CONTACT FORM

Today's Date: _____

Name: _____ Date of Birth: _____

Home Address: Mailing Address *(if different):*

Home Phone: Cell Phone:

Occupation:

☐Single ☐ Married/Partnership ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Emergency Contact

Name**:** Phone:

Relationship to patient: ☐Parent ☐Legal Guardian ☐Spouse ☐Family Member ☐Other:

How did you hear about us?

Add me to your e-mail list: ☐ Yes ☐ No Email:

If under 18 years old, parental consent required: I *(please print)* _____give Arizona Wellness Foundation permission to treat my child.

Parent/Guardian Signature: _____

Responsibility Agreement, Statement of Financial Policy and Fragrance Policy

By signing below, you acknowledge, understand and agree to the following:

1. I am responsible for payment for all services rendered- payment is due in full at the time of service.
2. Arizona Wellness Group, INC is out of network with all insurance companies and does not file insurance claims. Arizona Wellness Group, INC will provide a receipt for me to submit to my insurance company.
3. I understand that unless 24 hours advanced notice is given, a canceled, rescheduled or no-show appointment will result in a $50 charge to my account and that I will be asked for a deposit to be made for my next visit at the time of scheduling.
4. Arizona Wellness Group, INC treats allergies and environmental illnesses; we ask that all those who come to the office respectfully refrain from wearing perfumes, colognes, fragrance lotions, sprays or other scented products. Sensitive patients may experience adverse reactions such as respiratory distress, fainting or balance problems. If this occurs, I understand that I may be asked to reschedule.

I have read and understand/agree to the information on this form.

Patient Name: *(please print)*	**Date:**	**Patient/Guardian Signature:**

Patient Questionnaire

What is the main reason for your appointment?

Have there been any major changes in your life within the past year? ☐ Yes ☐ No

Do you currently see a medical doctor? ☐ Yes ☐ No
If you are currently under the care of another medical professional, Dr. Andria Orlowski is happy to work with both you and your physician(s) to create a treatment plan to serve you effectively and efficiently.

Lifestyle

Alcohol:	☐ N/A Type: _____	Amount: _____	☐day ☐week ☐month
Caffeine:	☐ N/A Type: _____	Amount: _____	☐day ☐week ☐month
Exercise:	☐ N/A Type: _____	Amount: _____	☐day ☐week ☐month
Tobacco:	☐ N/A Type: _____	Amount: _____	☐day ☐week ☐month

Diet:

Family History

☐ Asthma/Allergies	☐ Heart Attack	☐ Kidney Disease	☐ Pacemaker
☐ Auto-Immune Disease	☐ Heart Disease	☐ Lung Condition	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Mental Illness	☐ Tuberculosis
☐ Diabetes	☐ High Cholesterol	☐ Osteoporosis	☐ Family History Unknown
☐ Epilepsy	☐ HIV/AIDS	☐ Other:	

Patient Medical History

Please list all sensitivities/allergies/reactions to:

Drugs:

Foods:

Environment:

Please list all current prescription medications and nutrient supplements/herbs:

Please list any past accidents, hospitalizations, or surgeries:

Please indicate if you have ever experienced any of the following:

☐ Anemia	☐ Heart Attack	☐ Kidney Disease	☐ Stroke
☐ Auto-Immune Disease	☐ Heart Disease	☐ Lung Disease	☐ Thyroid Disease
☐ Cancer	☐ Hepatitis	☐ Neuromuscular Disease	☐ Tuberculosis
☐ Diabetes	☐ High Cholesterol	☐ Osteoporosis	Other:
☐ Epilepsy	☐ HIV/AIDS	☐ Pacemaker	

Review of System: Please check **Y** if you regularly experience it or **P** if you have in the past but no longer are. If you have never experienced it, leave it blank.

General

☐ Y ☐ P Always feel cold	☐ Y ☐ P Cold hands/feet	☐ Y ☐ P Fever/Chills
☐ Y ☐ P Always feel hot	☐ Y ☐ P Fatigue	Other:

Head & Neck

☐ Y ☐ P Dandruff	☐ Y ☐ P Hair Loss	☐ Y ☐ P Oily Hair
☐ Y ☐ P Dizziness	☐ Y ☐ P Headache	☐ Y ☐ P Stiffness
☐ Y ☐ P Dry Hair	☐ Y ☐ P Head Injury	☐ Y ☐ P Swollen Glands
☐ Y ☐ P Fainting	☐ Y ☐ P Migraine	Other:

Skin

☐ Y ☐ P Acne	☐ Y ☐ P Excessive Sweating	☐ Y ☐ P Night Sweats
☐ Y ☐ P Bruising	☐ Y ☐ P Itchiness	☐ Y ☐ P Psoriasis
☐ Y ☐ P Brittle/Weak Nails	☐ Y ☐ P Hives	☐ Y ☐ P Rash
☐ Y ☐ P Color change	☐ Y ☐ P Keloid	☐ Y ☐ P Warts
☐ Y ☐ P Dryness	☐ Y ☐ P Lump	Other:
☐ Y ☐ P Eczema	☐ Y ☐ P Mole	

Eyes & Ears

☐ Y ☐ P Blurry vision	☐ Y ☐ P Double vision	☐ Y ☐ P Itchiness
☐ Y ☐ P Burning eyes	☐ Y ☐ P Dry eyes	☐ Y ☐ P Poor night vision
☐ Y ☐ P Cataracts	☐ Y ☐ P Earache	☐ Y ☐ P Ringing in the ears
☐ Y ☐ P Chronic ear infection	☐ Y ☐ P Eye pain	☐ Y ☐ P Sties
☐ Y ☐ P Darkness under eyelids	☐ Y ☐ P Eye strain	☐ Y ☐ P Vertigo
☐ Y ☐ P Decreased hearing	☐ Y ☐ P Floaters/Spots	☐ Y ☐ P Visual changes
☐ Y ☐ P Discharge of the eyes	☐ Y ☐ P Glaucoma	Other:

Respiratory/Nose

☐ Y ☐ P Allergies/Hay fever	☐ Y ☐ P Chronic cough	☐ Y ☐ P Coughing up blood
☐ Y ☐ P Asthma	☐ Y ☐ P Chronic sinus infection	☐ Y ☐ P Cough with phlegm
☐ Y ☐ P Bronchitis	☐ Y ☐ P Congestion	☐ Y ☐ P Difficulty breathing
☐ Y ☐ P Frequent colds	☐ Y ☐ P Pneumonia	☐ Y ☐ P Shortness of breath
☐ Y ☐ P Nosebleeds	☐ Y ☐ P Polyps	☐ Y ☐ P Wheezing
☐ Y ☐ P Painful breathing	☐ Y ☐ P Postnasal drip	Other:

Genital/Urinary

☐ Y ☐ P Bed wetting	☐ Y ☐ P Genital lesions	☐ Y ☐ P Nighttime urination
☐ Y ☐ P Blood in urine	☐ Y ☐ P Genital pain	☐ Y ☐ P Pain with urination
☐ Y ☐ P Decreased libido	☐ Y ☐ P Hernia	☐ Y ☐ P Prostate disease
☐ Y ☐ P Frequent infections	☐ Y ☐ P Impotency	☐ Y ☐ P STD/STI
☐ Y ☐ P Frequent urination	☐ Y ☐ P Incontinence	☐ Y ☐ P Testicular swelling
☐ Y ☐ P Genital discharge	☐ Y ☐ P Increased libido	☐ Y ☐ P Urgency
☐ Y ☐ P Genital itching	☐ Y ☐ P Kidney stone	Other:

Cardiovascular

☐ Y ☐ P Chest pain/tightness	☐ Y ☐ P Irregular heartbeat	☐ Y ☐ P Rheumatic fever
☐ Y ☐ P Edema	☐ Y ☐ P Murmurs	☐ Y ☐ P Swollen feet/ankles
☐ Y ☐ P Heart palpitations	☐ Y ☐ P Poor circulation	☐ Y ☐ P Varicose veins
☐ Y ☐ P High blood pressure	☐ Y ☐ P Low blood pressure	Other:

Mouth & Throat

☐ Y ☐ P Bitter taste in mouth	☐ Y ☐ P Dentures	☐ Y ☐ P Loss of taste
☐ Y ☐ P Bleeding gums	☐ Y ☐ P Difficulty swallowing	☐ Y ☐ P Lump in throat
☐ Y ☐ P Canker sores	☐ Y ☐ P Dry mouth	☐ Y ☐ P Recurrent sore throat
☐ Y ☐ P Cavities	☐ Y ☐ P Gum disease	☐ Y ☐ P Ulcers
☐ Y ☐ P Cold sores	☐ Y ☐ P Hoarseness	Other:

Muscles & Joints

☐ Y ☐ P Arthritis	☐ Y ☐ P Heaviness of body/limb	☐ Y ☐ P Leg cramps
☐ Y ☐ P Body aches/stiffness	☐ Y ☐ P Joint discoloration	☐ Y ☐ P Numbness/tingling
☐ Y ☐ P Generalized pain	☐ Y ☐ P Joint pain	☐ Y ☐ P Tremors
☐ Y ☐ P Generalized weakness	☐ Y ☐ P Joint swelling	Other:

Gastrointestinal

☐ Y ☐ P Abdominal pain	☐ Y ☐ P Diarrhea	☐ Y ☐ P Loose/soft stool
☐ Y ☐ P Acid reflux/heartburn	☐ Y ☐ P Gall bladder disease	☐ Y ☐ P Mucus in stool
☐ Y ☐ P Bad breath	☐ Y ☐ P Hemorrhoids	☐ Y ☐ P Nausea
☐ Y ☐ P Black stool	☐ Y ☐ P Hiccups	☐ Y ☐ P Pancreatitis
☐ Y ☐ P Bloating	☐ Y ☐ P Indigestion/gas	☐ Y ☐ P Vomiting
☐ Y ☐ P Blood in stool	☐ Y ☐ P Intestinal pain	☐ Y ☐ P Ulcer
☐ Y ☐ P Constipation	☐ Y ☐ P Liver disease	Other:

Appetite/Thirst

☐ Y ☐ P Change in appetite	☐ Y ☐ P Hunger w/no desire to eat	☐ Y ☐ P Thirst w/no desire to drink
☐ Y ☐ P Exceedingly hungry	☐ Y ☐ P No thirst	Other:
☐ Y ☐ P Excessive thirst	☐ Y ☐ P Poor appetite	

Sleep

# of hours sleep: _____	☐ Y ☐ P Sleep apnea	☐ Y ☐ P Vivid dreams
☐ Y ☐ P Difficulty waking	☐ Y ☐ P Sleepwalk	☐ Y ☐ P Wake easily
☐ Y ☐ P Grind teeth	☐ Y ☐ P Snore	☐ Y ☐ P Wake refreshed/rested
☐ Y ☐ P Nap during the day	☐ Y ☐ P Trouble falling asleep	Other:
☐ Y ☐ P Nightmares	☐ Y ☐ P Trouble staying asleep	

Mental/Emotional

☐ Y ☐ P Angry/irritability	☐ Y ☐ P Forgetful/poor memory	☐ Y ☐ P Relaxed/calm
☐ Y ☐ P Anxiety	☐ Y ☐ P High-strung/tense	☐ Y ☐ P Stressed
☐ Y ☐ P Depression	☐ Y ☐ P Impatient	☐ Y ☐ P Suicidal
☐ Y ☐ P Fearful/panic	☐ Y ☐ P Manic	Other:

Menstrual and Reproductive History

Menses

Age of first period:

Date last period began:

Regular Periods ☐ Yes ☐ No ☐ Sometimes — Periods every _____ days *(length of entire cycle)*

Flow: ☐ Heavy ☐ Medium ☐ Light — Duration of flow: _____ days

Spotting: ☐Yes ☐ No — Midcycle? ☐Yes ☐ No — Instead of period? ☐Yes ☐ No

Bloating: ☐Yes ☐ No — Weight Gain? ☐Yes ☐ No — If yes, how much? _____ lbs

Cramps: ☐Yes ☐ No — Duration: _____ days — Intensity: ☐Mild ☐Moderate ☐Severe

PMS: ☐Yes ☐ No — Describe:

Number of days you feel PMS symptoms:

Pelvic

Date of last pelvic exam: _____ Performed by: _____

Date of last PAP smear: _____ Results: _____

Previous abnormal PAP? ☐Yes ☐ No Date: _____

Recurring vaginal yeast infections? ☐Yes ☐ No Onset: _____

Did your mother take the drug DES during her pregnancy? ☐Yes ☐ No

Breast

Breast Pain: ☐Yes ☐ No

Breast Lumps: ☐Yes ☐ No

Breast Discharge: ☐Yes ☐ No

Date of last mammogram: _____ Results: _____

Do you examine your own breasts each month? ☐Yes ☐ No If not, how often?

Hormones

Menopausal: ☐Yes ☐ No Perimenopausal? *(just beginning symptoms)* ☐Yes ☐ No

Hot Flashes: ☐Yes ☐ No Onset: _____

Frequency: _____time(s) per day/week for _____ minutes. Intensity: ☐ Mild ☐ Moderate ☐ Severe

Painful Intercourse: ☐Yes ☐ No

Vaginal Dryness: ☐Yes ☐ No

Is there anything about your sexual experience you are unhappy with?

Pregnancy

Currently Pregnant: ☐Yes ☐ No Planning to become pregnant? ☐ Yes ☐ No When? _____

Prior Pregnancies: # _____ Prior Births: # _____ C-sections: # _____

Miscarriages: # _____ Abortions: # _____

Complications: ☐Yes ☐ No Describe: _____

Sexually Active: ☐Yes ☐ No Type of birth control you use now: _____