SONORAN
NATUROPATHIC
CENTER

9316 E. Raintree Dr. Suite #140
Scottsdale, AZ 85260
T: 480-614-2322
F: 480-614-2522

NEW PATIENT INTAKE

Name: _____

Date of Birth: _____ **Age** _____ **Gender** _____

Street Address _____

City_____ **State**_____ **Zip Code**_____

Phone: (Home) _____ (Cell) _____ (Work) _____

HIPPA compliance does not allow for email communication involving personal/identifying information, medical records, health information, or treatment recommendations. In order to communicate with your Provider via email and see medical documents such as lab results and treatment protocols, you will need to enroll in our Patient Portal. Please provide the email that you would like to use for the registration of your portal.
E-mail Address _____
(PLEASE NOTE, you cannot change the email once it has been registered)

Sonoran Naturopathic Center may use this email for appointment reminders and other communication not involving personal/medical information

YES_____NO_____

Social Security Number (used for insurance purposes) _____

Pharmacy: _____**Phone:**_____

How did you hear about us? * (If someone referred you here, please name them so that we may thank that person)

* **Friend Referral** (Please let us know who referred you to our office.)

_____

* **Social Media** (Please indicate which version you used to find out about our office)

❑ Facebook ❑ Twitter ❑ Youtube ❑ Other (If other please specify below)

_____

Name:_____ Date:_____

EMERGENCY CONTACT:

Name _____ **Phone** _____

Relationship to you _____

What are your main health concerns? (Please list your concerns in their order of importance to you. Give a brief history of when it started, other treatments or doctors/practitioners you have seen, etc.)

1. _____
   _____
   _____

2. _____
   _____
   _____

3. _____
   _____
   _____

4. _____
   _____
   _____

5. _____
   _____
   _____

PAST MEDICAL HISTORY:

- Significant previous Diagnoses or Illnesses:

- Major accidents or traumas:

- Hospitalizations/Surgeries: (Please list the date & the nature of the visit or procedure)

Family History (Please indicate if the following family members are alive or deceased – list their age, health concerns and/or cause of death)

- Mother:
    - Maternal Grandmother
    - Maternal Grandfather
- Father:
    - Paternal Grandmother
    - Paternal Grandfather
- Siblings:

- Children:

Medications/Supplements: (Please Include Dosage & Brand Name, if known)

- Medications (Including Prescription and Over-the-Counter)

- Supplements

Allergies: (Include Food and/or Drug Allergies – please also describe the type of reaction you have had)

Social/Lifestyle History:

- **Occupation:**

- **Sleep:**
  - Hours Per Night:
  - Quality of Sleep:
  - Wake feeling rested?

- **Energy Level:**
  - Scale of 1-10 (10 being the most energy)

- **Living Situation:**
  - Marital Status

- **Alcohol Consumption:**
  - Number of Drinks per week:

- **Cigarette Smoking:** (past or present)
  - Amount (packs per day):
  - Duration (in years):

- **Recreational Drug Use:** (past or present)
  - Type
  - Duration and Frequency

- **Exercise:**
  - Type
  - Duration & Frequency
  - Restrictions (any type of activity or exercise you are unable to do)

- **Stress Level:**
  - Current level of Satisfaction/Happiness with your life?

- **Typical Diet:**
  - Breakfast:
  - Lunch:
  - Dinner:
  - Snacks:

- **Beverages:** (please specify amounts and types of the following)
  - Caffeine:
  - Water:
  - Juice/Soda, etc:

ENVIRONMENTAL HISTORY

Please check the boxes below if you have current or past exposure to any of the following:

❑ Dental Amalgams (silver) ❑ Commercial hair coloring ❑ Home Fragrances (i.e. Sented Candles)

❑ Perfumes/Colognes ❑ Scented Lotions ❑ Commercial Dry Cleaning

❑ Nail or Hair Salons

Do you consume any of the following? If so, how often?

❑ Raw Fish/Sushi ❑ Farm Raised Fish ❑ Beef/ Red Meat

❑ Tuna ❑ Shellfish

Home/Office Environment

❑ New Paint ❑ New Carpeting

❑ New Furniture ❑ Home or office built before 1978

❑ Composite/Synthetic Wood Furniture

Do you use any of the following?

❑ Shower Filters ❑ Home Water Filtration ❑ HEPA Air Filters

❑ Bottled Water ❑ Non-toxic Hair and Body Care ❑ Organic Fruits and Vegetables

❑ Organic Dairy Products ❑ Organic Meats

What city and town were you born in?

How long did you live there?

Have you ever had a job where you had known and/or documented chemical exposure?

Have you had any reactions or known sensitivities to chemicals?

Have you lived near any industrial plants or factories? If so, what type of industry and how long did you live there?

Have you ever been tested for heavy metals, solvents, or other environmental medicine panels? If so, were there any significant findings?

REVIEW OF SYSTEMS:

(Please review the following list and check the box to indicate if you currently experience or have previously experienced any of the following symptoms. Use the space in the right column to elaborate, if necessary)

(Check positive findings and chart to right)	Details/Specifics
General: ❑ Hot ❑ Cold ❑ Chills ❑ Fever ❑ Sweats ❑ Night sweats ❑ Weight loss ❑ Weight gain ❑ Fatigue ❑ Restless legs ❑ Snoring ❑ Difficulty staying awake ❑ Difficulty falling asleep ❑ Difficulty staying asleep **Current Weight**:_____ **Weight One year ago**:_____ **Ideal Weight:** _____	
Skin, Hair, Nails: ❑ Dry Skin ❑ Frequent or Easy Bruising ❑ Rashes ❑ Hair Loss or Thinning Hair ❑ Fungal Infections of the skin or nails ❑ Eczema ❑ Poor Wound Healing ❑ Psoriasis ❑ Itching ❑ Jaundice ❑ Breaking Nails **Any abnormal skin lesions?** _____ **Do you see a dermatologist regularly?** _____ **Most recent Dermatological Exam:** _____	
HEENT: **Head:** ❑ Headache ❑ History of head injury ❑ Migraines **Eyes**: ❑ Double vision ❑ Blurred Vision ❑ Cataracts ❑ Vision changes ❑ Pain ❑ Redness ❑ Itching	

Most recent visit to eye doctor?

Wear glasses or contacts?

Ears:

- ❑ Discharge
- ❑ Hearing changes
- ❑ Ringing in the ears
- ❑ Pain
- ❑ Dizziness

Nose:

- ❑ Sinusitis
- ❑ Decreased smell
- ❑ Discharge/mucus
- ❑ Nose bleeds
- ❑ Congestion
- ❑ Seasonal allergies

Mouth/Throat:

- ❑ Canker sores
- ❑ Sore throats
- ❑ Persistent hoarseness
- ❑ Difficulty swallowing
- ❑ Toothache
- ❑ Bleeding gums
- ❑ Gingivitis

Most recent dental visit?

Any fillings or dentures?

NECK:

- ❑ Injuries
- ❑ Masses
- ❑ Pain
- ❑ Stiffness

CHEST:

- ❑ Asthma
- ❑ Bronchitis
- ❑ COPD
- ❑ Chronic cough
- ❑ Coughing up blood
- ❑ Shortness of breath
- ❑ Sleep apnea
- ❑ Pain
- ❑ Wheezing
- ❑ Pneumonia

CARDIOVASCULAR:

- ❑ Palpitations
- ❑ Murmurs
- ❑ Arrhythmias
- ❑ Chest pain/Angina
- ❑ Congestive Heart Failure
- ❑ Claudication (pain in the legs with exercise)
- ❑ Heart Attack
- ❑ Coronary Artery Disease
- ❑ Cyanosis (blue hands or feet)

❑ Dizziness
❑ Shortness of Breath with exercise
❑ High Blood Pressure
❑ Difficulty Breathing while lying flat
❑ Phlebitis
❑ Varicose Veins
❑ Stroke or TIA

GASTROINTESTINAL:

❑ Constipation ❑ Diarrhea
❑ Blood in the stool ❑ Gallbladder problems
❑ Nausea ❑ Vomiting
❑ Gas or Bloating ❑ Hemorrhoids
❑ Undigested food or mucus in the stool
❑ Indigestion ❑ Belching
❑ Acid Reflux ❑ Ulcers
❑ Abdominal Pain or Cramping
❑ Irritable Bowel Syndrome

Bowel Movement frequency?

Do you have to strain or do you experience any pain with passing stool?

Most Recent Colonoscopy:

GENITOURINARY:

❑ Pain with Urination ❑ Blood in the urine
❑ Frequent Urination ❑ Discharge
❑ Waking frequently at night to urinate
❑ Change in frequency
❑ Difficulty initiating stream
❑ Decreased force of urine stream
❑ Incontinence
❑ Chronic or Frequent UTI's
❑ Kidney Stones ❑ Interstitial Cystitis

SEXUAL HEALTH

❑ Genital Pain ❑ Itching
❑ Pain During Intercourse
❑ Discharge ❑ Decreased Libido
❑ Difficulty with arousal
❑ Inability to achieve orgasm

Have you ever been diagnosed or treated for an

STD? (please specify when & which STD)

Number of sexual partners in the past year:

Most recent testing for STD's

Method of Contraception:

BREASTS:

❑ Discharge ❑ Enlargement
❑ Pain ❑ Tenderness
❑ Prior surgery or biopsy

Most Recent Mammogram:

FEMALE/GYN:

- **Number of Pregnancies:**
- **Number of Live Births:**
- **Abortions or Miscarriages:**
- **Date of Last Menstrual Period**:
- **Length of Cycle:**

❑ Discharge ❑ Short ❑ Long
❑ Irregular ❑ Regular ❑ Clots
❑ Painful ❑ Discharge ☐ Foul Odor

- **PMS Symptoms:**
- **Menses started at age:**
- **Menses stopped at age:**
- **Last Pap Smear:**
- **History of Abnormal Paps?**

Gynelocial Surgeries or Procedures (date & type)

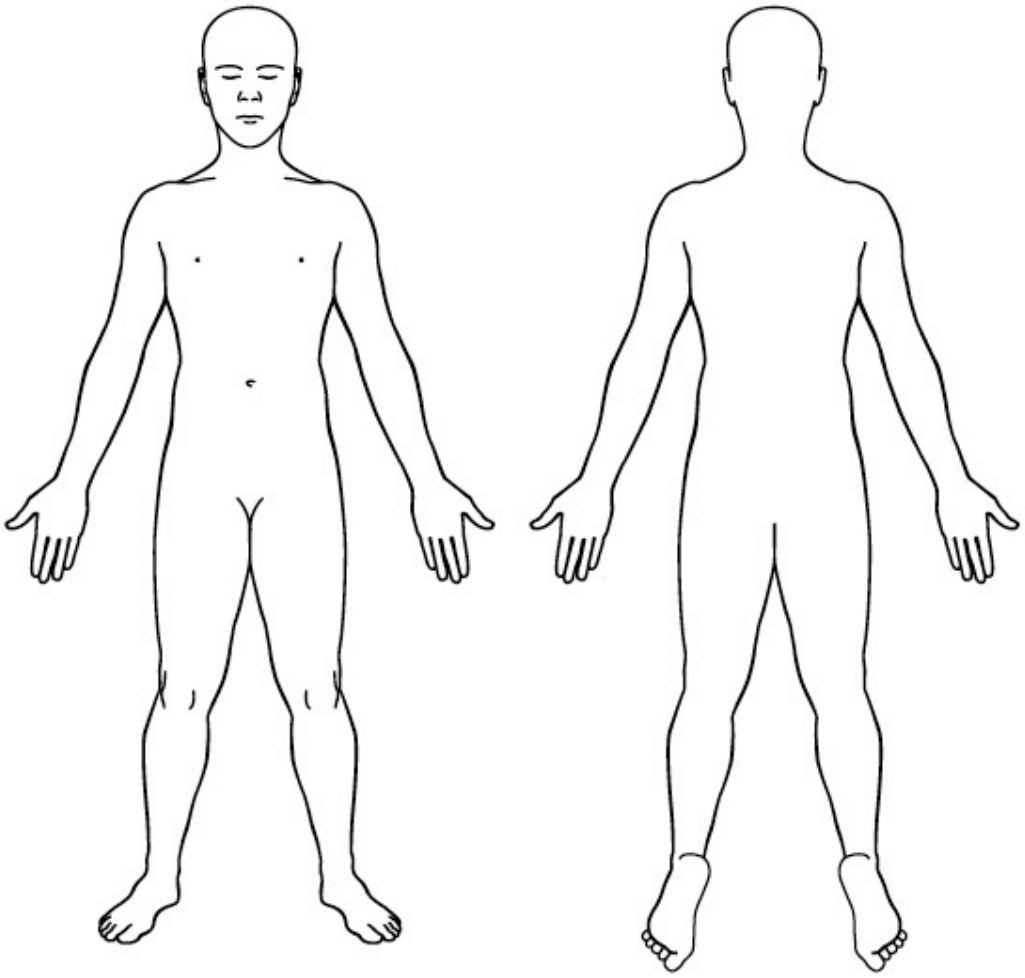
MALE:

❑ Prostatitis ❑ Lesions
❑ Benign Prostatic Hypertrophy
❑ Erectile Dysfunction ❑ Testicular Trauma

NEUROMUSCULAR:

❑ Numbness ❑ Tingling ❑ Joint Pain ❑ Arthritis ❑ Joint Swelling ❑ Muscle Pain ❑ Syncope (fainting) ❑ Vertigo ❑ Weakness ❑ Tremors ❑ Poor Balance ❑ Loss of Consciousness	
ENDOCRINE: ❑ Heat intolerance ❑ Cold intolerance ❑ Increased Thirst ❑ Increased Appetite ❑ Anemia ❑ Excessive bruising ❑ Easy bleeding ❑ Diabetes ❑ Thyroid Problems ❑ Fatigue	
MENTAL/EMOTIONAL: ❑ Depression ❑ Anxiety ❑ Panic Attacks ❑ Bipolar Disorder ❑ Phobias ❑ Anger/Rage ❑ PTSD ❑ Schizophrenia ❑ Poor Memory ❑ Brain Fog ❑ Behavioral or Conduct Disorders ❑ ADHD/ADD Have you ever had suicidal thoughts or attempted suicide? Were you ever emotionally or physically abused? Have you ever been hospitalized for Psychiatric Reasons?	

Please circle, highlight, or indicate any areas of pain, numbness, tingling, or other concerns. Be as specific and descriptive as possible.



Better with: (check all that apply)

❑ Hot ❑ Cold ❑ Motion ❑ Rest ❑ Pressure ❑ No pressure

Anything else make it feel better?

- Severity _____
  - (on a scale of 1-10, 10 being the worst pain you've ever experienced)
- Worst Time of Day:
  ❑ Mornings ❑ Evenings ❑ Afternoons ❑ Night-time
- Are these Symptoms:
  ❑ Constant ❑ Random ❑ Increasing in Severity
- Any known triggers?

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CLINIC FEE AGREEMENT

Please read items A-F carefully and initial where indicated.

A. **Dr. Brian Popiel** is currently classified as out of network provider for all insurance companies. In order to potentially have insurance coverage for our services your insurance plan needs to have **out of network coverage and the OON deductible must be met before reimbursement will happen.** Billing for labs is handled by the lab(s) selected by your physician. The lab(s) will submit charges to your insurance company and coverage is determined by deductible status and your insurance plan policies. **Please note, that Sonoran Naturopathic Center is not involved in the lab billing.** Most insurance companies will cover all or a portion of the bill for lab services. Be aware that out of pocket medical expenses can be used as tax deductions in some circumstances. **Please keep your receipts as we do not keep financial records of your visits. We will not be providing year end statements for taxes.**

_____ **(initial)**

B. **Dr. Popiel's fee for in-office or phone consultations is based on time and billed at a rate of $250/per hr.** There will be separate costs for certain procedures, supplements, IV therapies, injections, lab work and diagnostic testing. Follow up appointments will be billed at the same rate mentioned above.
_____ **(initial)**

C. We require a 24 hour advance notice to cancel appointments. For all **LATE cancels (less than 24hr notice)** you will be charged **$25.00**. For all **NO SHOW appts**, where notice has not been provided, you will be charged **$75.00.**
_____ **(initial)**

D. **IV THERAPY**
The IV therapies already include Dr. Popiel's time and you **will not** be billed for his time twice. The following are the charges for IV's.

- Nutritional/Hydration/Vitamin C IV's - **$195-$250**
- DMPS Chelation (Heavy Metals Testing/Removal) - **$95**
- Glutathione (Detoxification) IV Push - **$45**
- IV OZONE **- $150-$195**
- IV Push **- $80**

IVS ARE MADE PRIOR TO CLIENT ARRIVAL. 24 HR NOTICE IS REQUIRED TO CANCEL AN IV APPT. IN THE EVENT OF A NO SHOW OR LATE CANCEL (LESS THAN 24 HR NOTICE), CLIENTS WILL BE HELD FINANCIALLY RESPONSBILE FOR THE FULL IV COST

_____ **(initial)**

E. **INJECTABLE THERAPIES/OTHER:**

- Blood Draw - **$20**
- B-12/Iron/Testosterone injection - **$20-$35**
- Prolotherapy- **$125-$400**
- Infrared Sauna- **$25**

- Acupuncture - **$95** (new patients) **$75** (follow ups)
- Prolozone - **$125-$400**
- Amnio Fix – **Cost determined by injection site location and dose required**

_____ (initial)

F. **PAYMENT IS DUE AT THE TIME OF SERVICE. Dr. Popiel will bill insurance on behalf of the patient, but there is no guarantee of insurance reimbursement, due to the fact that he is an out of network provider.**

_____ (initial)

Client Signature: **Date**

_____ _____

By signing I agree to the above terms as outlined.

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INFORMED CONSENT

Welcome to Sonoran Naturopathic Center and the medical practice of **Dr. Brian Popiel.**

I consent to treatment and understand that my physician is a licensed Naturopathic Doctor who will conduct a thorough case history with me before initiating any treatment protocols. Naturopathic doctors are recognized as primary care physicians in the state of Arizona with the ability to diagnose and treat disease conditions. Naturopathic doctors utilize principles and practices that treat the whole person and assist in the body's own ability to heal.

Evaluation and diagnoses will be based on physical exam, specific blood and/or urinary laboratory reports. Evaluation of these laboratory reports may be interpreted differently from other practitioners of naturopathic or allopathic medicine. Treatment protocols may or may not be consistent with mainstream medical tests/evaluations and are based on clinical experience and scientific/medical literature.

Treatments may include procedures such as but not limited to nutritional supplements, homeopathic medicines, botanical medicines, intravenous vitamin/mineral therapy, acupuncture, prolotherapy injections, mesotherapy injections, trigger point injections, and prescriptive medications (including bio-identical hormones). Certain treatments may be deemed "experimental" since the FDA has not issued any guidelines or statements as to the safety or efficacy of these treatments. I understand that my doctor will inform me of the potential risks of treatment and answer any questions that I may have.

I understand that even "natural" treatments may have side effects and it is my responsibility to inform my doctor in a timely manner of any side effects or adverse effects that I may be experiencing. I will make sure to inform my doctor of all dietary supplements, non-prescriptive medicines and prescriptive medications that I am taking; as well as updating any changes to this list.

I acknowledge that if I have any questions or concerns about my lab evaluation and treatment protocol; I will address them with my doctor in a timely manner. My consent to treatment is voluntary and informed.

I assume full responsibility for costs regardless of my insurance coverage; these costs may include office visits/procedures and labs not covered by insurance, as well as medications, and supplements.

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E-mail Address _____
(PLEASE NOTE, you cannot change the email once it has been registered)

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YES_____NO_____

Signature _____ Date _____

Print Name _____

Doctors' Signature _____ Date _____

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HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to

_____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

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6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Date

_____/_____/_____