



DR. WILES GOSS NATURAL HEALTH
Your Journey Through Health & Life

NEW PATIENT PACKET

Welcome To Our Clinic

First Visit Checklist

- Completed **intake forms**
If forms are completed before the day of your appointment, please scan and send by email to drwilesgoss@gmail.com.
- Please bring all **supplements/medications** and recent **lab work**.
- Please plan to arrive **5 minutes early**. We have a “no wait” policy. Every effort will be made to be respectful of your time by keeping on schedule.
- Upon entering the office, a receptionist will be there to greet you, please **check in** and **wait in the seating area** and I will be with you shortly.
- All payments are expected at the **time of service**. We accept cash, check, Visa, and MasterCard.
- If we accept your insurance, please bring your insurance information so that we can provide you with all the necessary information to submit to your insurance provider.

ADULT INTAKE

Contact Info:

Name: _____ Date: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone (home): _____ (cell): _____
 E-mail: _____

Emergency Contact: _____ Relationship: _____
 Phone: _____
 How did you hear about this clinic? _____

Occupation: _____ Hours per wk: _____ Retired: _____
 Employer: _____

Demographics:

Age: _____ Date of Birth: _____ Gender: F M
 Ethnicity: _____

Are you: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___
 Relationship _____

Live With: Spouse ___ Partner ___ Relatives ___ Friends ___ Alone ___ Parents ___

Occupation: _____ Hours per wk: _____ Retired: _____
 Employer: _____

Thank You For Your Time & Effort

Holistic health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Health History Questionnaire

Do you currently have a primary care doctor? Y N

Name: _____ Location: _____ Phone: _____

Are you currently under the care of any other physician/healthcare providers?

Name: _____ Location: _____ Phone: _____

Specialty/Reason for seeing: _____

Name: _____ Location: _____ Phone: _____

Specialty/Reason for seeing: _____

Name: _____ Location: _____ Phone: _____

Specialty/Reason for seeing: _____

What are your most important health problems? List in order of importance.

- 1.) _____ Onset: _____
- 2.) _____ Onset: _____
- 3.) _____ Onset: _____
- 4.) _____ Onset: _____
- 5.) _____ Onset: _____

When was the last time you had excellent/optimal health? _____

How long do you think it will take for you to return to excellent health? _____

What is your present level of commitment to address any *underlying causes* of your signs & symptoms? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What three expectations do you have of me personally as your health care provider?

General

Height _____ Weight _____ Maximal Weight _____ When _____
Weight one year ago _____

Family History

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay fever	Hives	

Childhood

Were there any complications with your birth? Y N
What? _____

How would you rate your health & happiness as a child? (0 = worst, 10 = best)

0 1 2 3 4 5 6 7 8 9 10

As a teenager?

0 1 2 3 4 5 6 7 8 9 10

Childhood illnesses?

Scarlet Fever Y N Diphtheria Y N Rheumatic Fever Y N
 Mumps Y N Measles Y N German Measles Y N
 Other _____

Immunization History

Polio Y N Pertussis Y N
 Tetanus shot Y N Diphtheria Y N
 Measles/Mumps/Rubella Y N HIB Y N
 Flu Shot Date _____ Y N Hepatitis _____ Y N
 Chicken Pox Y N Other _____

Hospitalization, Surgery or Imaging (x-rays, CAT scans, MRI's, EEG, EKG)

_____ year _____ year _____
 _____ year _____ year _____
 _____ year _____ year _____

Mental Health

Have you had any times of major psychological trauma? Y N

Age: _____
 Age: _____
 Age: _____

Allergies & Hypersensitivities

Drugs? _____
 Foods? _____
 Environmental or chemical? _____

Medications & Supplements

Please list any **prescriptions & over the counter medications** you take *consistently*.
 Attach additional sheet if needed.

Drug: _____ Dose: _____ How long? _____
 Drug: _____ Dose: _____ How long? _____
 Drug: _____ Dose: _____ How long? _____
 Drug: _____ Dose: _____ How long? _____
 Drug: _____ Dose: _____ How long? _____

Please list any **supplements** you are currently taking. Please include the **brand name**.

_____ Dose: _____ How long? _____
 _____ Dose: _____ How long? _____
 _____ Dose: _____ How long? _____

_____	Dose: _____	How long? _____
_____	Dose: _____	How long? _____
_____	Dose: _____	How long? _____

Diet

Do you follow a certain diet? Y N
If yes, please circle.

Vegetarian Vegan Paleolithic Anti-inflammatory Blood-type Atkins
Low-fat/low calorie Gluten-free Dairy-free Other _____

What do you typically eat for each meal?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How much water do you drink each day? _____

Toxic Exposures

Have you had any past or present careers or hobbies that led to toxic exposures?
(for example- hair dresser, lived on a farm, artist, cleaners, painters, dentist)

_____	Age: _____
_____	Age: _____
_____	Age: _____

Do you have mercury fillings in your teeth? Y N P

Habits, Hobbies, and Lifestyle

What are your interests? What do you love to do? What brings you passion in your life?

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are unhealthy or self-destructive?

Please rate your stress on a scale from 1 to 10 (10 = most)

0 1 2 3 4 5 6 7 8 9 10

Please rate your energy on a scale from 1 to 10 (10 = most)

0 1 2 3 4 5 6 7 8 9 10

Please answer Y = yes, N = no, or P = in the past

Do You Exercise? Y N P

What Type? _____

How Often? _____

How Many Hours? _____

Do You Watch TV? Y N P Hours each day _____

Do You Read? Y N P Hours each day _____

Take regular vacations? Y N P

Date of last vacation _____

Do you have a religious or spiritual practice? Y N P

Describe _____

Give someone you know the gift of health. Our main marketing strategy is word of mouth, so we appreciate your referrals!

****For every person that becomes a patient who is listed below, you will receive a \$10 credit towards your next appointment. Continue on the back of this sheet if needed.**

People listed below will be contacted.**

1. Name _____ Phone _____ Relationship to you _____

Reason for referring _____

2. Name _____ Phone _____ Relationship to you _____

Reason for referring _____

3. Name _____ Phone _____ Relationship to you _____

Reason for referring _____

Review of Symptoms

Please Circle All That Apply

Y = Current issue N = never had P = Past problem S = Sometimes a problem

General

Do you sleep well	Y	N	P	S
Do you wake rested	Y	N	P	S
Average 6-8 hours sleep	Y	N	P	S
Fatigue	Y	N	P	S
Enjoy your work	Y	N		S
Spend time outside	Y	N		S
Do you eat three meals daily	Y	N		S
Do you go on diets often?	Y	N	P	S
Do you eat out often?	Y	N	P	S
Use alcoholic beverages	Y	N	P	S
How much _____				
Been treated for alcoholism	Y	N		
Use tobacco	Y	N	P	S
How much _____				
If in past, how many years _____				
Use recreational drugs	Y	N	P	S
Treated for drug dependence	Y	N		

Skin

Rashes	Y	N	P	S
Itching	Y	N	P	S
Color Change	Y	N	P	S
Acne	Y	N	P	S
Eczema	Y	N	P	S
Lumps	Y	N	P	S
Hair Loss	Y	N	P	S
Other _____				

Head

Headaches	Y	N	P	S
Head Injury	Y	N	P	S
Jaw issues	Y	N	P	S
Other _____				

Neck

Lumps	Y	N	P	S
Swollen Glands	Y	N	P	S
Goiter	Y	N	P	S
Pain or Stiffness	Y	N	P	S
Other _____				

Eyes

Impaired Vision	Y	N	P	S
Glasses or Contacts	Y	N	P	S
Eye Pain	Y	N	P	S
Tearing	Y	N	P	S
Dryness	Y	N	P	S
Double Vision	Y	N	P	S
Glaucoma	Y	N	P	S
Cataracts	Y	N	P	S
Other _____				

Ears

Impaired hearing	Y	N	P	S
Ringing	Y	N	P	S
Earaches	Y	N	P	S
Dizziness	Y	N	P	S
Other _____				

Nose and Mouth

Frequent Colds	Y	N	P	S
Sore Tongue	Y	N	P	S
Hoarseness	Y	N	P	S
Gum Problems	Y	N	P	S
Tooth Problems	Y	N	P	S
Sinus Problems	Y	N	P	S
Other _____				

Respiratory

Cough	Y	N	P	S
Excess Sputum	Y	N	P	S
Spitting up Blood	Y	N	P	S
Wheezing	Y	N	P	S
Asthma	Y	N	P	S
Bronchitis	Y	N	P	S
Pneumonia	Y	N	P	S
Pleurisy	Y	N	P	S
Emphysema	Y	N	P	S
Difficulty Breathing	Y	N	P	S
Pain with Breathing	Y	N	P	S
Shortness of Breath	Y	N	P	S
Lying down	Y	N	P	S
Tuberculosis	Y	N	P	S

Shortness of Breath	Y	N	P
At night	Y	N	P
Lying down	Y	N	P
Tuberculosis	Y	N	P

Cardiovascular

High Blood Pressure	Y	N	P	S
Heart Disease	Y	N	P	S
Angina	Y	N	P	S
Chest Pain	Y	N	P	S
Murmurs	Y	N	P	S
Rheumatic Fever	Y	N	P	S
Swelling in ankles	Y	N	P	S
Palpitations, Fluttering	Y	N	P	S
Other _____				

Gastrointestinal

Trouble Swallowing	Y	N	P	S
Heartburn	Y	N	P	S
Change in Thirst	Y	N	P	S
Change in Appetite	Y	N	P	S
Nausea	Y	N	P	S
Vomiting	Y	N	P	S
Vomiting Blood	Y	N	P	S
Bowel Movements				
How frequent? _____				
Is this a change	Y	N		
Blood in Stool	Y	N	P	S
Belching or passing gas	Y	N	P	S
Jaundice (yellow skin)	Y	N	P	S
Liver Disease	Y	N	P	S
Gall Bladder Disease	Y	N	P	S
Ulcer	Y	N	P	S
Hemorrhoids	Y	N	P	S
Other _____				

Urinary

Pain on Urination	Y	N	P	S
Increased Frequency	Y	N	P	S
Frequency at Night	Y	N	P	S
Inability to hold urine	Y	N	P	S
Frequent Infections	Y	N	P	S
Kidney Stones	Y	N	P	S
Other _____				

Sexual Orientation**Female Reproductive**

Age of 1st Menses _____				
Last Menses (if menopausal) _____				
Duration of Menses _____				
Length of Cycle _____				
Regular Cycles	Y	N		S
Bleeding Between Periods	Y	N	P	S
Painful Menses	Y	N	P	S
Excessive Flow	Y	N	P	S
Vaginal problems	Y	N	P	S
PMS Symptoms	Y	N	P	S
Pain with Intercourse	Y	N	P	S
Menopausal Symptoms	Y	N	P	S
Currently Sexually Active	Y	N	P	S
Birth Control	Y	N		S
What Type? _____				
Sexual Difficulties	Y	N	P	S
Sexually Transmitted Disease	Y	N	P	S
Number of Pregnancies _____				
Number of Live Births _____				
Number of Miscarriages _____				
Number of Abortions _____				
Difficulty Conceiving	Y	N	P	S
Other _____				

Breasts

Do You Self Examine	Y	N	P	S
Lumps	Y	N	P	S
Pain (or Tenderness)	Y	N	P	S
Nipple discharge	Y	N	P	S
Other _____				

Male Reproductive

Hernias	Y	N	P	S
Testicular Masses	Y	N	P	S
Testicular Pain	Y	N	P	S
Penis problems	Y	N	P	S
Discharge or Sores	Y	N	P	S
Prostate Disease	Y	N	P	S
Currently Sexually Active	Y	N	P	S
Birth Control?	Y	N		S
What Type? _____				

Sexual Difficulties Y N P S
 Premature Ejaculation Y N P S
 Sexually Transmitted Disease Y N P S
 Other _____

Musculoskeletal

Joint Pain or Stiffness Y N P S
 Arthritis Y N P S
 Broken Bones Y N P S
 Muscle Spasms Y N P S
 Weakness Y N P S
 Sciatica Y N P S
 Other _____

Neurologic

Fainting Y N P S
 Seizures Y N P S
 Paralysis Y N P S
 Muscle Weakness Y N P S
 Numbness/Tingling Y N P S
 Loss of Memory Y N P S
 Other _____

Peripheral Vascular

Deep Leg Pain Y N P S
 Cold Hands and Feet Y N P S
 Varicose Veins Y N P S
 Thrombophlebitis Y N P S
 Other _____

Mental/Emotional

Treated for emotional issue Y N P
 Depression Y N P S
 Mood Swings Y N P S
 Anxiety Y N P S
 Tension Y N P S
 Easily Stressed Y N P S
 Memory Problems Y N P S
 Brain Fog Y N P S
 Poor Concentration Y N P S
 Other _____

Endocrine

Hypothyroid Y N P S
 Heat/Cold Intolerance Y N P S

Excessive Thirst Y N P S
 Excessive Hunger Y N P S
 Other _____

Blood

Anemia Y N P S
 Easy Bleeding or Bruising Y N P S
 Other _____

Immune

Reactions to immunizations Y N P S
 Chronically swollen glands Y N P S
 Slow wound healing Y N P S
 Chronic fatigue syndrome Y N P S
 Chronic infections Y N P S
 Night sweats Y N P S

*Thank you for your time and
 patience in filling out these forms.
 I look forward to working with you
 on your journey through health & life...*

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that *you identify* who are involved in your health care or health care bills.
- To protect the public’s health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

Please do not phone me at home. Use this alternate phone number: _____

Please do not phone me at work. Use this alternate phone number: _____

Please do not leave messages on my answering machine.

Please do not contact me by email.

Please send mail, including my bills, to this alternate address: _____

 Other request (please describe): _____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Patient Signature (Parent/guardian signature if minor)

_____/_____/_____
Date

PAYMENT AGREEMENT

Dear New Patient,

Welcome to Dr. Wiles Goss Natural Health. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care.

Please **read and initial** the following statements:

_____ Payment for all services, tests, and medicinary items is due at the time of service. We accept cash, checks, Visa and MasterCard. Returned checks will be subject to a \$35.00 NSF fee.

_____ We use a variety of nutritional supplements, homeopathic remedies, and botanical medicines. Once these products leave our office, we cannot bear responsibility for their storage or their use. For the health and safety of our patients, we cannot accept returns on any medicinary products.

_____ We only accept certain insurance plans at this time. If your plan has out-of-network naturopathic coverage, we will happily provide all the appropriate coding and documentation to submit to the insurance provider.

_____ Your health care provider may prescribe medication, which may be purchased at the clinic or elsewhere. Your insurance company may not cover the medicinary items that are prescribed.

_____ To provide you with the most comprehensive care, we must set aside large blocks of time for your treatments. Please understand that you will be charged a missed appointment fee of \$50.00 for any missed appointments or late cancellations (less then 24 hours notice).

I have read and understand the above-stated policies of Dr. Wiles Goss Natural Health, LLC and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ Date ____/____/_____
Patient Signature (Parent/guardian signature if minor)