Wholistic Medicine Specialists of Atlanta

Bradley Bongiovanni, ND

3502 Old Milton Pkwy
Alpharetta, GA 30005
678-456-5022
888-338-3634 (fax)
info@wmsoa.com

Name _____ DOB _____

Address _____

_____

Phone _____

Work Phone _____

Email _____

Employer _____

Occupation _____

Whom may we thank for referring you? _____

Reason for visit _____

How long have you had this concern/condition? _____

I think my health problems are caused by _____

I have seen these other practitioners for my health: _____

Review of Systems (check all apply)

	Have Now	Had in Past		Have Now	Had in Past
Anxiety _____	☐	_____ ☐	Cancer _____	☐	_____ ☐
Depression _____	☐	_____ ☐	Diabetes _____	☐	_____ ☐
Fatigue _____	☐	_____ ☐	Osteoporosis __	☐	_____ ☐
Auto-Immune Disease __	☐	_____ ☐	Headaches ____	☐	_____ ☐
Digestive problems ____	☐	_____ ☐	Arthritis _____	☐	_____ ☐
Thyroid disease _____	☐	_____ ☐	PMS _____	☐	_____ ☐
Infertility _____	☐	_____ ☐	Irregular cycles _	☐	_____ ☐
Heart disease _____	☐	_____ ☐	High Blood Press	☐	_____ ☐
Skin problems _____	☐	_____ ☐	Chronic Infection	☐	_____ ☐
Asthma _____	☐	_____ ☐	Stress _____	☐	_____ ☐
Insomnia _____	☐	_____ ☐	Other _____	☐	_____ ☐

I am allergic to _____

Previous surgeries (with dates) _____

Recent medical tests (type/dates) _____

Other medical conditions I should know about _____

_____

I take the following medications/supplements:

☐ Antibiotics	☐ Heart medicine	☐ Minerals	☐ Vitamins
☐ Anti-depressants	☐ Herbs	☐ Pain relievers	☐ Other _____
☐ Blood thinners	☐ Insulin	☐ Sedatives	☐ Other _____
☐ Chemotherapy	☐ Laxatives	☐ Sleeping pills	☐ Other _____

The following are part of my life (to the degree indicated):

	None	Small	Medium	Large		None	Small	Medium	Large
Alcohol	☐	☐	☐	☐	Sugar	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐	Exercise	☐	☐	☐	☐
Nicotine	☐	☐	☐	☐	Fun	☐	☐	☐	☐
Stress	☐	☐	☐	☐	Meditation	☐	☐	☐	☐

Are you familiar with Naturopathic Medicine?

Very Much ☐ A Moderate Amount ☐ Some ☐ Little ☐ None ☐

Is it okay to leave messages regarding your care on your answering machine? _____

Further information you wish to provide: _____

_____

_____

_____

What are your goals/expectations for the appointment(s)? _____

_____

_____

_____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks through the day: _____

Sweets: _____

Dairy products: _____

Alcohol: _____

Exercise

Do you exercise? _____ How often? _____ What kind/type? _____

Lifestyle/Habits

Do you smoke? _____
Do you use recreational drugs? _____
Do you enjoy your work? _____
Do you have a religious or spiritual practice? _____

About You

Why did you decide to pursue naturopathic healthcare with Dr. Bongiovanni? _____

_____

Do you think the signs and symptoms that you are experiencing could be purposeful in anyway? How so?

_____

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms which relate to your lifestyle? (**Be honest with yourself here**.) Rate from 0-10. _____

What behaviors/lifestyle choices/habits do you currently engage in that support your health? _____

_____

What behaviors/lifestyle choices/habits do you currently engage in that are detrimental to your health?

_____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you ?

_____

_____

Who can support you with the lifestyle changes you will be making? _____

_____

Mental/Emotional Inventory

Choose one statement from among the group of four statements in each question that best describes how you have been feeling during the **past couple weeks**. Circle the number beside your choice. Total your score at the end and inform your health care provider.

1	**0** I do not feel sad. **1** I feel sad. **2** I am sad all the time and I can't snap out of it. **3** I am so sad or unhappy that I can't stand it.	8	**0** I don't feel I am any worse than anybody else. **1** I am critical of myself for my weaknesses or mistakes. **2** I blame myself all the time for my faults. **3** I blame myself for everything bad that happens.
2	**0** I am not particularly discouraged about the future. **1** I feel discouraged about the future. **2** I feel I have nothing to look forward to. **3** I feel that the future is hopeless and that things cannot improve.	9	**0** I don't have any thoughts of killing myself. **1** I have thoughts of killing myself, but I would not carry them out. **2** I would like to kill myself. **3** I would kill myself if I had the chance.
3	**0** I do not feel like a failure. **1** I feel I have failed more than the average person. **2** As I look back on my life, all I can see is a lot of failure. **3** I feel I am a complete failure as a person.	10	**0** I don't cry any more than usual. **1** I cry more now than I used to. **2** I cry all the time now. **3** I used to be able to cry, but now I can't cry even though I want to.
4	**0** I get as much satisfaction out of things as I used to. **1** I don't enjoy things the way I used to. **2** I don't get any real satisfaction out of anything anymore. **3** I am dissatisfied or bored with everything.	11	**0** I am no more irritated by things than I ever am. **1** I am slightly more irritated now than usual. **2** I am quite annoyed or irritated a good deal of the time. **3** I feel irritated all the time now.
5	**0** I don't feel particularly guilty. **1** I feel guilty a good part of the time. **2** I feel quite guilty most of the time. **3** I feel guilty all of the time.	12	**0** I have not lost interest in other people. **1** I am less interested in other people than I used to be. **2** I have lost most of my interest in other people. **3** I have lost all of my interest in other people.
6	**0** I don't feel I am being punished. **1** I feel I may be punished. **2** I expect to be punished. **3** I feel I am being punished.	13	**0** I make decisions about as well as I ever could. **1** I put off making decisions more than I used to. **2** I have greater difficulty in making decisions than before. **3** I can't make decisions at all anymore.
7	**0** I don't feel disappointed in myself. **1** I am disappointed in myself. **2** I am disgusted with myself. **3** I hate myself.	14	**0** I don't feel that I look any worse than I used to. **1** I am worried that I am looking old or unattractive. **2** I feel that there are permanent changes in my appearance that make me look unattractive. **3** I believe that I look ugly.

15	**0** I can work about as well as before. **1** It takes an extra effort to get started at doing something. **2** I have to push myself very hard to do anything. **3** I can't do any work at all.	19	**0** I haven't lost much weight, if any, lately. **1** I have lost more than five pounds. **2** I have lost more than ten pounds. **3** I have lost more than fifteen pounds. (Score 0 if you have been purposely trying to lose weight.)
16	**0** I can sleep as well as usual. **1** I don't sleep as well as I used to. **2** I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. **3** I wake up several hours earlier than I used to and cannot get back to sleep.	20	**0** I am no more worried about my health than usual. **1** I am worried about physical problems such as aches and pains, or upset stomach, or constipation. **2** I am very worried about physical problems, and it's hard to think of much else. **3** I am so worried about my physical problems that I cannot think about anything else.
17	**0** I don't get more tired than usual. **1** I get tired more easily than I used to. **2** I get tired from doing almost anything. **3** I am too tired to do anything.	21	**0** I have not noticed any recent change in my interest in sex. **1** I am less interested in sex than I used to be. **2** I am much less interested in sex now. **3** I have lost interested in sex completely.
18	**0** My appetite is no worse than usual. **1** My appetite is not as good as it used to be. **2** My appetite is much worse now. **3** I have no appetite at all anymore.		

Please add the total score here:

Total Score = _____

Informed Consent

Referral Source: _____

Nature and Purpose of Assessment: The goal of a naturopathic assessment is to determine the underlying cause(s) of your health concerns and to treat them effectively with safe, natural and non-toxic therapies. In addition to an interview where we will be asking you questions about your background and current medical symptoms, we may be using laboratory tests including but not limited to conventional blood testing (CBC and chemistry testing) and functional testing (nutritional, hormonal, and food allergy).

Communication: Speaking with Dr. Bongiovanni should be primarily reserved for office visits. Emailing quick questions or comments is perfectly acceptable. Phone conversations less than 5 min are also acceptable. Phone conversations greater than 5-10 min will be billable for time.

Laboratory testing: Lab results typically require 2-3 weeks from the time the lab receives your specimen. Lab results will be reviewed and explained at your follow up visit

Fees:

- Payment does NOT include laboratory testing or supplements
- *Please pay consultation fee using cash, check, or credit card at time of service*

Effective January 1, 2013:

- Initial-Comprehensive Visit = $245 (60 min)
- Follow up visit = $95 (30 min)

Limits of Confidentiality: Information obtained during assessments is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults; and c) issuance of a subpoena from a court of law.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits. I also understand that I may revoke this authorization at any time by notifying the practitioner in writing.

I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have had an opportunity to clarify any questions and discuss any points of concern before signing.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian or Authorized Surrogate (if applicable) Date

Medical Records Release Form

Patient Name: _____

Address: _____

City:_____ State: _____ Country: _____

Zip/Postal Code: _____ Telephone:_____

Fax: _____ Email: _____

Date of Birth: _____ Social Security Number:_____

Doctor/Practice: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

I authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment during the period of _____ to _____ ; to be sent to the following person or company:

Wholistic Medicine Specialists of Atlanta
3502 Old Milton Pkwy
Alpharetta, GA 30005
www.wmsoa.com
Phone: 678-456-5022
Fax: 888-338-3634

* Please send the following health records:

_____

_____

Patient Signature: _____ Date: _____