Name: ____Date: ______________________

Avalon Health & Wellness LLC
3524 East 15th Ave Anchorage, Alaska 99508
P 906-222-6601 • F 907-222-6602
www.AnchorageAlternativeMedicine.com

New Patient Instruction Sheet

Please bring the following information with you for your appointment:

1. Completed and signed HIPPA form
2. Completed Patient Information Sheet
3. List of all prescriptions taken in the last five years
4. Timeline of significant medical history
5. List of any surgeries (including tonsils and appendix)
6. Significant dental history (including amalgams, root canals, cavitations)
7. Current symptoms and reason for visit
8. Bring a copy of any recent/significant labs or imaging
9. Bring all supplements and medications you are taking

New Patient Visits (2 hours) $480
Follow-up visits are $240.00 per hour

Cancellation Policy

If you have to cancel an appointment, please provide 48 hours notice. Any non-emergency cancellation or no-show within 24 hours of appointment time will be charged 50% of the service fee. Patient initials: ________

Patient Information

Name: ____ Date of Birth: ___________________________
Address: ____
City: ___________________________ State: ______________ Zip: _______________
Phone (Cell) ___________________
Phone (Other)___________________ Email: ____
Any Known Allergies to Medication: ____
Reason For Visit: ____
Referred by: ____
Primary Care Physician: ____
Spouse's Name (if applicable): ____

Name: ____Date: ______________________

Emergency Contact Information

Name of Emergency Contact: ____

Phone(s): ______________________________ Relationship to you: ___________________________

If patient is under 18:

Name of parents: ____

"I am the parent or legal guardian of the above named minor and I authorize Dette Avalon ANP to conduct appropriate examinations and to administer appropriate care to him/her."

Signature of parent/guardian allowing treatment: ______________________________

Signature of parent/guardian allowing treatment: ______________________________

Is there a number we can leave messages containing confidential health information?

☐No, please don't leave messages.

☐Yes, it's ok to leave messages at: _______________________________

Notice of Privacy Practices Patient Acknowledgment

Patient Name: ____ Date of Birth: ________________

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and healthcare operations.
- A description of each of the other purposes for which the practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS, if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.
      This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: ____Date: _________________

Relationship to patient (if signed by a personal representative of patient): _______________________________________

Name: ____Date: _____________________

Email Policy—Informed Consent

Dette Avalon ANP may provide email consultations according to the following guidelines:

1. For established patients of Avalon Health & Wellness
2. For non-emergent issues
3. In cases where the doctor determines that an office visit is not necessary or possible
4. For clarification of on-going treatment or treatment received within the past 30 days. (**No new health issue will be addressed by email consultation).**
5. When Dette Avalon ANP can address the concern with a single reply, requiring 10 minutes or less. Anything longer than this, or that requires multiple emails will be charged according to time spent at the typical hourly rate.

If an email is received about a condition that in her opinion cannot be properly assessed without an office visit, the patient will be notified by return email to schedule an appointment, with time frame recommended. In this case, no treatment advice will be given by email.
Dette Avalon ANP will generally respond to emails within 48 hours, Monday through Friday only. **If you have not received a response within these parameters, call the office at 206-849-1156 and leave a phone message** stating your question and/ or concern. All urgent questions should be addressed by calling 206-849-1156.
Email communication with Dette Avalon ANP and the reply become part of the patient's permanent record—a copy is added to the patient's medical chart. Email communication is password protected for patient privacy—no one but Dette Avalon ANP can access your email communication.

I, ___________________________________(Patient Name), have read the above
policy of Avalon Health & Wellness LLC for consultation by email. I have had an opportunity to ask questions about this policy. I understand the policy, and the conditions that are required for email consultation. I realize that I may not receive a response for up to 48 hours, and am expected to call the office to leave a message for the nurse practitioner by phone if I have not received a reply in that time frame. I agree to abide by the above email policy if I contact my nurse practitioner by email.

Patient Signature: ___________________________________ Date: _____________

CONSENT FORM

It is my understanding that in conjunction with a conventional approach, Dette Avalon ANP may use integrative diagnostic and treatment methods. I choose to explore this expanded approach to diagnosis and treatment in order to help overcome my (or my child's) health problems. I agree to maintain my own primary care physician, with the understanding that Avalon Health & Wellness does not provide primary health care or after hour's coverage. I also understand Dette Avalon ANP may incorporate a form of kinesiology called Autonomic Response Testing, and that she will use this methodology to help guide treatments, but not solely as a diagnostic method.

Patient Signature: _________________________________ Date___________________________

ACKNOWLEGEMENT OF SELF FILLING INSURANCE BENEFITS

I fully understand that Avalon Health & Wellness Services does not and will not bill for any medical services rendered and that it is completely and totally my responsibility to file and accept payment from my insurance carrier on my own. I acknowledge that some or all services may not be covered under my insurance policy. I acknowledge that payment of all services is my complete financial responsibility.

Patient Signature: _________________________________ Date___________________________

Name: ____ Date: ____________________

Avalon Health & Wellness, LLC
New Patient Medical History
Adult Form

Your answers to the following questions will help Dette better understand your health and wellness concerns. If you cannot remember specific dates, please answer to the best of your ability.

What is your single priority for today's visit?

____

____

____

What is your goal over the next 1-3 months?

____

____

____

What is your long-term goal?

____

____

What are you willing to do to improve your health? What will you NOT do? Please be specific. Examples could include food, beverages, vitamin products, exercise, habits etc.

____

____

____

What are your specific expectations of Avalon Health & Wellness?

____

____

____

What are your top three concerns with your health and if you can, please name your top three symptoms:

____

____

____

What additional information are you seeking?

____

Name: ____Date: _____________________

How would you rate your general health & vitality? Excellent_____ Good_____ Fair_____ Poor_____

Please explain:

____

____

When did you first notice your main concern?

____

Was the onset of your problem sudden or gradual?

____

Was there an event or illness that seemed to bring on or trigger your symptoms?

____

____

Please describe any other event or experience that you think may have contributed to your condition.
Be as detailed as possible.

____

____

Your Medical history: (examples: Alcoholism or other addictions, Allergies, Anemia, Arthritis, Asthma, Bleeding/clotting problems, Cancer, Diabetes, Digestive problems, Chronic ear, sinus, tonsil, or chest infections, Eczema, Gallstones, Gout, Any cardiovascular disease, chest pain, elevated blood pressure, elevated cholesterol, heart murmur, heart palpitations, rheumatic heart disease, syncope, chronic swelling of the legs/feet, Hepatitis, Herpes, Kidney problems-frequent urinary tract infections/vaginal yeast infections, kidney cysts, kidney stones, kidney failure, Mental health concerns-depression, anxiety, ADD, ADHD, OCD, Bipolar disorder etc., Chronic migraines, Psoriasis, Seizure, STD's, Strokes/TIA, Thyroid problems, Vision or hearing problems, etc.)

____

____

____

____

____

____

____

____

Dental Intervention (dental amalgam filling, braces, retainer, root canal, extractions, etc.)

____

____

Your Surgical History:

Name: ____Date: ______________________

____
____
____
____
____
____

FAMILY HISTORY:

Mother: Age_____________________ Medical history: ____
____
____

Father: Age____________________ Medical history: ____
____
____

Siblings: How many? ___________ Medical history: ____
____

Maternal grandparents medical history:
____
____

Paternal grandparents medical history:
____
____

Other family members with pertinent medical history:
____
____

SOCIAL HISTORY/Health Habits:

- What is your occupation: ____
- Marital status: ____
- With whom do you live? (Include children, parents, relatives, and/or friends): ________________________
- Do you have children? Yes ____ No ____ What ages? ____
  Do you have any pets or farm animals? Yes___ No___ What kind? ______________________________
  If yes, where do they live? Indoors ___________ Outdoors ___________ Both ___________
  Have you used or been exposed to tobacco? ________What kind and for how long? ____________________

Name: ____Date: ______________________

How much alcohol do you consume? ____

Do you use recreational/Illicit drugs? (What kind and for how long?) _________________________________

Occupational exposures to chemicals of heavy metals? (What kind and how long was the exposure?)

____

Please describe your sleep most nights? ____

____

Have you lived or traveled outside of the United States, especially to developing countries?

Yes____ No____ If so, when, where and for how long: ____

- Have you ever donated blood? ____
- Current Exercise: (What kind, how often, time frame?) ____
- How is your energy after exercise? ____
- What are your hobbies? ____

Have you or your family recently experienced any major life changes? Yes___________ No____________

If yes, please comment if you wish: ____

____

Have you experienced any recent major losses in your life? Yes______________ No______________

If so, please comment if you wish: ____

____

How important is religion (or spirituality) for you and your family's life?

a. _____ Not at all important

b. _____ Somewhat important

c. _____ Extremely important

CURRENT MEDICATIONS:

Medication Name	Dosage	Date Started
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Regular Over-the-Counter medications:

____

Name: ____Date: ______________________

____

____

Current SUPPLEMENTS/VITAMIN products: (example: calcium carbonate, calcium citrate, ascorbic acid, Vit. C ascorbate etc.)

Name of Product	Dosage (mg/IU)	Name of Company making product
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ALLERGIES/SENSITIVITIES:

Medications: ____

____

Food/Environmental Allergies: ____

____

Have you used antibiotics on a chronic basis? (Examples: chronic sinus infections or other infections, treated for acne etc.) Yes____________________________ No____________________________

MOST RECENT HEALTH SCREENING: (Year, where performed and who performed the screening)

Most recent eye exam: ____

Most recent hearing exam: ____

Most recent dental exam: ____

PAP (Female): ____

Mammogram (Female): ____

Prostate exam (Male)____

Colonoscopy: ____

EKG: ____

Heart Stress test: ____

Year of last normal TB test: ____

Name: ____Date: ____________________

Vaccinations received in the last 10 years:
____
____
____

Current concerns: (please circle and briefly explain current concerns.)

	General	Greater or less than one year	COMMENTS
	Generalized fatigue		
	Cancer		
	Mononucleosis/EBV		
	Unusual fever, chills, sweats		
	Unusual weight loss/gain		
	Exposure to toxic chemicals or heavy metals		
	Chronically enlarged lymph nodes		
	Anemia		
	Do you have chronic sinus issues?		
	Have you been exposed to mold?		
	Are you sensitive to EMF’s (Wi-FI)		
	Eyes	Greater or less than one year	COMMENTS
	Chronic double vision		
	Cataracts		
	Glaucoma		
	Macular degeneration		
	Chronic watery/itchy eyes		
	Chronic dark circles under/around the eyes		
	Tunnel vision		
	Spots in the field of vision		
	Difficulty with night vision		
	Eye pain		
	Other		
	Other		

Name: ____Date: ____________________

	Ears	Greater or less than one year	COMMENTS
	Chronic ear infections		
	Changes in hearing		
	Hearing loss (which ear?)		
	Chronic ear ringing (tinnitus)		
	Chronic itchy ears		
	Chronic drainage from the ears		
	Other		
	Other		
	Nose	Greater or less than one year	COMMENTS
	Distorted sense of smell		
	Chronic sinus infections		
	Chronic stuffy nose		
	Chronic sinus infection(s)		
	Hay fever		
	Excessive mucous production		
	Other		
	Other		
	Throat/Dental	Greater or less than one year	COMMENTS
	Distorted sense of taste		
	Chronic sore throat		
	Chronic voice hoarseness		
	Chronic gum problems/disease		
	Frequent canker/cold sores		
	Tongue concerns		
	Root canal(s)/which teeth?		
	Metal (amalgam) fillings (how many?)		
	Did you wear braces/for how long?		
	Chronic voice hoarseness		
	Other		
	Other		

Name: ____Date: ______________________

	Lungs	Greater or less than one year	COMMENTS
	Chronic cough/dry or productive		
	Chronic wheezing		
	Chronic congestion		
	Chronic shortness of breath		
	Chronic Bronchitis		
	Asthma		
	Exercise or cold induced asthma		
	Emphysema (COPD)		
	Sleep apnea		
	Pneumonia		
	Tuberculosis		
	Other		
	Other		
	Heart	Greater or less than a year	COMMENTS
	Irregular or skipped beats		
	Heart attack		
	Chronic chest pain (angina)		
	Rheumatic heart disease		
	Heart arrhythmia		
	Heart murmur		
	Dizziness/fainting spells		
	Heart failure		
	Lower leg/ankle swelling		
	High blood fats (cholesterol, triglycerides)		
	High blood pressure (hypertension)		
	Other		
	Intestines (GI/Gut)	Greater or less than one year	COMMENTS
	Difficulty swallowing		
	Chronic heartburn		
	Excessive belching/gas		
	Distention/bloating after meals		

Name: ____Date: _____________________

	Chronic nausea or vomiting		
	Stomach/intestinal ulcers		
	Chronic diarrhea		
	Blood in stool		
	Mucous in stool		
	Fat in stool		
	Undigested food in stool		
	Chronic constipation		
	Hemorrhoids		
	Gallstones		
	Fatty liver		
	Hepatitis (A, B, C)		
	Other liver disease		
	Irritable bowel syndrome		
	Inflammatory bowel disease		
	Other		
	Neurologic	Greater or less than a year	COMMENTS
	Difficulty falling asleep		
	Difficulty maintaining sleep		
	Daytime sleepiness (what time?)		
	Night waking		
	Lack of dreaming?		
	Chronic night terrors		
	Chronic dizziness, blackouts, lightheadedness/vertigo		
	Migraine or other chronic headache		
	Head trauma		
	Epilepsy, convulsions, or seizures		
	Chronic insomnia		
	Stroke		
	Other		
	Other		

Name: ____Date: ______________________

	Muscles/Bones/Joints	Greater or less than one year	COMMENTS
	Tension Headache		
	Arthritis (Rheumatoid, Osteo.)		
	Osteoporosis/Osteopenia		
	Restless legs		
	Chronic muscle cramps (where/when?)		
	Chronic pain (where?)		
	Other		
	Other		
	Skin	Greater or less than a year	COMMENTS
	Acne		
	Rosacea		
	Changes in hair		
	Changes in fingernails/toenails (brittle, curved up, pitted, ridged, soft, thickened, changes in color)		
	Chronic rashes/hives		
	Minimal sweating		
	Changes in moles		
	Skin cancer		
	Shingles		
	Vitiligo		
	Other		
	Kidneys/Bladder	Greater or less than a year	COMMENTS
	Chronic urinary tract infections		
	Chronic blood in the urine		
	Chronic pain urinating		
	Chronic urine leaking		
	Chronic kidney pain		
	Kidney stones		
	Kidney cysts		
	Other		

Name: ____Date: ______________________

	Reproductive (Female)	Greater or less than a year	COMMENTS
	First day of last menstrual cycle		
	Number of pregnancies		
	Number of children		
	Miscarriages		
	Termination (s)		
	Age at first menses		
	Contraceptive method		
	Changes in menstruation (heavy, irregular, absent, scanty, spotting between periods)		
	PMS (may review in appt.)		
	Uterine fibroids		
	Endometriosis		
	Ovarian cysts		
	Low libido		
	Vaginal dryness, discharge, odor, itching, pain		
	Chronic breast tenderness		
	Breast cysts/lumps		
	Chronic yeast infections		
	STD		
	Other		
	Other		
	Reproductive (male)	Greater or less than one year	COMMENTS
	Penile discharge		
	Pain or problems with ejaculation		
	Pain or problems with erections		
	Cysts/lumps in testicles		
	Changes in libido		
	STD		
	Other		
	Other		

Name: ____ Date: ______________________

	Endocrine	Greater or less than one year	COMMENTS
	Chronically cold hands/feet		
	Internal cold intolerance		
	Internal heat intolerance		
	Diabetes		
	High/low thyroid		
	Hypoglycemia		
	Other		
	Mental Health/Moods	Greater or less than one year	COMMENTS
	Eating disorders		
	Agoraphobia		
	Anxiety		
	Panic attacks		
	Depression		
	Difficulty concentrating		
	Fearfulness		
	Irritability		
	Current suicidal thoughts		
	Bipolar disorder		
	Other		
	Other		
	INJURIES	Greater or less than a year	COMMENTS
	Broken bones (describe)		
	Head injury		
	Other (describe)		
	Other		

What childhood illnesses or vaccinations have you had and how did you tolerate them?

____

____

____

NUTRITIONAL ASSESMENT:

Name: ____Date: _____________________

How would describe your current eating habits? (Place (X) by your desired answer)

Junk food________ Standard American Diet_________ Majority of processed food________
Majority of whole food __________ Vegetarian __________ Other ___________________________________

Are you currently on a special diet?
____

Typical breakfast
____
____
____

Typical lunch:
____
____
____

Typical dinner:
____
____
____

What do you snack on?
____
____
____

What foods do you gravitate toward?
____
____

What foods do you avoid or have aversions to?
____
____

How do you feel after eating onions, garlic, shallots, leeks, chives, broccoli, cauliflower, and/or cabbage?
____
____

Name: ____Date: ______________________

Caffeine intake (amount/what kind/how often):

____

____

Water intake (amount/kind-tap, bottled, well, or filtered):

____

____

ELECTROMAGNETIC EXPOSURE:

Do you sleep on a waterbed or use an electric blanket on your bed? Yes ___________No ________________

What is your cumulative exposure (minutes/hours) to electronic devices daily? _________________________
What time of day do you use them?

____

____

____

Any additional comments:

____

____

____

With your non-dominant hand, please print your name on the line below:

____

Signature: ____ Date: ____/____/________

Thank you for taking the time to provide this information so
we may make an attainable and sustainable plan for your health goals.
And thank you for allowing me to journey on the path with you!

To Your Health!

Dette Avalon ANP