	Difficulty breathing	Y P N
Pain on breathing	Y P N	Shortness of Breath	Y P N
Pneumonia/Pleurisy	Y P N	Emphysema	Y P N
Bronchitis	Y P N	Tuberculosis	Y P N

Cardiovascular

Heart Disease	Y P N	Chest pain/Angina	Y P N
High/Low Blood Pressure	Y P N	Murmurs	Y P N
Palpitations/Flutterings	Y P N	High Cholesterol	Y P N
Swelling in Ankles	Y P N	Fainting	Y P N

Gastrointestinal

Heartburn/Reflux	Y P N	Abdominal pain or cramps	Y P N
Nausea/Vomiting	Y P N	Belching or passing gas	Y P N
Constipation	Y P N	Diarrhea	Y P N
Blood in stool or black stool	Y P N	Change in appetite/thirst	Y P N
Hemorrhoids	Y P N	Ulcer	Y P N
Gall Bladder Disease	Y P N	Liver Disease/Jaundice	Y P N
Bowel Movements: How often	_____	Slow digestion	Y P N
Food cravings (sweets/salt)	Y P N	Excessive hunger	

Urinary

Pain on urination	Y P N	Increased Frequency/urgency	Y P N
Frequent infections	Y P N	Incontinence	Y P N
Frequency at night	Y P N	Kidney Stones	Y P N

Musculoskeletal

Joint pain or stiffness	Y P N	Arthritis	Y P N
Muscle spasms/cramps	Y P N	Restless leg	Y P N
Back pain			

Blood/Vascular

Easy bleeding or bruising	Y P N	Anemia	Y P N
Cold hands/feet	Y P N	Varicose Veins	Y P N
Blood clots/Thrombophlebitis	Y P N	Deep leg pain	Y P N

Male Genital

Hernias	Y P N	Testicular masses or pain	Y P N
Prostate disease	Y P N	Discharge or sores	Y P N
Erectile dysfunction	Y P N	Decreased sex drive	Y P N
Are you sexually active	Y P N	Birth control _____ Type _____	

STDS (circle those that apply): Gonorrhea Chlamydia Syphilis Herpes HPV Condyloma(genital warts)

Female Reproduction

Age at first menses _____		Age at last menses _____	
Are cycles regular	Y N	Length of cycle _____days	
Duration of bleeding _____		Heavy or excessive flow	Y P N
Painful menses/cramps	Y P N	Bleeding between cycles	Y P N
PMS	Y P N	Vaginal discharge	Y P N
PMS symptoms _____		Vaginal pain/discomfort	Y P N
Pain with intercourse	Y P N	Decreased sex drive	Y P N
Number of pregnancies _____		Number of live births _____	
Number of miscarriages _____		Difficulty Conceiving	Y P N
Endometriosis	Y P N	Ovarian Cysts	Y P N
Cervical Dysplasia	Y P N	Abnormal PAP	Y P N
Menopausal symptoms	Y P N	Hot flashes/Night Sweats	Y P N
Self breast exams	Y N	Breast lumps	Y P N
Breast pain/tenderness	Y P N	Nipple discharge	Y P N
Are you sexually active	Y P N	Birth Control _____ Type _____	

SSTDS (circle those that apply): Gonorrhea Chlamydia Syphilis Herpes HPV Condyloma(genital warts)

Thank you for taking the time to complete this form. It will aid us in your journey towards optimal health.

Please write any additional information you would like me to know before your appointment.

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Informed Consent for Naturopathic Medical Care:

I, _____ (Patient / Parent or Guardian Name), acknowledge that _____ (Patient Name) is accepting treatment from Dr. Deb Bossio. I understand that there are intrinsic differences between the care of Naturopathic practitioners and medical doctors. I also understand that Dr. Deb Bossio holds a current license to practice medicine in the state of Connecticut (license # 000395). At this time it is my decision to pursue Naturopathic Medical Care for any condition I have. Also, I understand that, as with medical treatment, there is no guarantee that this form of care will offer complete resolution to any or all conditions that I may have.

Consent to Pay for Services Rendered:

I have been informed that it is my responsibility to pay in full for services rendered at the time of the patient visit. I recognize that Dr. Deb Bossio currently accepts payment via cash, personal check, and credit card. She does not accept payment from insurance providers. At the end of the visit, I will be provided with a comprehensive invoice of services rendered for payment and method of payment. I understand that if I elect to have Dr. Bossio review my medical case and to provide the requested service, I must pay for this service in full at the time of the visit.

Insurance: Many insurance companies will reimburse "out of network" for my services. The office will provide you a form containing all the information needed to submit to your insurance carrier after each visit. In this way, you may then apply for reimbursement for some or all of the charges you've already paid. If you have any questions about how this process works, my staff and I will be happy to assist you.

Payment Fee Schedule for 2017

All office visits and telephone appointments are charged on a **$250.00 per hour prorated basis.**

Cancellation and Rescheduling:

Cancelling or rescheduling a New Patient appointment requires notice by 9:00am two full business days prior.
Cancelling or rescheduling without proper notice will result in a late fee of $75.
Cancelling or rescheduling a follow-up appointment requires notice by 9:00am one full business day prior.
Cancelling or rescheduling a follow-up appointment without proper notice will result in a charge of $50.

I, _____ (Patient or Parent/Guardian Name), have read the above policies of the private practices of Dr. Bossio

Patient or Parent/Guardian Signature: _____Date: _____

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Email Consultation Policy:

It is the policy of Dr. Bossio to do email consultations under the following conditions only:

1. Only for established patients of Dr. Bossio.
2. For non-emergency issues.
3. In cases where the doctor determines that an office visit is not necessary or possible.
4. For clarification of on-going treatment or treatment received within the past 30 days.
5. When the doctor can address the concern with a single reply, requiring 5 minutes or less.
6. Complicated or lengthy emails requiring more than 5 minutes response time will incur a charge.

No new health issues will be addressed by email consultation.
If the doctor receives an email about a condition that in her opinion cannot be properly assessed without an office visit, the patient will be notified by return email to schedule an appointment, with time frame recommended. In this case, no treatment advice will be given by email. Dr. Bossio generally responds to emails within 24-48 hours, Monday through Friday only. **If you have emailed the doctor and have not received a response within these parameters, please call the office and leave a phone message** stating your question and/or concern.

Supplement Returns:

As with prescription medication purchased at a pharmacy, we do not accept supplement returns.

Newsletter:

Would you like to receive a copy of our monthly newsletter? Yes ☐ No ☐

I, _____ (Patient or Parent/Guardian Name), have read the above policies of the private practices of Dr. Bossio

Patient or Parent/Guardian Signature: _____Date: _____

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Credit Card Consent Form

Complete this form only if you would like us to keep a credit card on file for ease of payment on visit fees, supplement refills, lab fees, etc.

I, _____, give Deb Bossio, ND LLC, permission to charge my credit card (specified below) for services rendered, laboratory fees, supplement purchases, shipping and handling fees and/or other charges.

This agreement commences on _____.
(Date)

This agreement includes charges for services rendered to:

☐ Myself
☐ Other (as indicated below)

1.) _____

2.) _____

3.) _____

4.) _____

Account to be charged: ☐ Mastercard ☐ Visa ☐ Discover

Name on credit card: _____

Account #: _____ Exp. Date: _____

Validation Code: _____

Signature: _____Today's Date: _____

Verbal Consent: Spoke to _____ on _____
(Date/Time)

Staff's Signature: _____ Date: _____

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HIPAA DISCLOSURE

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like patient reviews.

I have been informed that I may review the practice's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree with the request. If the practice agrees to my requested restrictions, they must follow the restrictions.

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

If signed by Patient Representative, please state relationship to Patient.

A Patient/Personal Representative:

- Has complete access to medical records and can discuss your condition with Dr. Bossio
- Picks up supplements and test kits
- Schedule medical appointments on your behalf

If you would like to appoint a Patient/Personal Representative, please indicate access and then sign and date form. If not, please sign and date this form.

Patient/Personal Representative(s):

Name:	Complete Access	☐
Relationship:	Supplements/Kits	☐
Phone:	Scheduling	☐

Name:	Complete Access	☐
Relationship:	Supplements/Kits	☐
Phone:	Scheduling	☐

Signature: _____ **Date**: _____