WELCOME

by DR PENELOPE MCDONNELL

Patient Name:

Date:

Email Address:

GENERAL INFORMATION

Age:

DOB:

☐ Male
☐ Female

Address:

Day Time Phone:

Evening Phone:

Occupation:

Employer:

Emergency Contact:

Emergency Contact's Phone:

Other healthcare you are currently receiving:

Reason for your visit today:

Primary Health Concerns (in order of priority):

1.
2.
3.

Have you traveled outside of the US?

☐ Yes
☐ No

If so, where?

How did you hear about us?

Would you like to receive our monthly newsletter, The Wellness Minute?

☐ Yes
☐ No

CONTACT

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partners.com

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drpenelopemcdonnell.com

ADDRESS

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New York, NNY 10003

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SOCIAL

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@drpenelopemcdonnell

MEDICAL HISTORY

Allergies (medications, food, environmental) and their presenting symptons:

Sensitivities:

- [ ] Perfumes
- [ ] Cleaning Supplies
- [ ] Cigarettes
- [ ] Other

Current diagnoses, if any:

Medications you are currently taking (including dosage):

Supplements you are currently taking (including dosage):

When were you last on antibiotics, and why?

If you have any questions on the questionnaire, please visit *drpenelopemcdonnell.com/contact* or email us directly.

PAST HEALTH HISTORY

Date of last physical exam:

Where was it?

Women:

- [ ] Mammogram
- [ ] Pap Smear
- [ ] Breast Exam by Medical Professional
- [ ] Self Breast Exam

Men:

- [ ] Testicle Exam by Medical Professional
- [ ] Self Testicle Exam
- [ ] Prostate Exam by Medical Professional

Stool:

- [ ] Blood Test
- [ ] Rectal Exam
- [ ] Scope of Lower Bowel (if 50+)
- [ ] Other

Blood:

- [ ] Cholesterol
- [ ] Hormone Panel
- [ ] Blood Sugar
- [ ] Other

As a child, your health was considered:

- [ ] Good
- [ ] Fair
- [ ] Poor

Select any illnesses you experienced:

- [ ] Scarlett Fever
- [ ] Mon
- [ ] Rheumatic Fever
- [ ] German Measles
- [ ] Ear Infections
- [ ] Polio
- [ ] Mesles
- [ ] Diptheria
- [ ] Pneumonia
- [ ] Pertussis
- [ ] Mumps
- [ ] Strep Throat
- [ ] Chicken Pox

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Select any immunization you have received:

- [ ] MMR
- [ ] DTap
- [ ] Hep B
- [ ] Hep A
- [ ] Pneumococcal
- [ ] Varicella
- [ ] Rota
- [ ] Meningococal
- [ ] HPV
- [ ] Polio
- [ ] Hib

PAST HEALTH HISTORY (CONT'D)

Select any recent immunizations:

- [ ] Tetanus
- [ ] Flu Shot
- [ ] Hep A/B
- [ ] Other

Have you ever tested positive for TB?

- [ ] Yes
- [ ] No

Have you had a TB Test in the past 12 months?

- [ ] Yes
- [ ] No

List any vaccine/immunization adverse reactions:

List any past surgeries and/or hospitilizations (please include dates):

FAMILY HISTORY

Family Member	Age (if alive)	Age (at death)	Health Problems
Father			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Aunts/Uncles			
Sibling			
Other			

If you have any questions on the questionnaire, please visit *drpenelopemcdonnell.com/contact* or email us directly.

REVIEW OF SYSTEMS

Weight:

Height:

Rate your energy 1-10 (10 being best):

Rate your sleep 1-10 (10 being best):

Rate your stress 1-10 (10 being best):

Rate your pain 1-10 (10 being best):

Do you smoke cigarettes?

- [ ] Yes
- [ ] No

Do you drink alcohol?

- [ ] Yes
- [ ] No

If yes, give a brief description of your alochol consumption (kind and amount):

Are you sexually active?

- [ ] Yes
- [ ] No

Is it easy for you to fall asleep and stay asleep?

- [ ] Yes
- [ ] No

How many hours of sleep do you get on average per night?

Do you do recreational drugs?

- [ ] Yes
- [ ] No

If yes, give a bried description of your drug consumption (kind and amount):

Do you consume caffeine?

- [ ] Yes
- [ ] No

Do you excercise?

- [ ] Yes
- [ ] No

What kind of activity are you doing, and how frequently?

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REVIEW OF SYSTEMS (CONT'D)

Please Select "now" or "past" next to all areas that apply to your health. Select both if both apply to you.

HEENT

Symptom	Now	Past	Symptom	Now	Past
Headaches	☐ Now	☐ Past	Migraines	☐ Now	☐ Past
Fainting	☐ Now	☐ Past	Loss of Balance	☐ Now	☐ Past
Hair Loss	☐ Now	☐ Past	Head Injury	☐ Now	☐ Past
Dizziness	☐ Now	☐ Past	Blurry Vision	☐ Now	☐ Past
Eye Pain	☐ Now	☐ Past	Tearing	☐ Now	☐ Past
Eye Dryness	☐ Now	☐ Past	Double Vision	☐ Now	☐ Past
Glaucoma	☐ Now	☐ Past	Cataracts	☐ Now	☐ Past
Light Sensitivity	☐ Now	☐ Past	Fequent Colds	☐ Now	☐ Past
Puffiness	☐ Now	☐ Past	Hay Fever	☐ Now	☐ Past
Earaches	☐ Now	☐ Past	Loss of Smell	☐ Now	☐ Past
Difficulty Hearing	☐ Now	☐ Past	Hoarse Voice	☐ Now	☐ Past
Congestion	☐ Now	☐ Past	Neck Pain	☐ Now	☐ Past
Frequent Infections	☐ Now	☐ Past	Sore Throat	☐ Now	☐ Past
Sinus Issues	☐ Now	☐ Past	Difficulty Swallowing	☐ Now	☐ Past
Grinding Teeth	☐ Now	☐ Past	Dark Circles	☐ Now	☐ Past
Neck Swelling	☐ Now	☐ Past	Glasses/Contacts	☐ Now	☐ Past
Dental Problems	☐ Now	☐ Past	Ringing in Ears	☐ Now	☐ Past
Sore Gums	☐ Now	☐ Past	Nosebleeds	☐ Now	☐ Past
Cold Sores/ Canker Sores	☐ Now	☐ Past			

ENDOCRINE

Symptom	Now	Past	Symptom	Now	Past
Always Hot	☐ Now	☐ Past	Always Cold	☐ Now	☐ Past
Chronics Fatigue	☐ Now	☐ Past	Weakness	☐ Now	☐ Past
Increased Thirst	☐ Now	☐ Past	Increased Hunger	☐ Now	☐ Past

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REVIEW OF SYSTEMS (CONT'D)

Please Select "now" or "past" next to all areas that apply to your health. Select both if both apply to you.

CHEST

Symptom	Now	Past	Symptom	Now	Past
Wheezing	☐ Now	☐ Past	Asthma	☐ Now	☐ Past
Coughing Blood	☐ Now	☐ Past	Coughing Sputum	☐ Now	☐ Past
Coughing	☐ Now	☐ Past	Heart Palpitations	☐ Now	☐ Past
High Blood Pressure	☐ Now	☐ Past	Bronchitis	☐ Now	☐ Past
Pneumonia	☐ Now	☐ Past	Emphysema	☐ Now	☐ Past
Chest Pain	☐ Now	☐ Past	Chest Colds	☐ Now	☐ Past
Shortness of Breath	☐ Now	☐ Past			

GASTROINTESTINAL

Symptom	Now	Past	Symptom	Now	Past
Stomach Pain	☐ Now	☐ Past	Indigestion	☐ Now	☐ Past
Nausea	☐ Now	☐ Past	Clay-colored Stool	☐ Now	☐ Past
Blood in Vomit	☐ Now	☐ Past	Jaundice	☐ Now	☐ Past
Constipation	☐ Now	☐ Past	Blood in Stool	☐ Now	☐ Past
Diarrhea	☐ Now	☐ Past	Vomiting	☐ Now	☐ Past
Gas/Bloating	☐ Now	☐ Past	Rectal Pain/Itch	☐ Now	☐ Past
Loss of Appetite	☐ Now	☐ Past	Excessive Appetite	☐ Now	☐ Past
Light-Colored Stool	☐ Now	☐ Past			

GENITOURINARY

Symptom	Now	Past	Symptom	Now	Past
Frequent Urination	☐ Now	☐ Past	Urge to Urinate	☐ Now	☐ Past
Incontinence	☐ Now	☐ Past	Difficulty Urinating	☐ Now	☐ Past
Change in Urine Color	☐ Now	☐ Past	Odorous Urine	☐ Now	☐ Past
Blood in Urine	☐ Now	☐ Past	Kidney Stones	☐ Now	☐ Past
Sexual Difficulty	☐ Now	☐ Past	Pain w/ Urination	☐ Now	☐ Past
Bladder Infections	☐ Now	☐ Past	Genital Sores	☐ Now	☐ Past
STDs	☐ Now	☐ Past	Genital Discharge	☐ Now	☐ Past

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REVIEW OF SYSTEMS (CONT'D)

Please Select "now" or "past" next to all areas that apply to your health. Select both if both apply to you.

MUSCULOSKELETAL

Symptom			Symptom		
Aching Muscles	☐ Now	☐ Past	Numbness/Tingling	☐ Now	☐ Past
Restless Legs	☐ Now	☐ Past	Broken Bones	☐ Now	☐ Past
Weakness	☐ Now	☐ Past	Swollen Joints	☐ Now	☐ Past
Sore Joint s	☐ Now	☐ Past	Leg Cramps	☐ Now	☐ Past
Tender Points	☐ Now	☐ Past			

SKIN

Symptom			Symptom		
Acne	☐ Now	☐ Past	Itching	☐ Now	☐ Past
Rashes	☐ Now	☐ Past	Lesions	☐ Now	☐ Past
Hives	☐ Now	☐ Past	Lumps	☐ Now	☐ Past
Warts	☐ Now	☐ Past	Night Sweats	☐ Now	☐ Past
Color Change	☐ Now	☐ Past	Easy Bruising	☐ Now	☐ Past
Fungus	☐ Now	☐ Past	Boils	☐ Now	☐ Past

NERVOUS SYSTEM

Symptom			Symptom		
Anxiety	☐ Now	☐ Past	Loss of Sensation	☐ Now	☐ Past
Tremor	☐ Now	☐ Past	Fainting	☐ Now	☐ Past
Foggy Thinking	☐ Now	☐ Past	Loss of Strength	☐ Now	☐ Past
Convulsions	☐ Now	☐ Past	Loss of Memory	☐ Now	☐ Past
Lack of Concentration	☐ Now	☐ Past	Muscle Weakness	☐ Now	☐ Past
Paralysis	☐ Now	☐ Past			

BLOOD/IMMUNE

Symptom			Symptom		
Painful Lymphnodes	☐ Now	☐ Past	Frequent Bleeding	☐ Now	☐ Past
Bruising	☐ Now	☐ Past	Flu/Cold	☐ Now	☐ Past
Anemia	☐ Now	☐ Past	Fluid Retention	☐ Now	☐ Past
Swollen Glands	☐ Now	☐ Past	Wounds Heal Slowly	☐ Now	☐ Past

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REVIEW OF SYSTEMS (CONT'D)

Please Select "now" or "past" next to all areas that apply to your health. Select both if both apply to you.

MALE REPRODUCTIVE

Condition			Condition		
Prostate Problems	☐ Now	☐ Past	Painful Erections	☐ Now	☐ Past
Painful Urination	☐ Now	☐ Past	Infertility	☐ Now	☐ Past
Discharge	☐ Now	☐ Past	Hernias	☐ Now	☐ Past
Premature Ejaculation	☐ Now	☐ Past	Swelling in Testes	☐ Now	☐ Past
Painful Testicles	☐ Now	☐ Past	Testicular Masses	☐ Now	☐ Past
Sexual Difficulties	☐ Now	☐ Past	Erection Difficulty	☐ Now	☐ Past

FEMALE REPRODUCTIVE

Condition			Condition		
Lumps in Breasts	☐ Now	☐ Past	Breast Pain	☐ Now	☐ Past
Nipple Discharge	☐ Now	☐ Past	Vaginal Discharge	☐ Now	☐ Past
Missed Periods	☐ Now	☐ Past	Heavy Periods	☐ Now	☐ Past
Lack of Sex Drive	☐ Now	☐ Past	Genital Eruptions	☐ Now	☐ Past
Pelvic Pain	☐ Now	☐ Past	Pain with Sex	☐ Now	☐ Past
Vaginal Itching	☐ Now	☐ Past	Vaginal Burning	☐ Now	☐ Past
Yeast Infections	☐ Now	☐ Past	Loss of Sensation	☐ Now	☐ Past
Orgasm Difficulty	☐ Now	☐ Past	Fainting	☐ Now	☐ Past
Painful Menses	☐ Now	☐ Past	Loss of Strength	☐ Now	☐ Past
Facial Hair	☐ Now	☐ Past	Loss of Memory	☐ Now	☐ Past
Use of Birth Control	☐ Now	☐ Past	Muscle Weakness	☐ Now	☐ Past
Difficulty Conceiving	☐ Now	☐ Past	Abortion	☐ Now	☐ Past

Number of Pregnancies: ____________

Number of Live Births: ____________

Number of Miscarriages: ____________

Additional Notes, if any: ____________

If you have any questions on the questionnaire, please visit *drpenelopemcdonnell.com/contact* or email us directly.

REVIEW OF SYSTEMS (CONT'D)

Please Select "now" or "past" next to all areas that apply to your health. Select both if both apply to you.

MENTAL/EMOTIONAL

Depressed Mood	☐ Now	☐ Past	Suicidal Thoughts	☐ Now	☐ Past
Angered Easily	☐ Now	☐ Past	Frequent Crying	☐ Now	☐ Past
Afraid of Being Alone	☐ Now	☐ Past	Shy/Timid	☐ Now	☐ Past
Restless	☐ Now	☐ Past	Excessive Worry	☐ Now	☐ Past
Loneliness	☐ Now	☐ Past	Critical of Others	☐ Now	☐ Past
Nightmares	☐ Now	☐ Past	Mood Swings	☐ Now	☐ Past
Mental Confusion	☐ Now	☐ Past	Suspicious/Jealous	☐ Now	☐ Past
Confident/Secure	☐ Now	☐ Past	History of Trauma	☐ Now	☐ Past
Bulemia	☐ Now	☐ Past	Anorexia	☐ Now	☐ Past

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PRACTICE TERMS & PRICING

Please read and sign.

I understand that Dr. Penelope McDonnell is a graduated Naturopathic Doctor.

I understand that naturopathic medical consultaions and recommendations may be different from those offered by other health care providers and that I am at liberty to seek other care.

I understand that payment is expected at the time of service and rates are listed below.

Appointment Rates

Introductory Consultation $375 (1 hour, 20 min)

Ongoing Consultation $225 (50 min)

Acute Consultation $150 (30 min)

I understand the privacy practices of this office, required by HIPAA, and have had the opportunity to read them if I wish.

I understand that if I cancel an appointment without providing 24 hours notice, I will be responsible for a $50 cancellation fee.

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Patient or responsible part signature: **Date:**

If you have any questions on the questionnaire, please visit *drpenelopemcdonnell.com/contact* or email us directly.

DIET DIARY

by DR PENELOPE MCDONNELL

Welcome to your Diet Diary! Please record your meals for the next four days. This will help us better evaluate your current health status and show us exactly where/ how you can improve in order to achieve optimal wellness.

DAY 1	DAY 2	DAY 3	DAY 4
BREAKFAST			
LUNCH			
DINNER			
SNACKS			
LIQUIDS			

INFORMED CONSENT FOR TREATMENT

I hereby authorize the Naturopathic physicians and other practitioners of Naturopathic Partners to perform the following specific procedure(s) as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, pap smears, radiography, laboratory and x- ray.

Minor office procedures: e.g., dressing a wound, ear cleansing.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation of vitamins, minerals, amino acids and other nutritional or therapeutic substances.

Botanical Medicine: botanical substances (herbal medicines) may be prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, plasters or suppositories.

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: diet therapy, fasting, elimination diets, promotion of wellness including recommendations for exercise, sleep, stress reductions and balancing of work and social activities.

Psychological counseling, physical Medicine, acupuncture and bodywork.

Practitioners of the Naturopathic Partners have discussed and explained to my satisfaction the basic procedures of the above therapies and the risks and benefits of the care I will receive and I have been given the opportunity to ask questions about the treatment plan and procedures. I recognize certain potential risks and benefits of the procedures I am receiving, as they were described to me and as described more generally below:

POTENTIAL RISKS: allergic reactions to prescribed herbs and supplements; side effects of natural medications; inconvenience of lifestyle changes; bleeding, bruising or pain with venipuncture; possible prescription drug interaction with prescribed natural supplements or products. Acupuncture may produce temporary numbness, tingling, bruising, bleeding or redness. Physical Medicine may result in temporary pain or discomfort.

POTENTIAL BENEFITS: restoration of health and the body's maximal function capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

NOTICE TO PREGNANT WOMEN - All female patients must inform the treating doctor if they know or suspect that they are pregnant as some of the procedures and therapies described above may present a risk to the pregnancy.

ALTERNATIVES - I understand that the practitioners at Naturopathic Partners are not primary care physicians, and the procedures that I will receive from Naturopathic Partners are supplementary care to my primary care physician and/or specialist. It has been recommended to me that I consult with a primary care physician and/or a specialist to obtain information about all of the conventional medicine treatment alternatives available to me.

CONSENT- With this knowledge, I voluntarily consent to the above procedure(s), realizing that no guarantees have been given to me by Naturopathic Partners or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

CONFIDENTIALITY - I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my lawful representative, or me or unless law permits or requires it. I understand that my request to view or receive a copy of my medical record can only been done with a signed form of records release obtainable from Naturopathic Partners. A Naturopathic Partners assistant may access my files in order to place orders and offer assistance to Dr.McDonnell and myself.

I understand that my medical record will be kept for a minimum of seven years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that my practitioner will answer any questions I have, to the best of his/her ability.
I certify that I have read and fully understand this consent and the matters that have been explained to me. I further certify that I have full authority and accept full responsibility to execute this consent for and on behalf of the above-named patient and that I am signing freely and voluntarily.

Patient name (print)

Signature Date

Signature of patient guardian

Notes

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY BEFORE SIGNING.

Federal law requires us to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept confidential. HIPPA gives you, the patient, new rights to understand and control how your health information is used. That law also requires us to give you this explanation of how we maintain the privacy of your health information. We reserve the right to change our privacy practices, provided the changes conform to applicable laws. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available on request.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, heath care operations, health care reminders, and for public benefit. Any other disclosure will require your written authorization.

Treatment: means providing or managing health care and related services by one or more health providers. An example of this is the disclosure of information between student interns and the supervising doctor.
Payment: means such activities as obtaining reimbursement for services, billing or collection activities and utilization review. An example of this is the disclosure from the student intern to the front desk personnel of the billing.
Health care operations: include the business aspects of running the clinic, quality assessment, evaluating practitioner, provider and intern performance, training programs, accreditation, certification or credentialing activities. An example of this would be student case review with supervising doctors and/or the clinic director.
Reminders: means providing you with appointment reminders or to inform you of changes in the clinic services or hours by such means as postcards, voicemail messages or letters.
Public benefit: means the disclosure of information for the following types of reasons: for public health activities including disease and vital statistic reporting; to report abuse, neglect or domestic violence; to health oversight agencies; to law enforcement officers pursuant to subpoenas and other lawful processing; to medical examiners and coroners; to avert a serious threat to health or safety; in connection with certain research activities; and as authorized by state and federal laws.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with YOUR WRITTEN AUTHORIZATION. You must give such authorization in writing to disclose it for any purpose, including but not limited to having a copy sent to another physician or receiving a copy for your own personal use. You may revoke such authorization in writing and we are required to honor that written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Chief Medical Officer.

—The right to request restrictions on certain uses and disclosures of protected health information, including those related disclosures to family members, relatives, close personal friends or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
—The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
—The right to inspect and copy your protected health information. You must make a request in writing to obtain access to your health information. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs and postage. If you prefer, we may (but are not required to) prepare a summary or explanation of your health information for a fee.
—The right to amend your protected health information. Your request must be in writing and must include an explanation why we should amend your records. We may deny your request under certain circumstances.
—The right to receive an accounting of disclosures of your protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

You have recourse if you feel your privacy protections have been violated. If you want more information about our privacy practices or have any questions or concerns, please contact us using the information listed at the end of this notice. You may also submit a written complaint to the US Department of Health and Human Services, Office of Civil Rights about violations of provisions of this notice or the policies and procedures of our clinic. We will not retaliate against you for filing a complaint.

I have read and understand the above-stated information.

Patient's Name

Patient's Signature Date

Legal Guardian (if under 16)

Relationship to patient

For more information about HIPAA or to file a complaint:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 2020
Phone: 202-619-0257
Toll Free: 877-696-6775

NOTE ABOUT SIGNATURES

You can sign this form without printing/scanning using Adobe Reader. If you don't have that on your computer, Google "How to sign a pdf" + "[your computer, ex. on a Mac]". If you still can't figure it out, please just email it back to us. We'll have you sign it during your first consultation. Thanks so much!