Riverwalk Natural Health Clinic & Natural Pharmacy
Deborah A Wiancek, N.D.
280 Main St., Ste C-105 Edwards, CO 81632
970.926.7606

Name:____ DOB:________ Date:___________
Mailing address:____
City, State, Zip:____
Home Phone:____________________________ Cell Phone:_______________________
(Please Circle Answer) May we leave messages on your Home Phone? yes/no Cell phone? Yes/no

Email:__________________________________ SS#_____________________________________
Occupation:_____________________________ Gender___________________________________

Employer:______________________________________ Work Phone:________________________
Employer address:____

(Please circle the situation that applies). Single/committed relationship/Married/Divorced

In case of emergency, please contact:

Name:______________________________________ Relationship:_____________________________
Address:____ Phone:_____________________________

Insurance Information
Insurance Company Name:____
Insurance Company Address:____
Insurance Company Phone:______________________________

Name of Policy Holder:______________________________ DOB of Policy Holder:____________
Relationship of Client to Policy Holder (Please circle answer) self/ spouse/ child/ other
Policy Number:_________________________________ Group Number:____________________________

I understand that co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid for by my insurance. Please contact your insurance company directly with questions about coverage.

Signature:____ Date:_____________________________

A Note to the Client: Please complete the questionnaire as thoroughly as possible in order for the physician to have a complete picture of the client physically, mentally, and emotionally. This is a confidential record of your medical health history ad will not be released except when you have authorized me to do so. Thank you.

Present Health Concerns: Please list your current health concerns **in their order of significance** and indicate the concern that motivated you to come in today.

1.____

2.____

3.____

4.____

5.____

Personal History: Circle any of the following illness that you have had.

Mononucleosis	Asthma	Stomach Ulcer	Rheumatic Fever
Frequent lung infection	Emphysema	Colitis	Angina pectoris
Gallbladder disease	Heart Attack	Diabetes	Jaundice
Other heart disease	Tuberculosis	Hepatitis	High Blood Pressure
Cancer	Arthritis	Kidney Disease	Frequent kidney/bladder infections
Migraine Headache	Gout	Anemia	Nervous Breakdown
Thyroid Disease	Depression	Hay Fever	Sexually Transmitted Disease
Alcoholism	Other		

List all operations & approximate dates:____

____

____

List all hospitalizations (other than operations) w/ reason admitted and approximate dates:______________________

____

____

List all serious injuries (other than above) w/ approximate dates:______________________________

____

____

Family History: Fill in all that apply

	Father	**Mother**	**Brother(s)**	**Sister(s)**	**Other**
Age (if living)					
Age at death					
General Health					
Allergies					
Anemia					
Asthma					
Cancer					
Diabetes					
Epilepsy					
Glaucoma					
Heart Disease					
Hepatitis					
High Blood Pressure					
Kidney Disease					
Mental Illness					
Stroke **Other:**					

GENERAL HEALTH
Date of last physical exam ____________ dental exam___________ eye exam___________
weight_____________________________ Weight 1 year ago_____________Height_________

REVIEW OF SYSTEMS: Circle which, if any, of the following symptoms you currently have.

Dizziness
Fatigue
Headache
Insomnia
Anxiety
Appetite changes
Night sweats
Cold hands/feet
Itching
Coughing

Slow wound healing
Eye pain
Vision changes
Hearing changes
Ringing/buzzing in the ear
Earaches/discharge
Nasal discharge
Nosebleeds
Sinus problems
Frequent sore throats
Persistent hoarseness
Lump in the throat
Sore tongue or mouth

Bleeding Gums
Dental Problems
Frequent chest colds
Persistent cough
Coughing up blood
Shortness of breath
Shortness of breath at night
Irregular heart beat
Chest pain/tightness
Rashes

Blood clots/phlebitis
Abdominal discomfort
Burping
Difficulty swallowing
Indigestion/heartburn
Vomiting blood
Constipation
Diarrhea/loose stools
Change in bowel habit
Hemorrhoids
Bleeding from rectum
Black or tarry stool
Nausea

Bloating/gas
Rectal pain
Frequent urination
Large amount of urine
Pain w/ urination
Urinate at night
Trouble urinating
Dribble urine
Urinate when sneezing or
Swelling of feet/ankles
Genital sores
Genital discharge
Pain w/ intercourse
Memory changes
Seizures
Fainting
Coordination changes
Changes in strength
Numbness/tingling
Neck/back pain
Muscle pain
Joint pain

For Women only:
Age menses began at:_______________ Length of menses:______________________Type of Birth control used:______________
Type of STD protection used:________________________ Last breast exam/pap:___________________________
Date of last menstrual period:_________________________ # of pregnancies:__________ # of abortions:_________
# of miscarriage__________ Normal? If not, please describe.____

Circle which, if any of the following symptoms you currently have:
Vaginal discharge Heavy menses Breast Lumps Pain w/ intercourse
Missed Menses Painful menses Nipple discharge Brest tenderness
Bleed between menses

For Men only:
Date of last prostate exam:_____________ Normal? If not, please describe.____
Type of Birth control used:__________________ Type of STD protection used:_________________________________

Medications: List all current medications (prescription & nonprescription drugs), herbs and supplements w/ dosages:_________
____
____

Allergies: List any allergies you have to drugs, food, or environment agents. Please indicate what type of reaction you have:____
____
____
____

Childhood Health: Generally described (please circle): GOOD FAIR POOR
Please circle which, if any, of the following illness you have had:

Asthma	German Measles	Scarlet Fever	Hepatitis
Diphtheria	Measles	Mumps	Chicken Pox
Whooping Cough	Rheumatic fever		

Vaccinations: (year. Type, adverse reactions?)____
____

Habits/Lifestyle: Please circle and/or give a brief description where indicated.
Alcohol: How much?________________________ How often?_______________________________
Tobacco: Type: smoke of chew How long?___________________________
Caffeine: How much?________________________ Recreational drugs: How much?________________
How long used?____________________________ Diet restrictions:______________________________
Food cravings:____ Exercise program:___________
____________________________________ Average hours of sleep?____________ Do you sleep well?__________
Do you wake rested? Yes or No Occupation:___________________ Do you like your job?_____________
Stress level (home/job/other):____
Living situation (house/apt.,number in household, etc.)____
Social life/activities you enjoy:____
____

Spiritual practice:____
____

***Please read carefully and sign the following pages, the Colorado Mandatory Disclosure Statement and Notice of Privacy Practices. Thank you.**

Colorado Mandatory Disclosure Statement

Deborah A. Wiancek, N.D.
Riverwalk Natural Health Clinic & Natural Pharmacy LLC
280 Main St., Ste C-105
Edwards, CO 81632
970-926-7606

Education and Experience

Deborah A Wiancek has been through four years of pre-med from Metropolitan State College in Denver, CO. and graduated with a double major in science and holistic counseling. She has a doctrine degree in Naturopathic Medicine from Bastyr University, which is a four year Naturopathic medical program. She currently has a license in the state of Washington. Colorado currently does not license naturopathic physicians.

Naturopathic physicians (N.D.) are general practitioners trained as specialists in natural medicine. Naturopathic physicians treat disease and restore health using therapies from the sciences of clinical nutrition, botanical medicine, homeopathy, physical medicine, exercise therapy and hydrotherapy.

Insurance Information

Dr. Wiancek is currently covered by Cofinity and Aetna. Not all of these insurance plans may cover natural medicine. Therefore, it is your responsibility to call your insurance plan and check available coverage. All other individuals will be charged at the time of the visit and given and insurance form to submit to their insurance company if requested.

Fee Schedule

Initial Consultation and Treatment 1.5hr- $350 + cost of supplements or labs
Return Office Visit 45min-1hr -$125-$175 + cost of supplements or labs

Patient Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used and the duration of therapy.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- The patient is responsible for all charges of fees and services at the time of visit.

The practice of Naturopathic Medicine is regulated by the Director of Registrations, Washington Department of Regulatory Agencies.

Please sign. I have read and fully understand this document.
Patient's Signature____ Date________________

Notice of Privacy Practices
Riverwalk Natural Health Clinic and Natural Pharmacy, LLC

Who will follow this notice

- All members of the Riverwalk Natural Health Clinic and Natural Pharmacy, LLC (hereafter referred to at Riverwalk Natural Health Clinic), to include healthcare providers and staff.

Our responsibilities

- Riverwalk Natural Health Clinic respects your privacy. We understand that your personal health information is very sensitive. We will not disclose information to others unless you tell us to do so, or unless the law allows us or requires us to do so.
- The law protects the privacy of the health information we create and obtain in providing care and services to you.

How we may use and disclose medical information about you

For Treatment: Information obtained by members of our healthcare team will be recorded in your medical record and used to help decide what care may be right for you. For example, your doctor may need to consult with specialists about your care.
For Payment: When we request payment form your health plan or other payees, they need information from us about your medical care such as diagnosis, procedures performed, or recommended care in order to cover the services provided to you. We will not disclose your health information to third party payers without your authorization unless allowed to do so by law. We may release medical information about you for worker's compensation or similar programs.
Communication with family and friends: We may release medical information about you to a family member or friend who is involved in your care and/or helps pay for your care. We will not disclose your information to other family members or friends without your authorization.
Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at our clinic.
Research: We may disclose information to researchers when an institutional review board has approved the research proposal and established protocols to ensure the privacy of your health information.
As required by law: We will disclose medical information about you when required to do so by federal, state, or local law.
To avert a serious threat to health or safety: We may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. This may include disclosure to law enforcement officials, public health officials, national security, and intelligence agencies.

Your Health Information Rights

Right to this notice: You have a right to a paper copy of this notice. You may ask us to give you a copy at any time.
Right to inspect and copy: You have a right to inspect and receive a copy of certain health care information including certain medical and billing records. If you request a copy of this information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.
Right to request restriction: You have the right to ask us to restrict certain uses and disclosures of your health information. We will comply with all reasonable requests.
We reserve the right to change this notice at any time. Any revised or changed notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of our current notice in our clinic.
Please contact us if you have any concerns. You may also contact the Secretary of the US Department of Health and Services.

I have read and understand this document:

Signature:_______________________________
Date:_______________________________