Good Tree Natural Health, LLC
Dr. Carmen Jones, ND

Welcome!

Congratulations on taking steps for better health!
I am excited to meet you and discuss your health concerns. My goals for you begin with getting to the root cause of your health concerns and identify the organ systems involved, so we can begin to address the imbalances you have and begin your journey to optimal wellness!

You will find the following items included.

1) New intake form
2) Patient Information form
3) Privacy Practices (for you to keep for your records)
4) Consent Form

Please have these forms filled out **prior** to our visit.
If possible, please send me your forms 1 week prior to our appointment.
You can scan them and send via email to info@DrCarmenJones.com or via mail to
Dr. Carmen Jones 501 E 9th St, Ada, OK 74820

This will help me to focus on your specific concerns and help to connect the dots as to what organ systems are involved to help determine the root cause of your health concerns, so we can make the most of our time together during your appointment.

Please bring this packet and any current labs or imaging you've had done in the last 12 months to your first visit.

My main office is located at 501 E 9th St Ada, Ok 74820. It is a white house on the corner with a welcome flag on the porch.

I look forward to our appointment and your journey to optimal wellness!

Dr. Carmen Jones

Good Tree Natural Health, LLC
Dr. Carmen Jones, ND

Initial Consult Intake Form

Date: _____

Patient Name: _____ **DOB:** _____Age:_____

List your health concerns in order of importance:

1) _____
2) _____
3) _____
4) _____
5) _____

Name and telephone number of Primary Care physician: _____

_____

Last Time you had blood work done and with what doctor: _____

Family History										
	Father		**Mother**		**Siblings**		**Grandparents**		**Spouse**	**Children**
Age if living:										
Age when died:										
Reason for death:										
Cancer type:										
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) _____

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Patient Name: _____ **DOB:** _____

Medical History

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 **Hemophilus (Hib)**: D I N
Rubella: D I N **Tetanus**: D I N **Whooping Cough**: D I N
Mumps: D I N **Hepatitis B**: D I N
Any vaccination reactions: _____

Allergies

List all known Allergies (Sensitivities/Allergies/Reactions)

Drugs: _____
Foods: _____
Environment: _____

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**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 & Nutrient Supplement/Herbs that you are taking and including dosage:

_____

_____

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Patient Name: _____ **DOB:** _____

Review of Systems:

Present Weight: _____ **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**.

Good Energy: Y N P

Fatigue: 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:	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
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
		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

Decreased Smell	Y N P	**Nasal Fracture:**	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
		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
		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

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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**	
Full movement:	Y N P		**Tension:**	Y N P

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:			Sexual Orientation:	
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
Bone Density Test:	Y N P		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/ Dizzy:	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

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Patient Name: _____ **DOB:** _____

Social History

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

What is your greatest health concern: _____

How does it limit you the most: _____

How committed are you towards making valuable changes: Little Moderately Very

Additional Information

Please list any additional information/topics which you believe is important we address during your office visit:

_____

_____

_____

Good Tree Natural Health, LLC
Dr. Carmen Jones, ND
Confidential Patient Information

Today's Date: _____

Name:_____ ____ ___/___/___
(Last) (First) (Sex) (Date of birth)

Mailing. Address: _____ City: _____ State: ____ Zip: _____

Home Phone : _____ Cell Phone: _____ Phone Work: _____

Email Address: _____ ☐ I give permission to communicate over email

Drivers License # _____ State: _____

How did you hear of us?

Friends:_____(name for referral discount) Health Food Store:_____ Internet:_____Sign:_____

Were you referred by another physician: ☐ Yes ☐ No

Referring Physician's Name: _____ Phone: _____

Address, City, State, Zip: _____

Who is your current Physician: _____ Phone: _____

Employer: _____ Occupation:_____ Phone: _____

Employer Address: _____ City: _____ State: ____ Zip: _____

Nearest relative not living with you: _____Relation: _____ Phone:_____

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

Name of Spouse (or parent for minor child): _____

Emergency Contact: _____ Relationship to you: _____ Phone: _____

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Clinic Policy requires payment at time of services.
Please make checks payable to Good Tree Natural Health

_____ _____ _____
Patient's Signature **Parent or Guardian's Signature** **Date**

_____ _____

Good Tree Natural Health, LLC
Dr. Carmen Jones, ND
NOTICE OF PRIVACY PRACTICE

Keep for your records

To our clients: This notice describes how health information about you, as a client of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose you health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have a right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family

members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including client medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to
   Good Tree Natural Health, LLC, Dr. Carmen Jones, PO Box 101, Paoli, OK 73074

4. Note: We must respond to this request within 30 days.
   You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, you request must be made in writing and submitted to Good Tree Natural Health, LLC, Dr. Carmen Jones, PO Box 101,Paoli, OK 73074

5. You must provide us with a reason that supports your request for amendment.

   Note: We must respond within 60 days. The Privacy Officer or the client's doctor will usually do this. If the doctor believes the information is complete and accurate, the doctor can refuse to make any changes.

6. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact office manager.

7. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager at Good Tree Natural Health, LLC All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Good Tree Natural Health, LLC
Dr. Carmen Jones, ND
CONSENT FORM

Patient Name: _____ Date of Birth: _____

- I voluntarily consent to naturopathic outpatient care with Good Tree Natural Health, encompassing a thorough history and interviews, review of medical records, labs, and diagnostic tests, but not limited to laboratory work (such as blood, urine and other studies), and suggestions of recommendation options by a naturopathic medical health consultant.
- I understand that Oklahoma/Arkansas does not YET license Naturopathic Doctors, but that Dr. Carmen Jones holds a doctorate degree of Naturopathic Medicine and medical license in Arizona. Therefore, Good Tree Natural Health cannot diagnose or treat my health issues. I understand and welcome recommendations and suggestions from Dr. Carmen Jones to address my health concerns.
- I understand that not ALL of the recommendations and suggestions provided are accepted by the United States FDA and therefore should not be taken as such.
- I understand that this consent form will be valid and remain in effect as long as I receive naturopathic care with Good Tree Natural Health and Carmen Jones, ND.

This form has been explained to me and I fully understand this *Consent To Care* and agree to its contents.

Signature :_____Date:_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to view it.

Name: _____ Birthdate:_____

Signature: _____ Date: _____

****

If the patient is a minor or is unable to consent, please complete the following:

- Patient is a minor and is _____ years of age.

Name of Father _____ Name of Mother _____

- Patient is unable to consent because_____

_____ _____

Signature of Closest Relative or Legal Guardian Please Print Name

Relationship: _____