Welcome to Newport Integrative Health!

Our goal is to provide you with the highest level of personalized care. We are committed to helping you on your path to health and healing.

It is important to read all the enclosed information carefully. You may mail, fax, or email completed forms prior to your appointment. This will allow Dr Siani to help solve your problems more efficiently and enhance the quality of your care. Alternatively you may bring the forms in with you to your first appointment.

Your initial consultation with Dr Siani will be a 60 minute visit. During this visit Dr Siani will incorporate and discuss any necessary laboratory/diagnostic testing she may think is necessary in order to design your personal health care program as well as uncover the root causes of your medical condition. Nutritional supplements are often recommended and Dr Siani will help you select and find the highest quality products. Follow up appointments to review lab results or treatment programs are 30 minutes visits.

Jessica Siani ND does not accept insurance or Medicare and we cannot assure you that services will be reimbursed. You will be provided with diagnosis and procedure codes to assist you with possible insurance reimbursement. Laboratory tests may or may not be covered, which will depend on your particular insurance plan.

We encourage your questions and participation in all aspects of your care. We are looking forward to meeting you and providing you with naturopathic health care.

In Health,

Dr Jessica Siani ND

Newport Integrative Health
1831 Orange Ave, Suite A
Costa Mesa, CA 92627

P: 949.574.4978
F: 949.574.9854
Web: NPIhealth.com

IMPORTANT PATIENT INFORMATION AND CLINIC POLICIES

Please read and initial the following statements:

_____ Payment for all services and dispensary items is due at the time of the visit. Initial consultation with Dr Siani is $300 for 60 minutes. Follow-up appointments in person or by phone are $150 for 30 minutes. We accept cash, checks, Visa and MasterCard. Returned checks will be subject to a $35.00 NSF fee.

_____ We do not bill your insurance or Medicare for your naturopathic care and we cannot assure you that services (office visits, phone consultations or lab tests) will be reimbursed. You will be provided with diagnosis and procedure codes to assist you with possible insurance reimbursement. Your insurance provider may reimburse you for some or the entire fee at their discretion. Laboratory tests may or may not be covered, this will depend on your particular insurance plan.

_____ There is no charge for reasonable patient portal messaging or phone calls. For non urgent matters that would be best attended to during an appointment Dr Siani will request you schedule and appointment or hold your question until your next appointment (this generally applies to questions that change the course of care or take longer than 5 minutes to respond to either by phone or messaging).

_____ In fairness to our patients and to our practitioners our office has a twenty-four hour cancellation policy. You will be charged a Missed Appointment Fee of $50.00 for any missed appointments or late cancellations (less then 48 hours notice).

_____ Lab testing may be ordered during your visit with Dr Siani. Fees for such tests are billed directly by the lab to the patient. In many cases, the lab will work directly with the patient's insurance care provider. Some lab tests take up to 5 weeks to be finalized and sent to the office, Dr Siani cannot guarantee turn-around time on laboratory testing. Dr Siani does not mark up or profit in any way from the sale of lab testing kits that she orders for her patients.

_____ Any therapy, no matter how well appointed, may fail to resolve your symptoms and improve your health. Dr Siani makes no claim of cure for any condition. You have the choice to accept, refuse or terminate therapy at any time. By agreeing to make every effort to implement an agreed upon program, you will receive the full benefit of your visits with Dr. Siani. You are responsible for seeking professional medical attention from Dr. Siani or another facility for a worsening of your condition. You are aware that many medical conditions require additional treatment and that follow-up visits are often necessary. You are aware that you may be referred to another physician for treatment when needed.

_____ Nutritional supplements are available for patient convenience at Newport Integrative Health. Patients are under no obligation to purchase their supplements at the office. Newport Integrative Health will ship supplements to your home at standard shipping fees. Return policy: all sales are final. We are unable to return any supplements.

_____ Dr Siani does not maintain regular call on the evenings and weekends. If you have a non-urgent question please call during clinic hours or use the patient portal to direct message Dr Siani or call and leave a message at the office and she will respond to your question during the work week.

_____ In the event of an emergency you are responsible to obtain medical attention, call 911 or go to the nearest emergency room.

I have read and understand the above-stated policies of Dr Jessica Siani and will comply with them in all respects.

_____

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

_____ _____/_____/_____

Patient Signature (Parent/guardian signature if minor) Date

Consent for Naturopathic Treatment

Dr. Jessica Siani ND
1831 Orange Ave., #A
Costa Mesa, CA 92627
Tel: 949.574.4978
Fax: 949.574.9854

I, _____ (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not. I have also read and understand the attached NOTICE OF PRIVACY PRACTICES, which discusses my rights under the Health Insurance Portability and Accountability Act of 1996.

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act, which may include but are not limited to nutritional counseling, western herbs, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections, and IV therapy.

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements because they may be toxic when taken in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat the medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.

I have read, or have had read to me, the above information and I consent. I have also had an opportunity to ask questions about the consents content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME, (printed) _____

PATIENT SIGNATURE _____ Date: _____
(or Patient Representative)

Indicate relationship if signing on behalf of patient _____

You are entitled to a copy of this consent after you sign it.
Please ask our staff for a copy if you want a copy

TeleHealth Consent Form

Patient Name _____ DOB _____

"TeleHealth" means that you may be evaluated and treated by a health care provider from a distant location via electronic communication. The information may be used for diagnosis, therapy, follow-up, and/or education, and may include any of the following: patient medical records, medical images, live two-way audio and video, and/or output data from medical devices and sound and video files.
Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- The consulting health care provider will be at a different location from me. Additional medical or registration personnel may also be present in the room with the Provider.
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation.
- I understand that I may be released before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care.
- I understand that payment will be collected at the time of service.

Authorizations

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

- By signing below, I am granting permission to Jessica Siani ND to perform and administer care and treatment of the patient via telehealth.
- Grants permission to release to third party payor(s) (such as private insurance companies), their representatives, and/or other physician(s) involved in the patient's care, any information needed in connection with all care rendered to patient. (For example laboratory testing or imaging recommended at the appointment then performed for which the patient is submitting the lab/imaging fee to insurance)
- If the patient is under the age of 18 or lacks capacity, the signing party affirms that they are either the parent or legal guardian of such patient and has full legal authority to seek medical assistance on behalf of the patient.

Printed Name of Signer_____

Relationship to Patient _____

Signature _____Date _____

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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): _____

Email Communication: Dr. Siani often utilizes email to correspond with her clients and other physicians regarding her clients. However, such email correspondences are not secure. They could theoretically be intercepted, read and information could be misused. I understand that such communications are not secure and hereby release Dr. Siani from any responsibility or liability in connection with using unsecured email for communication. I understand that I can choose not to provide an email address or to request, in writing, that my email be removed from my file and Dr. Siani will no longer use email correspondence with me. Regardless, if at any time I email a question to Dr. Siani, I hereby authorize a reply via unsecured email and agree not to hold Dr. Siani responsible for any interception or misuse of such information.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available upon request. We encourage you to read it carefully before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices at any time by contacting:

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I have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

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

_____ _____/_____/_____
Patient Signature Date

Doctor-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the doctor including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the doctor, and the doctor's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the doctor to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the doctor within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered at any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services. _____ Patient Initials

If any provision if this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____

Signature Authorized Provider Representative

_____ _____

Date Date

If this consent is signed by a personal representative on behalf of the patient complete the following:

Personal representative's name: _____Relationship to patient: _____

A signed copy of this document is to be given to Patient
Original is to be filed in Patient's medical records

DR. JESSICA SIANI, ND
1831 Orange Ave, Suite A Costa Mesa, CA 92627
P: 949.574.4978 F: 949.574.9854
Web: NPIHEALTH.COM

Patient Intake

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # (home): _____(cell):_____ (work): _____

Email address: _____ Age: _____Date of Birth: _____ Gender: F / M

Married:_____ Separated:_____ Divorced:_____ Widowed:_____ Single:_____ Partnership:_____

Live with: Spouse:_____ Partner:_____ Parents:_____ Children:_____ Friends:_____ Alone:_____

Occupation: _____ Hours per week: _____

Employer Name and Address: _____

Insurance Provider: _____ Type: HMO / PPO

How did you hear about this clinic? Who may we thank for your referral? _____

Google search Brochure Public health talk Yelp

Has any other family member already been a patient at this clinic? _____

Emergency contact: _____ Relationship: _____

Phone: _____ Address: _____

_____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

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What motivated you to choose this clinic?

What do you know about our approach?

What three expectations do you have from this visit with us?

What long term expectations do you have from working with us?

What expectations do you have of us personally as your health care providers?

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

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

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 self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

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CURRENT HEALTH HISTORY

Are you currently receiving healthcare? Yes / No

If yes, where and from whom? _____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

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	

Any other relevant family history? _____

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

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ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

CURRENT MEDICATIONS AND SUPPLEMENTS

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

GENERAL

Height: _____ Weight: _____ Weight one year ago: _____

Maximum Weight: _____ When: _____

When during the day is your energy the best? _____ Worst? _____

Exercise: Y / N If so, what kind and how often: _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Number of servings per week: Fish_____ Red meat_____ Chicken_____ Alcohol_____

Number of servings per day: Vegetables_____ Fruit_____ Caffeine_____ Water_____

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FOR THE FOLLOWING, PLEASE CIRCLE:

Y=yes/condition you have now **N**=no/never had **P**=problem in the past **S**=sometimes a problem now

GENERAL

Do you sleep well?	Y	N	P	S
Average 6-8 hours?	Y	N	P	S
Awake rested?	Y	N	P	S
Have a supportive relationship?	Y	N	P	S
Have a history of abuse?	Y	N	P	S
Experienced a major trauma?	Y	N	P	S
Use recreational drugs?	Y	N	P	S
Treated for drug dependence?	Y	N	P	S
Use alcoholic beverages?	Y	N	P	S
Use tobacco?	Y	N	P	S
If in the past, how many years? _____				
How many packs per day? _____				
Do you enjoy your work?	Y	N	P	S
Take vacations?	Y	N	P	S
Spend time outside?	Y	N	P	S
Eat three meals a day?	Y	N	P	S
Do you go on diets often?	Y	N	P	S
Do you eat out often?	Y	N	P	S
Do you drink coffee?	Y	N	P	S
Drink black/green tea?	Y	N	P	S
Drink soda?	Y	N	P	S
Do you eat refined sugar?	Y	N	P	S
Do you add salt to your food?	Y	N	P	S

NEUROLOGIC

Seizures?	Y	N	P	S
Muscle weakness?	Y	N	P	S
Loss of memory?	Y	N	P	S
Vertigo or dizziness?	Y	N	P	S
Paralysis?	Y	N	P	S
Numbness or tingling?	Y	N	P	S
Easily stressed?	Y	N	P	S
Loss of balance?	Y	N	P	S

ENDOCRINE

Hypothyroid?	Y	N	P	S
Hypoglycemia?	Y	N	P	S
Excessive thirst?	Y	N	P	S
Fatigue?	Y	N	P	S

ENDOCRINE CONT.

Heat or cold intolerance?	Y	N	P	S
Hyperthyroid?	Y	N	P	S
Diabetes?	Y	N	P	S
Excessive hunger?	Y	N	P	S
Seasonal depression?	Y	N	P	S
Difficulty exercising?	Y	N	P	S

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

EARS

Impaired hearing?	Y	N	P	S
Ringing in ears?	Y	N	P	S
Dizziness?	Y	N	P	S
Ear aches?	Y	N	P	S

EYES

Impaired vision?	Y	N	P	S
Cataracts?	Y	N	P	S
Glaucoma?	Y	N	P	S
Spots in vision?	Y	N	P	S
Color blindness?	Y	N	P	S
Tearing or dryness?	Y	N	P	S
Eye pain or strain?	Y	N	P	S

HEAD

Headaches?	Y	N	P	S
Migraines?	Y	N	P	S
Head injury?	Y	N	P	S
Jaw or TMJ problems?	Y	N	P	S

NOSE AND SINUS

Frequent colds?	Y	N	P	S
Stuffiness?	Y	N	P	S

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NOSE AND SINUS CONT.

Sinus problems?	Y	N	P	S
Nose bleeds?	Y	N	P	S
Hayfever?	Y	N	P	S
Loss of smell?	Y	N	P	S

NECK

Lumps in neck?	Y	N	P	S
Goiter?	Y	N	P	S
Difficulty swallowing?	Y	N	P	S
Pain or stiffness in neck?	Y	N	P	S

MOUTH AND THROAT

Frequent sore throat?	Y	N	P	S
Copious saliva?	Y	N	P	S
Sore tongue or lips?	Y	N	P	S
Hoarseness?	Y	N	P	S
Jaw clicks?	Y	N	P	S
Teeth grinding?	Y	N	P	S
Gum problems?	Y	N	P	S
Dental cavities?	Y	N	P	S

SKIN

Rashes?	Y	N	P	S
Acne/boils?	Y	N	P	S
Change in skin color?	Y	N	P	S
Lumps or bumps on skin?	Y	N	P	S
Eczema or hives?	Y	N	P	S
Itching?	Y	N	P	S
Perpetual hair loss?	Y	N	P	S

RESPIRATORY

Cough?	Y	N	P	S
Sputum?	Y	N	P	S
Asthma?	Y	N	P	S
Wheezing?	Y	N	P	S
Bronchitis?	Y	N	P	S
Coughing up blood?	Y	N	P	S
Shortness of breath?	Y	N	P	S
Shortness of breath when lying down?	Y	N	P	S
Pain in breathing?	Y	N	P	S
Emphysema?	Y	N	P	S
Tuberculosis?	Y	N	P	S

GASTROINTESTINAL

Trouble swallowing?	Y	N	P	S
Change in thirst?	Y	N	P	S
Change in appetite?	Y	N	P	S
Nausea/vomiting?	Y	N	P	S
Ulcer?	Y	N	P	S
Jaundice?	Y	N	P	S
Gall bladder disease?	Y	N	P	S
Liver disease?	Y	N	P	S
Hemorrhoids?	Y	N	P	S
Pancreatitis?	Y	N	P	S
Heartburn?	Y	N	P	S
Abdominal pain or cramps?	Y	N	P	S
Belching or passing gas?	Y	N	P	S
Constipation?	Y	N	P	S

Bowel movements: how often? _____

Is this a change?_____

Black stools?	Y	N	P	S
Blood in stools?	Y	N	P	S

MENTAL/EMOTIONAL

Treated for emotional problem?	Y	N	P	S
Depression?	Y	N	P	S
Anxiety or nervousness?	Y	N	P	S
Poor concentration?	Y	N	P	S
Do you have mood swings?	Y	N	P	S
Considered suicide?	Y	N	P	S
Attempted suicide?	Y	N	P	S
Tension?	Y	N	P	S
Memory problems?	Y	N	P	S

URINARY

Increased frequency of urination?	Y	N	P	S
Inability to hold urine?	Y	N	P	S
Pain in urination?	Y	N	P	S
Frequency at night?	Y	N	P	S
Frequent UTI's?	Y	N	P	S
Kidney stones?	Y	N	P	S

MUSCULOSKELETAL

Joint pain or stiffness?	Y	N	P	S
Arthritis?	Y	N	P	S
Broken bones?	Y	N	P	S
Weakness?	Y	N	P	S
Muscle spasms or cramps?	Y	N	P	S
Sciatica?	Y	N	P	S

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BLOOD

Anemia?	Y	N	P	S
Easy bleeding or bruising?	Y	N	P	S
Cold hands/feet?	Y	N	P	S
Deep leg pain?	Y	N	P	S
Thrombophlebitis?	Y	N	P	S
Varicose veins?	Y	N	P	S

FEMALE REPRODUCTIVE

Age of first menses:_____
Age of last menses (if menopausal):_____
Length of cycle:_____days
Duration of menses:_____days

Are your cycles regular?	Y	N	P	S
Painful menses?	Y	N	P	S
Heavy or excessive flow?	Y	N	P	S
PMS?	Y	N	P	S

Symptoms:_____
_____

Bleeding between cycles?	Y	N	P	S
Clotting?	Y	N	P	S
Endometriosis?	Y	N	P	S
Ovarian cysts?	Y	N	P	S
Vaginal odor?	Y	N	P	S
Vaginal discharge?	Y	N	P	S

Date of last pap smear:_____

Abnormal PAP?	Y	N	P	S
Cervical dysplasia?	Y	N	P	S
Are you sexually active?	Y	N	P	S

Sexual orientation:_____
Birth control? Type:_____

Pain during intercourse?	Y	N	P	S
Gonorrhea?	Y	N	P	S
Herpes?	Y	N	P	S
Chlamydia?	Y	N	P	S
Genital warts?	Y	N	P	S
Syphilis?	Y	N	P	S
Difficulty conceiving?	Y	N	P	S

Number of pregnancies:_____
Number of live births:_____
Number of miscarriages:_____
Number of abortions:_____

Do you do self breast exams?	Y	N	P	S
Breast pain/tenderness?	Y	N	P	S

FEMALE REPRODUCTIVE CONT.

Breast lumps?	Y	N	P	S
Nipple discharge?	Y	N	P	S
Menopausal symptoms?	Y	N	P	S

MALE REPRODUCTIVE

Are you sexually active?	Y	N	P	S

Sexual orientation:_____
Birth control? Type:_____

Discharge or sores?	Y	N	P	S
Chlamydia?	Y	N	P	S
Gonorrhea?	Y	N	P	S
Genital warts?	Y	N	P	S
Herpes?	Y	N	P	S
Syphilis?	Y	N	P	S
Hernias?	Y	N	P	S
Testicular masses?	Y	N	P	S
Testicular pain?	Y	N	P	S
Prostate disease?	Y	N	P	S
Impotence?	Y	N	P	S
Premature ejaculation?	Y	N	P	S

Please Write any additional information here:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____