

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

Name _____	Date: _____	Age: _____
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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: _____ _____ _____ _____
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****TURN PAGE OVER PLEASE****

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

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

Which of the following contraceptive methods have you used: (please circle)

IUD	Foam	Other _____
Diaphragm	Vasectomy	None, same sex preference
Birth control pills	Tubal ligation	Natural family planning
Condoms	None	

How long have you been with your current sex partner? _____

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
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Number of:

Pregnancy: _____	Abortion/miscarriage: _____
Still births: _____	Full-term deliveries: _____

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

Original to: Chart

Copy to: Patient (if requested)

SEE PAGE TWO 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 _____ Date _____
Patient’s Signature

X _____ Date _____
Guardian/Representative’s Signature

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:

Naturopathic Care for Malignancy Consent Form

In accordance with the Washington state licensing law of naturopathy (which is the state Dr. Galloway is licensed under), naturopathic doctors may provide care in cases of malignancy only in concert with an M.D. or D.O.

I, _____, request naturopathic care at Austin's Natural Doctor.

An oncologist has diagnosed me with _____ cancer.
(type of cancer)

I am currently under the care of Dr. _____ (M.D. or D.O.) for my cancer treatment.
(name of doctor)

I understand that Washington law requires that any naturopathic care that I receive at Austin's Natural Doctor for adjunctive cancer care be rendered in concert with a medical or osteopathic doctor. My signature below attests to my understanding of this important relationship between my health care professionals and my commitment to cooperate with my care providers in this collaborative treatment.

I further understand that Dr. Jeanne Galloway, ND is not an oncologist and is not treating my cancer, but is using her expertise in natural and alternative medicine to help the wellness of my body as I undergo this current medical concern. As also stated in my Informed Consent Document, I understand that Dr. Galloway, nor any of her agents, have made promises of cure, or of successful outcomes.

Date

Patient's Name (Print)

Guardian's Name (Print)

Patient's Signature

Guardian's Signature

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 the appointment or giving us 24-business hours notice of cancellation. This means that if you are unable to make a Monday appointment, you will need to cancel on Friday, not on Sunday for this to count. Should you decide not to keep the appointment without giving the appropriate notice, you will be charged an \$85 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. Please note that insurance companies do not reimburse for missed appointments.

_____ 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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GallowayNaturalHealth.com