Beautiful Body Med-Spa, Inc.

Dr. Karla Alberts, NMD
15425 N. Greenway-Hayden Loop, Suite A200
Scottsdale, AZ 85260

T: 480-247-8660
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NEW PATIENT INTAKE

Name____

Date of Birth _________/__________/__________ **Age**________ **Gender**_____

Street Address ____

City_____________________________________ **State**_______ **Zip**_________

Phone (Home) ____________________ (Cell)______________________ (Work)__________________

E-mail Address ____

Social Security Number (used for insurance purposes) ____________________________________

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

*__Friend Referral__ ____

*__Social Media__ (Please indicate which version you used to find out about our office)

____**Facebook** ____**Twitter** ____**Website** _____**Other (please specify below)**

____

EMERGENCY CONTACT

Name ____ **Phone** __________________

Relationship to you ____

Beautiful Body Med-Spa

Patient Name:______________________________ **DOB:**____________________

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:	________	________	________	________	________	________
Age when died:	________	________	________	________	________	________
Reason for death:	________	________	________	________	________	________
CANCER TYPE (if had):						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1) ______________________________ 4) ______________________________

2) ______________________________ 5) ______________________________

3) ______________________________ 6) ______________________________

Please Note When & Why You Have Had Each of the Following:

X-Rays: ______________________________ MRI/Cat Scans: ______________________________

Ultrasounds: ______________________________ Accidents: ______________________________

TB Test: ______________________________ HCV: ______________________________

HIV: ______________________________ Last Dental Visit: ______________________________

Last Eye Exam: ______________________________

Did you have the following **D**isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**):

Measles: D I N **Chicken Pox:** D I N **Mumps:** D I N **Rubella:** D I N

Tetanus: D I N **Whooping Cough:** D I N **Hemophilus (Hib):** D I N **Hepatits B:** D I N

German Measles: D I N **Any vaccination reactions:** ______________________________

Patient Name: ____ **DOB:** ____________

List **Yes (Y)**, **No (N)** or **Past (P)** regarding use of the following:

Antacids: Y N P **Steroids:** Y N P **Smoking:** Y N P **Packs per day & number of years:** ____________
Analgesics: Y N P **Laxatives:** Y N P **Coffee:** Y N P **Cups per day if Yes/Past:** ________________
Soda Pop: Y N P **Ounces per day if Yes/Past:** ____________
Alcohol: Y N P **How often & how much if Yes/Past:** ________
Any Alcohol Addiction: Y N P **Any Alcohol Treatment:** Y N P
Recreational Drugs: Y N P **Any Drug Addictions:** Y N P
Any Drug Treatment: Y N P

List all Prescription Medicines that you are taking and include dosage if known

____

____

____

Review of Systems:

Present Weight: ____________**Weight one month ago:**____________**Weight one year ago:**______________ **Height:** __________
Maximum weight and when: __________ **Minimum weight as adult & when:** ______________________________
Ideal Weight: ________________

REGARDING THE NEXT LONG SECTION: Please circle **(Y)** if you have the problem **NOW**, **(N)** if you've **NEVER** had the problem, **(P)** if you had the problem in the **PAST**.

Do you have Good Energy? Y N P
Are you fatigued now? Y N P
If you have fatigue, when in morning, afternoon, evening is it the worst? ______________________________
If you have fatigue, can you do what you need to during the day? Y N

		SKIN		
Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
Cancer of the skin:	Y N P		**Perspiration:**	Y N P
		HEAD		
Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
Oil/dry hair:	Y N P		**Hair loss:**	Y N P
		NOSE		
Frequent Colds:	Y N P		**Nosebleeds:**	Y N P
Congestion:	Y N P		**Post Nasal Drip:**	Y N P
Polyps:	Y N P		**Seasonal Allergies:**	Y N P

Patient Name: ______________________________ DOB: __________

EYES			
Dry/Watery:	Y N P	Blurry Vision:	Y N P
Double Vision	Y N P	Cataracts:	Y N P
Glaucoma:	Y N P	Styes:	Y N P
Strain:	Y N P	Discharge:	Y N P
Itchy:	Y N P	Dark under Eyelid:	Y N P
MOUTH/THROAT			
Canker sores:	Y N P	Cold sores:	Y N P
Sore Throat:	Y N P	Gum disease:	Y N P
Dentures:	Y N P	Cavities:	Y N P
Loss of taste:	Y N P	Hoarseness:	Y N P
NECK			
Stiffness:	Y N P	Swollen Glands:	Y N P
Full movement:	Y N P	Tension:	Y N P
RESPIRATORY			
Cough:	Y N P	TB:	Y N P
Shortness of breath w/ exertion:	Y N P	Bronchitis:	Y N P
Shortness of breath sitting:	Y N P	Pneumonia:	Y N P
Shortness of breath lying down:	Y N P	Asthma:	Y N P
Wheezing:	Y N P	Painful breathing:	Y N P
CARDIOVASCULAR			
High Blood Pressure:	Y N P	Rheumatic Fever:	Y N P
Low Blood Pressure	Y N P	Murmurs:	Y N P
Arrhythmias:	Y N P	Palpitations:	Y N P
Edema:	Y N P	Chest Pain:	Y N P
URINARY TRACT			
Incontinence:	Y N P	Pain w/ Urination	Y N P
Frequent Infections:	Y N P	Kidney Stones	Y N P
Urgency:	Y N P	Discharge/Blood:	Y N P
GASTROINTESTINAL			
Heartburn:	Y N P	Bowel Movement Freq:	
Indigestion:	Y N P	Recent BM Change:	Y N P
Bloating:	Y N P	Diarrhea/Constipation:	Y N P
Nausea:	Y N P	Hemorrhoids:	Y N P
Vomiting:	Y N P	Gall Bladder Disease	Y N P
Change in Appetite:	Y N P	Liver Disease:	Y N P
Pancreatitis:	Y N P	Ulcer	Y N P

Patient Name: ______________________ DOB: ____________

		MALE GENITALIA		
Testicular pain/swelling:	Y N P		Sexually Active:	Y N P
Hernia:	Y N P		S.T.D.:	Y N P
Discharge:	Y N P		Prostate Disease/Symptoms:	Y N P
Impotency:	Y N P		Sexual Orientation:	Hetero Homo Bi

		FEMALE GENITALIA		
Age Period Began:			How Often Period Occurs:	
How long period lasts:			Heavy menstrual bleeding:	Y N P
Menstrual cramping:	Y N P		Menstrual Pain:	Y N P
PMS:	Y N P		Food cravings:	Y N P
Times Pregnant:			How many births:	
Miscarriages:			Abortions:	
Last Pap Smear:			Diagnosis:	
Any abnormal paps:	Y N P		When was abnormal:	
Menopausal since what age:			Use of hormones:	Y N P
Type of hormones used:			Healthy libido:	Y N P
Dry vagina:	Y N P		Sexually Active:	Y N P
Pain w/ Intercourse:	Y N P		Vaginitis:	Y N P
S.T.D.:	Y N P		Mammography:	Y N P
Sexual orientation (circle)	Hetero Homo Bi		If Yes, what were results:	

Please list any birth control used and ages used: ______________________________

		MUSCULOSKELETAL		
Weakness:	Y N P		Arthritis:	Y N P
Stiffness:	Y N P		Leg Cramps:	Y N P
Tremors:	Y N P		Pain:	Y N P

		NERVOUS		
Paralysis:	Y N P		Sciatica:	Y N P
Tingling/numbness:	Y N P		Carpal tunnel syndrome:	Y N P
Seizures:	Y N P		Fainting:	Y N P

		Mental/Emotional		
Depression:	Y N P		Anger/irritability:	Y N P
Suicidal:	Y N P		High-strung/tense:	Y N P
Anxiety:	Y N P		Fear/Panic	Y N P
Eating disorder:	Y N P		Psych Hospitalization:	Y N P

Patient Name: ______________________________ DOB: __________

Exercise

How often do you exercise? __________ What type of exercise? __________
For how long? __________ Hobbies: __________

Sleep

How long per night? __________ If you wake up frequently, what is the reason? __________
Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P
Sleep walk: Y N P Grind teeth: Y N P Snore: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? __________
Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? __________

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? __________
Are you particularly sensitive to perfumes, gasoline or other vapors? __________
Do you use pesticides, herbicides or other chemicals around your home? __________

Social Life

Enjoy job: Y N P Hours worked per week: __________ Highest Level of Education: __________
Active spiritual practice: Y N P Quality of significant relationship: __________
History of sexual, mental/emotional, physical abuse: Y N P If so, at what age and by whom: __________
What is your greatest health concern: __________
How does it limit you the most: __________
How committed are you towards making valuable changes: Little Moderately Very

Typical Day's Diet

Breakfast: __________
Lunch: __________
Dinner: __________
Snacks: __________

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CLINIC FEE AGREEMENT

Please read Items A-F carefully and initial where indicated

A. Dr. Briana Cain, Dr. Rebecca Miller, and Dr. Karla Alberts are currently classified as out-of-network providers for all insurance companies. In order to potentially have insurance coverage for Dr. Cain's and Dr. Miller's services, your insurance plan needs to have **out-of-nework coverage and you must have satisfied the deductible**. 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. Cain's/Dr. Miller's/Dr. Alberts' fee is normally **$100-$200 for New Patient appointments**, and **$50-$125 for follow-up appointments (billed at $200/hour)**. These fees vary depending on time spent in the appointment and complexity. There will be separate costs for certain procedures, supplements, IV therapies, injections, lab work and diagnostic testing. Phone consultations will be billed at the same rates mentioned above. Brief phone calls or emails to answer questions or discuss treatment protocols will not be billed.

____________ **(initial)**

C. We require a 24-hour advance notice to cancel appointments. If you do not show up for a scheduled appointment, you will be billed **$25**.

____________ **(initial)**

D. **IV THERAPY**

The IV therapies already include Dr. Cain's/Dr. Miller's/Dr. Alberts' time and you **will not** be billed for their time twice. The following are the charges for IV's:

- Nutritional/Hydration/Vitamin C IV's - **$150-$225**
- DMPS Chelation (Heavy Metals Testing/Removal) - **$75**
- Glutathione (Detoxification) IV Push - **$45**

IV'S ARE MADE PRIOR TO CLIENT ARRIVAL. ALL CLIENTS WILL BE HELD FINANCIALLY RESPONSIBLE FOR THE FULL IV COST AND $25 NO SHOW FEE IF APPOINTMENT IS MISSED.

____________ **(initial)**

E. **INJECTABLE THERAPIES/OTHER**

- B-12/Iron/Testosterone injection **- $20**
- Acupuncture **- $85** (new patients); **$50** (follow ups)

____________ **(initial)**

F. **PAYMENT IS DUE AT THE TIME OF SERVICE**

____________ **(initial)**

____ __________________________

Client Signature Date

By signing, I agree to the above terms as outlined.

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INFORMED CONSENT

Welcome to Beautiful Body Med-Spa and the medical practice of Dr. Briana Cain, NDM, Dr. Rebecca Miller, NMD, and Dr. Karla Alberts, NMD.

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, injections, mesotherapy injections, cosmetic 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.

____ ____________________________
Patient Signature Date

____
Print Name

____ ____________________________
Doctor's Signature Date