

PATIENT INFORMATION	
Date	_____
SS#	_____
Patient Name	_____
	Last
	First Middle
Address	_____
City	_____
State	_____ Zip _____
E-Mail	_____
Sex M F	Birth Date _____
Married Widowed Single Minor	
Separated Divorced Partnered for ___ Years	
Occupation	_____
Employer/School	_____
Employer/School Address	_____
Employer/School Phone	_____
Spouse's Name	_____
Spouse's Birth Date	_____
Spouse's SS#	_____
Whom may we thank for referring you?	_____

PHONE NUMBERS	
Home _____	Cell _____
Work _____	Other _____
Best time and place to reach you: _____	
I give permission for my doctor or staff to leave a message regarding my appointment or arrival of test results on my home telephone or cellular phone.	Yes No
I give permission to speak on matters regarding my healthcare to: _____	
IN CASE OF EMERGENCY CONTACT	
Name _____	Relationship _____
Home _____	Work _____

FAMILY HISTORY						
Date of last physical examination _____						
What is your reason(s) for today's visit? _____						
	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE DECEASED						
BROTHERS	# ALIVE	HEALTH		# DECEASED	CAUSE OF DEATH	
SISTERS	# ALIVE	HEALTH		# DECEASED	CAUSE OF DEATH	
CHILDREN	# ALIVE	AGES & HEALTH		# DECEASED	AGES & CAUSE OF DEATH	
CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES						
Diabetes    Cancer    Bleeding tendency    Kidney disease    Tuberculosis    Alcoholism/Drug Use Heart disease    Stroke    High Blood Pressure    Nervous Illness    Allergy    Other _____						

INSURANCE	
Insured's Name:	_____
Relationship to Patient:	_____
Name of Insurance:	_____
Insured's ID Number:	_____
Insured's Group Number:	_____
Employer/School Name:	_____
Insured's Address:	_____
City/State/Zip:	_____
Insured's Birth date:	_____
Telephone:	_____
SS# _____	Sex M F
Is the patient covered by additional insurance? Yes No	
INSURANCE ASSIGNMENT AND RELEASE	
I certify that I have coverage with	
_____	
Name of Insurance Company (ies)	
And assign directly to Dr Jennifer Calvo and Dr Don Underwood all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.	
The above named doctor may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.	
Signature of Beneficiary, Guardian, or Personal Representative	
_____	
Please Print Name of Beneficiary, Guardian, or Personal Representative	
Date _____ Relationship to Beneficiary _____	

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

**HEALTH HISTORY**

**SYMPTOMS**

Check all conditions that you have or have had in the past year.

<p><b>GENERAL</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Intolerant to Exercise <input type="checkbox"/> Irritable/Shaky when hungry <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Salt Cravings <input type="checkbox"/> Sensitive to Fumes/Chemicals <input type="checkbox"/> Stool Changes <input type="checkbox"/> Sweats <p><b>MUSCLE/JOINT BONE</b>                  Pain, weakness or numbness in</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Arms</td> <td><input type="checkbox"/> Hips</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Legs</td> </tr> <tr> <td><input type="checkbox"/> Feet</td> <td><input type="checkbox"/> Neck</td> </tr> <tr> <td><input type="checkbox"/> Hands</td> <td><input type="checkbox"/> Shoulders</td> </tr> </table> <p><b>GENITOURINARY</b></p> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Color change in Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Lack of Bladder Control <input type="checkbox"/> Painful Urination	<input type="checkbox"/> Arms	<input type="checkbox"/> Hips	<input type="checkbox"/> Back	<input type="checkbox"/> Legs	<input type="checkbox"/> Feet	<input type="checkbox"/> Neck	<input type="checkbox"/> Hands	<input type="checkbox"/> Shoulders	<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Appetite, poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Other: _____ <p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Swelling of Ankles <input type="checkbox"/> Water retention <input type="checkbox"/> Varicose Veins <p><b>PULMONARY</b></p> <input type="checkbox"/> Persistent cough <input type="checkbox"/> Spitting up blood or phlegm	<p><b>EYE, EAR, NOSE, THROAT</b></p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Ear ache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision- Blurry <input type="checkbox"/> Vision- Night Blindness <input type="checkbox"/> Vision- Flashes <input type="checkbox"/> Vision- Halos <input type="checkbox"/> Vision- Light Sensitivity <p><b>SKIN/HAIR/NAILS</b></p> <input type="checkbox"/> Acne <input type="checkbox"/> Bruise easily <input type="checkbox"/> Discoloration of skin <input type="checkbox"/> Hair loss <input type="checkbox"/> Hair excess <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars / Stretch marks <input type="checkbox"/> Sore that won't heal <input type="checkbox"/> Weak / brittle nails / hair	<p><b>MEN ONLY</b></p> <input type="checkbox"/> Breast Lump <input type="checkbox"/> Erection Difficulties <input type="checkbox"/> Lump or pain in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other: _____ Last PSA: _____ <p><b>WOMEN ONLY</b></p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between Periods <input type="checkbox"/> Breast Lump <input type="checkbox"/> Breast Tenderness <input type="checkbox"/> Decreased libido <input type="checkbox"/> Extreme Menstrual Pain <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Irregular Menses <input type="checkbox"/> Miscarriages <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Other: _____ <p>Date of Last Period: _____</p> <p>Date of Last Pap smear: _____</p> <p>Date of Last mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>
<input type="checkbox"/> Arms	<input type="checkbox"/> Hips										
<input type="checkbox"/> Back	<input type="checkbox"/> Legs										
<input type="checkbox"/> Feet	<input type="checkbox"/> Neck										
<input type="checkbox"/> Hands	<input type="checkbox"/> Shoulders										

**CONDITIONS**

Check all conditions that you have or have had in the past year.

<input type="checkbox"/> AIDS/ HIV Positive <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Infertility <input type="checkbox"/> Kidney Disease/Stones <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Ovarian Cysts <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcer <input type="checkbox"/> Vaginal Infection <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Other: _____
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**MEDICATIONS AND SUPPLEMENTS**

List what you are currently using and the dose


Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

**ALLERGIES**

To Medications, Foods or Other


Jennifer Gentry Calvo, NMD  
Don Underwood NMD, LAc  
42323 N Vision Way Suite 108 --- Anthem, AZ 85086  
Telephone 623-551-0027

Have you had any surgeries or hospitalizations (Please include date, hospital, condition treated, and outcome of the procedure).

Please list any significant life event that you feel has affected your health:

What is your current level of commitment to addressing these issues? (Please choose the one that best fits.)

- I am willing to make **any** changes and do whatever is necessary.
- I am willing to make **some** changes in my lifestyle to feel better.
- I am specifically looking for a medical/surgical alternative but **do not want to change** my lifestyle.
- I am here to learn more about my healthcare options and what you offer.
- Other: \_\_\_\_\_

What spiritual or religious activities do you have if any?

What type of exercise and frequency of exercise do you prefer?

What occupation do you currently have?

What previous occupations have you had?

What hobbies do you have?

What would you rate daily your stress level (0-10, 10 highest)

How do you feel on waking in the morning?

How do you feel at night before bed?

How many hours of sleep do you get per night during the week?

Have you had all childhood vaccinations? \_\_\_\_\_ When was you last tetanus vaccine? \_\_\_\_\_

Have you ever had a bad reaction to a vaccination? What reaction and to which vaccine. \_\_\_\_\_

Do you smoke? Yes No How often? \_\_\_\_\_ For How Many Years? \_\_\_\_\_ How many per day? \_\_\_\_\_

What motivates you to smoke? \_\_\_\_\_ Do you want to quit? Yes No

Do you experience gas, bloating or indigestion with any particular food, if so what food(s)? \_\_\_\_\_

Do you experience gas, bloating or indigestion when experiencing stress? \_\_\_\_\_

How frequently do you drink (per day/week) of the following (Daily and how many glasses, Weekly, Occasionally, Never)

Coffee? \_\_\_\_\_ Soda? \_\_\_\_\_ Juice? \_\_\_\_\_ Energy Drinks? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Water? \_\_\_\_\_

How frequently do you consume the following:

Bread	_____	Milk/Dairy	_____	Artificial Sweetener	_____	Pork	_____
Pasta	_____	Cheese	_____	Sugar	_____	Poultry	_____
Baked goods	_____	Eggs	_____	Fruits	_____	Beef	_____
Sweets	_____	Soy	_____	Vegetables/Salads	_____	Fish/Seafood	_____

If your condition is chronic (you have looked for answers for years without results), what do you think is the cause of your illness and what treatments have you tried successfully or unsuccessfully?

Is there anything else you would like the doctor to know which may help him or her to better understand you which has not been discussed?

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION.

Jennifer Gentry Calvo, NMD  
Don Underwood NMD, LAc  
42323 N Vision Way Suite 108 --- Anthem, AZ 85086  
Telephone 623-551-0027

**PATIENT AFFIRMATION OF CONTRACTS**  
**Regarding the Health Services, Notice of Privacy Practices, & Consent to Treat Contracts**  
All contracts are available to read in our office and on our website: [www.eastwestihc.com](http://www.eastwestihc.com)

**HEALTH SERVICES CONTRACT**

I have read the "Health Care Services Contract." I have read and understand my patient rights and the financial policies of East-West Integrated Healthcare and agree to the terms and conditions. I understand that there is a fee for missed appointments and for lengthy phone consults. Fees at East-West Integrated Healthcare may change, but I will always be made aware of any changes prior to my visit. East-West Integrated Healthcare will provide a copy of the "Health Care Services Contract" to me at my request or I may access this information at [www.eastwestihc.com](http://www.eastwestihc.com)

**NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have been provided information on how my personal health information may be used in accordance with HIPPA federal regulations. I have read, or have had read to me the "Notice of Privacy Practices" and agree to the terms and conditions. East-West Integrated Healthcare will provide a copy of the "Notice of Privacy Practices" to me at my request or I may access this information at [www.eastwestihc.com](http://www.eastwestihc.com).

**CONSENT TO TREAT CONTRACT**

I am seeking medical health care services at East-West Integrated Healthcare. I have read, or have had read to me the "Consent to Treat Contract" and agree to the terms and conditions. I will always have an opportunity to discuss the value of any treatment and will have an opportunity to verbally agree to a treatment before it is performed. If I refuse a particular therapy, this will be noted in my chart for future reference. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. East-West Integrated Healthcare will provide a copy of the "Consent to Treat Contract" to me at my request or I may access this information at [www.eastwestihc.com](http://www.eastwestihc.com).

**RELEASE OF INFORMATION**

I give the physician the authority to share with any consultant all information deemed necessary to coordinate my medical care. This includes sharing/mailling/faxing information such as office notes, EKGs, laboratory results, x-ray reports, medication lists and other consultant's notes to physicians, hospitals, pharmacists and insurance companies.

**INSURANCE AND ASSIGNMENT OF BENEFITS**

East-West Integrated Health Care is not an insurance provider. Super bills are gladly provided and insurance is filed on request; however, reimbursement is not guaranteed. Medicare does not cover naturopathic care. I understand I am always responsible for pre-payment regardless of the insurance coverage I may have.

I assign any insurance benefits to which I may be entitled to the physician providing the services. These benefits will be reimbursed to me if there is a credit on my account. I understand that I am responsible for any charges not covered by this assignment. I authorize release of any medical or other information necessary to process my insurance claims. I authorize the physician to provide from my records any and all information requested by my insurance company or other third party payer, in connection with payment for my incurred charges. I also authorize the physician to provide any quality review organization affiliated with my insurer the information it requests for use in Utilization Management/Review. Some plans may require a referral from my primary care physician and it is my responsibility. I authorize disclosure of records to my insurance carrier, lawyer, or referring practitioner.

**EMERGENCIES**

I understand that if I have an urgent medical condition, and I am unable to reach Dr. Calvo or Dr. Underwood it is my responsibility to seek appropriate medical care. I understand that **IF THERE IS A MEDIAL EMERGENCY I AM TO DIAL 911 IMMEDIATELY.**

Date: \_\_\_\_\_  
Patient Name (Printed): \_\_\_\_\_  
Parent or Legal Guardian if applicable (Printed): \_\_\_\_\_  
Patient Signature (or Parent or Legal Guardian): \_\_\_\_\_