Central Family Practice
Dr. Jeanne Galloway, ND
801 W. 34th Street, Suite 102
Austin, TX 78705
(512)695-2342

Name	Date:	Age:

Medical History

Have you had or do you have any of the following:
(Please circle)

Alcoholism/substance abuse
Allergies
Anxiety
Asthma/emphysema
Arthritis
Blood in stool
Cancer
Chronic skin problems/rash
Colitis
Constipation
Depression
Diabetes
Diarrhea
Difficulty achieving orgasm
Difficulty swallowing
Diverticulitis
Double/blurred vision
Epilepsy/seizures
Exposure to HIV
Frequent or severe headaches
Gall bladder problem
Heart attack
Heart disease
Hepatitis
Hernia (type) ____________
High blood pressure
High cholesterol
Impotence
Kidney or bladder infection
Kidney stone
Loss of hearing
Loss of vision
Night sweats
Osteoporosis
Pneumonia
Positive TB skin test
Rheumatic fever
Sexually transmitted disease:
- **Gonorrhea**
- **Chlamydia**
- **Syphilis**
- **Herpes**
- **HPV/warts**

Sinus problems
Stroke
Swelling in legs or feet
Tuberculosis
Thyroid problems
Vomiting of blood
Weight loss/gain

Are you experiencing any health problems today? If so, please describe: ________________________________
____
____
____
____

Please list any surgeries or hospitalization: ____
____
____

Please list any medication allergies: ____
____
____
____
____

****TURN PAGE OVER PLEASE****

Have your parents, siblings, or grandparents ever had any of the following: (please circle)

Diabetes	**substance abuse**	**Sickle cell trait/disease**
Cancer	**Heart Disease**	**High cholesterol**
Type ________	**Thyroid problems**	
Stroke	**Osteoporosis**	
Alcoholism/	**Depression**	

Sleeping Habits

Are you having difficulty sleeping?	**Yes**	**No**
Is stress in your life causing you to lose sleep?	**Yes**	**No**
Have your sleeping habits changed recently?	**Yes**	**No**

Eating Habits

Have you gained or lost a significant amount of weight recently?	**Yes**	**No**
If yes, how much? ____________________________________		
Are you concerned about your current eating habits?	**Yes**	**No**
Do you consider your diet healthy?	**Yes**	**No**
Are you having problems with over-eating?	**Yes**	**No**
Do you think you may have an eating disorder?	**Yes**	**No**

Personal Habits

Do you smoke cigarettes? **Yes** **No** **How many per day? _________**

Do you have regular bowel movements? **Yes** **No** **How often? ________________**

Do you exercise regularly?	**Yes**	**No**
Do you drink alcohol?	**Yes**	**No**
Do you feel overly stressed in your daily life?	**Yes**	**No**
Are you currently experiencing any feeling of depression?	**Yes**	**No**

Have you recently experienced any events that increase your stress level? Please describe: ________________

____

Menstrual/Pregnancy History

Age of first period __________ **Usual interval between periods __________**

Usual length of period __________ days **Age of first intercourse: __________**

Are you currently trying to get pregnant? **Yes** **No**

Number of:

Pregnancy: __________ **Full-term deliveries: __________**

Still births: __________

Abortion/miscarriage: __________

Have you had any of the following: (please circle)

Irregular periods	**Abnormal breast lumps**	**Infection in fallopian tubes**
Painful periods	**Abnormal pap smear**	**Ovarian cysts**
Infection in ovaries	**DES exposure**	

NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT &
RECEIPT OF HIPAA DOCUMENTS

I, ____________________________, hereby authorize Jeanne Galloway, ND to perform the following specific procedures as necessary to facilitate my wellness:

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation.
Botanical medicine: botanical substances may be recommended as teas, alcoholic tinctures, capsules, tablets, cremes, plasters, or suppositories.
Minor office procedures: e.g., ear cleansing to be done by nursing staff.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to recommended herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from procedures.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Jeanne Galloway or any of her agents regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or my representative, or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that any questions I have will be answered by my practitioner to the best of her ability.

________________________________ ________________________________
Signature of Patient/Guardian Date

SEE NEXT PAGE FOR ADDITIONAL SIGNATURES NEEDED

Acknowledgement of HIPAA form Receipt

Jeanne Galloway, ND is required to provide you with a copy of her Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The notice is available at www.gallowaynaturalhealth.com under the Patient Information Section, under HIPAA Forms. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please print this out and read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call Dr. Galloway's office at address provided.

I hereby acknowledge that I have received a copy of Jeanne Galloway, ND's Notice of Privacy Practices.

X ____ _______________

Patient's Signature Date

X ____ _______________

Guardian/Representative's Signature Date

____

Relationship to Patient/Representative Authority

OFFICE USE ONLY

Unable to Obtain Acknowledgement

This section serves as a record of the above practitioner's good faith effort to obtain written acknowledgement of receipt from the patient for the Notice of Privacy Practices. Patient was given a copy of the notice on: _______________.

- ❍ Patient refused to sign acknowledgement.
- ❍ Patient is physically unable to sign acknowledgement.
- ❍ Other:

____

____

SEE NEXT PAGE FOR ADDITIONAL SIGNATURES NEEDED

Welcome to Dr. Jeanne Galloway's office…

I look forward to working with you on your wellness strategies. This document contains important policy information that pertains specifically to you. Please read over the entire document, if you have any questions please feel free to ask.

Appointments

We consider an appointment to be an agreement between you and our office. This is a busy office and Dr. Galloway takes pride in helping each and every person. If for any reason you need to and do not cancel your appointment, Dr. Galloway becomes unable to provide service to another person during your scheduled time. We are responsible to be onsite and provide our services, or to inform you otherwise. You are responsible for keeping your appointment, or giving us 24-*business* hours notice of cancellation. Should you decide not to keep the appointment without giving the appropriate notice, you will be charged an **$50 cancellation fee**. In order to enforce this, we will be asking you for a credit card to hold your appointment. Your credit card will not be charged unless you miss your appointment without at least a 24-business hour cancellation. Obviously, in cases of illness or emergency we will be glad to waive this fee on a case by case basis. Thanks for communicating with us.

___________ Please initial.

Payment

Dr. Galloway requires payment in full at the time services are rendered. For your convenience we accept Check, Cash, Visa or MasterCard payments. We do not accept Discover or American Express. There will be a $25 fee for all returned checks.

___________Please initial.

Insurance

Dr. Galloway is not a "preferred" or "in network" provider for any insurance companies, nor do we submit claims to insurance companies on your behalf. We will however, provide you with the information necessary for you to submit your claim to your insurance company. This does not insure any coverage from you insurance company.

___________Please initial.

Emergencies

If you have a true medical emergency or serious medical concern you are to call 9-1-1 immediately. If you have an urgent medical concern please call the office; if it is after regular business hours (9am to 5pm CST) we will be unable to receive your call. If you feel you can not wait until the next business day, it is your responsibility to seek the appropriate emergency or other medical care.

___________Please initial.

I have read this document completely and I understand and agree with all of its contents demonstrated by my initials above and my signature below.

____

Client signature Date

____

Printed name

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