319 Airport Road
Hackettstown, NJ 07840
Ph: 908-850-0888 / FAX: 908-850-1005

Dear New Patient:

Thank you for choosing Holistic Family Healthcare as your holistic healthcare provider. Our goal is to help you find and understand the **causes** of your health challenges and create a customized treatment plan for you.

Your treatment plan will likely consist of significant changes to your normal diet and supplement regimen. Please be sure that you are **motivated** to make these changes before you meet with me. I prescribe dietary changes and nutritional supplements (such as vitamins, minerals, enzymes, amino acids, essential fatty acids, and herbs). I will occasionally prescribe medication, but only when necessary.

If you have copies of recent medical or laboratory reports, please bring them along as well. It is also helpful to bring bottles of any vitamins or supplement you are currently taking, so we can see the ingredient list.

We look forward to meeting with you!

Sincerely,

Elaine A Hardy, MS, RN, APN, C

Elaine A Hardy, MS, RN, APN, C
Board Certified Family Nurse Practitioner
Owner, Holistic Family Healthcare, PC

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ADULT HEALTH HISTORY QUESTIONNAIRE

Date:________________________

Name:______________________________**Birthdate:**___________**Age:**_______________

Address:____

City, State, Zip:____

Cell Phone #___________________**Home # :**__________________ **work#**___________________

E-mail:____

Name and Phone # of Pharmacy____

Referred by:____

Reason for today's visit **Date problem(s) began**

____
____
____
____

Height:__________________**Weight:**___________ **Usual Weight:**______________

Allergies to Medication:____

Allergies to foods: (please specify what type of allergy testing was performed)____

Surgeries:____

Hospitalizations:____

Current Medications:____

____

Nutritional
Supplements:____

____

Smoker? Yes_____ No______ If yes, how many years:________ # of packs per day_________

Drink Alcohol? Yes_______ No________ # of drinks per week or month___________________

Exercise Regimen____

Please circle or place a check mark next to any of the following. Please make comments as needed.

FAMILY HISTORY

Hypertension	Heart Disease	Cancer	Diabetes
Obesity	Tuberculosis	Emphysema	Birth Defects
Mental Illness	Renal Disease	Alcoholism	Blood Disorders
Migraine	Epilepsy	Jaundice	Anemia
Glaucoma	Lupus	Arthritis	Strokes
Asthma	Hay Fever	HIV	Thyroid Disorders

GENERAL STATE OF HEALTH

Sweating	Weakness	Fatigue	Malaise
Fever	Chills	Anemia	Bleeding Tendencies
Night Sweats	Bruise Easily	Can't Fall Asleep	Hot or Cold Spells
Wake Often	Dry Mouth	Sensitive to temp changes	

HEAD, EYES, EARS, NOSE, AND THROAT

Wears glasses	Frequent Colds	Tonsil Infections	Bleeding Gums
Eye irritation	Frequent sore throat	Breathe thru mouth	Ringing in Ears
Ear infections	Post-Nasal Drip	Dark circles under eyes	Hearing Changes
Hearing Problems	Throat Clearing	Itchy Throat	Dizziness
Thrush	Nose Bleeds	Bad breath	Blurred Vision
Sores in Mouth (describe)	Stuffy Nose	Dental Problems	Headaches

SKIN, NAILS, HAIR

Lesions	Itching	Excessive Dryness	Eczema
Psoriasis	Crust behind ears	Yellow or Crusty Nails	Brittle Nails
Thinning Hair	Excessive Flakiness	Itching of scalp	Oily Face

RESPIRATORY AND CARDIAC

Chest Tightness	Bronchitis	Palpitations	Chest Pain
Asthma
Chronic Cough	High Blood Pressure	Low Blood Pressure	Fainting
Edema or swelling	High Cholesterol	Rib Pain

GASTROINTESTINAL

Abdominal pain	Heartburn	Bloating	Abdominal cramping
Nausea	Vomiting	Jaundice	Excess Gas
Diarrhea	Loose Stools	Constipation	# of stools per day_______
Loss of appetite	Use of laxatives	Rectal Bleeding	Blood in stool
Hemorrhoids	Food Intolerances (please list)	Noisy digestion

GENITOURINARY

Dribbling of urine	Frequency of urine	Urgency	Painful Urination
Blood in urine	Foul odor of urine	Hesitancy	Incontinence
Itching	Wake to urinate	Prostate Problem	Dribbling
Discharge	Infertility/sterility	Impotence	Sexual Problems
Lack of sexual desire	Change in urine color

MENSTRUAL / MENOPAUSAL

Age at onset________	Heavy Flow	Cramps	Date of last period_______
Length of Cycle_____	Duration of flow____	Menopause	Hot Flashes
Last Pap___________	# of pregnancies_____	Endometriosis
Birth Control	# of births______	Miscarriages_____	Irregular periods

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ENDOCRINE

High Blood Sugar	Low Blood Sugar	Weight Change	Hot/Cold Spells
Known or suspected thyroid disorder

MUSCULOSKELETAL AND NEUROLOGICAL

Tenderness	Muscle Cramps	Joint Aches	Weakness
Decreased movement	Pain	Arthritis	Use of anti-inflammatories
Tremors	Convulsions	Loss of Consciousness
Balance or coordination problems

PSYCHOSOCIAL

Depression	Nightmares	Crying easily	Feeling trapped
Feeling fearful	Tense	Easily annoyed	Worried about things
Temper outbursts	Feeling blue	Feeling hopeless	Trouble concentrating
Blaming yourself	Feeling lonely	Anxiety	Childhood Trauma
Stressful job	Financial worries	Stressful relationships	Recent personal loss
Occupation_________________________

3 Day Diet History

Patient Name____

Please record breakfast,, lunch, dinner and snacks for any 3 days prior to your appointment. Please include drinks. It is not necessary to write amounts of each item. (Simply write peas. Not necessary to write ½ cup of peas)

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			
Snacks			

Office Policies and Procedures

We make no representations, claims or guarantees that you will be helped with your medical problems or conditions. However, we will do our best to help you accomplish your healthcare and wellness goals.

About Elaine Hardy
Elaine Hardy is a Master's prepared Family Nurse Practitioner. Nurse Practitioners are licensed to perform physical examinations, order laboratory tests and to prescribe medications. The Collaborating Physician for Holistic Family Healthcare is Dr. Muralidhar Reddy. He maintains his own separate practice, and is available for consultation and collaboration when needed.

Supplements
Some of your treatment plan may consist of nutritional supplements. We will recommend certain brands or products based on research and past experience with these products. While we will provide you with information on where you can purchase these supplements, you are free to purchase these products from any source that you choose.

Primary Care Providers
We prefer that all patients have a primary care provider for emergencies and after hours care. Our services are to act as a compliment to your primary healthcare. We do not perform certain routine screenings such as pap smears.

Payment
- Our current hourly rate is $250 per hour. We bill in 15 minute increments.
- **The INITIAL visit with Elaine is billed at a flat rate of $250, regardless of time spent.**
- Payment is due at the time of your consultation.
- Methods of payment are: all major credit cards, check and cash (exact change is appreciated).
- There is a $20 returned check fee for all returned checks.

Insurance
- We do not participate with or accept insurance of any kind.
- A receipt will be provided to you, which will detail diagnostic and procedure codes. You can submit this to your insurance company for reimbursement.
- We are not responsible for unpaid claims by your insurance company for services we provide.
- We are sometimes asked to write 'letters of medical necessity' to help our patients obtain insurance coverage for our services. This is a billable service. You will be charged our normal hourly rate for the time it takes us to review your file and generate a letter.

Phone Consultations
- **There is no price difference for phone consultations.** Each phone consultation is treated like any other consultation – the time spent with your provider is the same whether it is in person, or on the phone. The phone consultation is for the patient's convenience.
- Payment for phone consultations is required via credit card. We will obtain your credit card information after the phone consultation has ended, and e-mail or mail an invoice to you.

Cancellations
- 24 hours notice is required for ALL cancellations.
- There will be a $50 fee for any cancellation without 24 hours notice.

E-mail
- The American Medical Association acknowledges that e-mail communication between a provider and a patient is a **billable service.**
- Emails are welcomed for simple yes/no questions in order to clarify previous instructions, for refill requests, or to request a lab slip.

- Patients **will be billed** and charged for time spent, in 5 minute increments - for any email that is not a yes/no question, a refill request, or a request for a lab slip.

- Patients who are seeking answers to detailed questions are encouraged to schedule an appointment for either an office consultation or a telephone consultation. Thank you for respecting our email policy.

Follow-up Consultations

- We generally recommend that all patients minimally have an office consultation every 3 to 6 months, especially if you are taking prescription medications which we have ordered.
- All patients must be seen **once per year**, (in-office) in order to continue under our care.

Acceptance of Policies and Procedures

By completing the following, you agree to the policies and procedures detailed in the “Office Policies and Procedures”.
I have read and fully understand the Office Policies and Procedures of Holistic Family Healthcare, PC.

Patient (please print)____Date____________________

Signature (patient or responsible party)____

If signed by party other than patient, please print your name and relationship to patient below:

____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

I acknowledge receipt of Privacy Practices, amended 8/7/14.

________________________ ____________________________________ __________

Print Patient Name   Signature of Patient / Legal Representative   Date

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use and disclosure of individually indentifiable health information relating to me, which is also called " protected health information" under HIPPAA's Privacy Rule. I understand that if the person or entity receiving this information is not a health plan or health care provider covered by the federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Limitations of Discloser: Please describe below limitations you would like on the disclosure of your Protected Health Information and/or Financial Information

____

____

____

I understand that I may revoke this permission, in writing, at any time. Revoking permission, however, does not affect previous disclosures that were made with my consent.

______________________ ______________________________________ __________

Print Patient Name   Signature of Patient/Legal Representative   Date

AUTHORIZATION TO BE CONTACTED THROUGH EMAIL OR TEXT MSG

I hereby give permission to be contacted through alternate means such as email or text message. I understand that in doing so, my protected health information may be viewed by individuals I did not intend. I understand that I may revoke this request, in writing, at any time.

______________________ ______________________________________ __________

Print Patient Name   Signature of Patient/Legal Representative   Date