Be Well Associates, Inc., Dan O. Harper, M.D.
509 South Cedros Ave., Suite B, Solana Beach, CA 92075, 858-755-1126, Fax 858-755-3530

****PATIENT REGISTRATION****

Patient Name:

_____
Last First MI Preferred Name

Male / Female Married / Single Child Birth Date: _____ Age: _____

Address Street: _____

City: _____ State: _____ Zip: _____

Phone #'s: Home: _____ Cell: _____

E Mail Address: _____ **Home Fax:** _____

Are you a full time student/where? _____

What is the patient's religious or spiritual preference? _____

RESPONSIBLE PARTY

Name: _____ (Circle one): Self / Mother / Father / Legal Guardian

Address Street: _____

City: _____ State: _____ Zip: _____

Phone #'s: Home: _____ Cell: _____

E Mail Address: _____ **Home Fax:** _____

Employer Name: _____ Occupation: _____

Work: _____ Ext: _____ Work Fax: _____

Other Parent Name: _____ Phone: _____

Address: _____

APPOINTMENT REMINDER INFORMATION

May we discuss your medical conditions with any members of your household? Yes No
If YES, please list names of the household members below.

Names: _____ **Phone**: _____

Relationship to patient: _____

May we phone you to confirm appointments dates and times? Yes No

May we leave a message on your home voice mail? Yes No On your cell voice mail? Yes No

May we leave a message at your place of employment? Yes No
If YES, please name work contact person and/or work phone

Name: _____ Work Phone: _____ ext.:_____

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EMERGENCY CONTACT

_____
Last First MI Preferred

Gender: M F Relationship To Patient: _____

Address Street: _____ City: _____

State: _____ Zip: _____Cell_____

Home Phone: _____ Work Phone: _____

REFERRAL INFORMATION

How were you referred to our office? Another patient Friend Relative ☐Internet Medical Office

Newspaper ☐School ☐Work ☐Other_____

Name of person or office referring you to our practice: _____

Office Hours:

Monday	9:00-1:30
Tuesday	8:00-4:30
Wednesday	8:00-4:00
Thursday	8:00-3:30
Friday	9:00-1:30
Saturday	8:00-2:30

Please do not email the reception staff or Dr. Harper under any circumstances. Please call or fax.

FEE SCHEDULE

New Patient Appointments 2 hours (approx.): $1,000.00 (If longer than 2 hours the fee increases.)
Brief Appointment up to 15 minutes: $125.00
Limited Appointment up to 30 minutes: $250.00
Intermediate Appointment up to 45 minutes $375.00
Extended Appointment up to 1 hour: $500.00
Frequency Specific Microcurrent: $95 - $150
IV's: The cost of your custom IV may vary from $175.00 to $325.00 or more

Supplements, BIA analysis or other additional tests are not included in the new patient appointment fees. Charges for these items must be paid on the day of the new patient appointment.

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We do not accept checks for payment of the first visit. We accept cash, Visa, MasterCard and Discover. We do not accept American Express. Fees for young children may be less, as the first new patient appointment is usually, but not always one hour.

Payment is due in full at time of service. For each appointment we provide a super bill for submission to insurance companies. We do not bill insurance directly. Also, we do not accept Medicare or TRICARE. Due to normal inflation, prices are subject to change without notice. Other prices shall apply for various procedures. Most times, the day before appointments, our receptionist will give a courtesy reminder call to the phone number provided to us, but it is important to note that it is the responsibility of the patient or patient's guardian to remember the appointment date and time.

Please be aware of the need for prescription refills. We require that you notify us at least one week before requiring any refills. If a prior authorization is needed for your prescription refill, please notify us 2 weeks prior.

If you have any type of physical disability or injury, please notify us so we may schedule your appointment in the appropriate examination room. Handicap parking is in the back of the building on the lower level.

CANCELLATION AND RESCHEDULING AND POLICY

Please arrive at least 10 minutes prior to your scheduled appointment. All patients please note, the doctor's appointments run back to back and he cannot carry over into the next patient's appointment. If you arrive late you will receive the remaining time left in your appointment and you will be charged for the full fee of your scheduled appointment.

New Patients - All new patient forms must be received at our office prior to scheduling first appointment, We prefer that the forms are dropped off at the clinic or mailed to us. Please contact the office at 1-858-755-1126 to make other arrangements.

For **new patient appointment cancellations** we require that the patient or patient's parent or guardian call Be Well Associates **at least 48-hours or preferably as soon as possible** before the scheduled appointment**.**

For IV's we require that the patient or patient's parents or guardian call Be Well Associates at least **48-hours** in advance to cancel or reschedule**. Please note:** IV's are made of a custom mix of ingredients and cannot be used on any other patient. They are mixed each morning for the day. **Therefore patients will be charged for the full cost of the IV if we receive the cancellation or reschedule call after the IV is mixed.**

For **existing patient appointments** call at least **24-hours** before the appointment time to cancel or reschedule. If possible, **more than 24-hour notice is preferable,** so that another patient in need may have your appointment time.

If we do not receive cancellations or reschedules in the time periods listed above, the patient or patient's guardian will be charged the full cost of the scheduled appointment or procedure.

I agree to the above listed cancellation policy. I also agree to pay Be Well Associates for any missed appointments, IV's, phone consults, house calls, hospital visits and balances due on my account or for services, products and supplements. If I request products or supplements to be sent to me I agree to pay Be Well Associates for the items and the shipping/handling charge.

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The individual seeking treatment or consultation is not considered a patient until Dr. Harper has completed the new patient appointment. If Be Well Associates staff or Dr. Harper receives new patient forms, lab tests, or medical records this does not constitute a doctor /patient relationship until the new patient appointment is completed.

Audio or video taping of any consultations or treatments is strictly forbidden. This includes cell phone voice recording or pictures.

I am fully aware that I must pay in full at the first and every appointment. Note, new patient appointments may range from $1,000 (if only 2 hours) or more, not including supplements, tests, BIA, IV's or medications.

Please sign below to acknowledge your agreement:

Patient Name (print): _____

Patient Signature: _____

Date: _____

If applicable:

Patient's Legal Representative (Print): _____

Patient's Legal Representative Signature: _____ Date: _____

Patient's Legal Representative Phone:

Home_____ Work_____ Cell_____

Relationship to Patient: _____

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Patient's Request for Non-Medicare Services

Section 4507 of the 1997 Balanced Budget Act allows a physician or practitioner to enter a private contract with a Medicare beneficiary. Signatures from the provider, a witness and the patient/beneficiary or their legal representative are required below. The supplier must submit an affidavit to Medicare expressing his/her decision to opt-out. This agreement is between Dan O. Harper, MD (NPI-1811085244) and ("Patient").

Patient Name: _____

- I, Dan O. Harper, M.D., have not been excluded from Medicare under sections 1128, 1156, or 1892 of the Social Security Act.
- I (the Medicare beneficiary) or my legal representative accept full responsibility for payment of charges for all services furnished by Dan O. Harper, M.D.
- I (the Medicare beneficiary) or my legal representative understand that Medicare limits do not apply to what Dan O. Harper, M.D. may charge for items or services furnished.
- **I (the Medicare beneficiary) or my legal representative agree not to submit a claim to Medicare or to ask Dan O. Harper, M.D. to submit a claim to Medicare**.
- I (the Medicare beneficiary) or my legal representative understand that Medicare payment will not be made for any items or services furnished by Dan O. Harper, M.D. that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- I (the Medicare beneficiary) or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out. The effective date of the opt-out period is July 1, 2016 and there is no expiration date.
- I (the Medicare beneficiary) or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
- I (the Medicare beneficiary) or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.
- This contract cannot be entered into by me, (the Medicare beneficiary), or my legal representative during a time when I, (the Medicare beneficiary), require **emergency care services or urgent care services**. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual).
- I, Dan O. Harper, M.D., understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

Please sign below to acknowledge your agreement:

Patient Name (print): _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

If applicable:

Patient's Legal Representative (please print): _____

Patient's Legal Representative Signature: _____ Date: _____

Patient's Legal Representative Phone: _____

Relationship to Patient: _____

Medical Office Signature:

Witness Signature: _____Date:_____

https://med.noridianmedicare.com/web/jeb/enrollment/opt-out

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Notification Regarding TRICARE

This form is to notify you that Dan O. Harper, M.D. is not an authorized provider for patients covered by TRICARE. Please read the following information:

- I (the TRICARE beneficiary) or my legal representative accept full responsibility for payment of charges for all services furnished by Dan O. Harper, M.D.
- I (the TRICARE beneficiary) or my legal representative understand that the TRICARE limits do not apply to what Dan O. Harper, M.D. may charge for items or services furnished.
- I (the TRICARE beneficiary) or my legal representative agree not to submit a claim to TRICARE or to ask Dan O. Harper, M.D. to submit a claim to TRICARE.
- I (the TRICARE beneficiary) or my legal representative understand that TRICARE payment will not be made for any items or services furnished by Dan O. Harper, M.D. that would have otherwise been covered by TRICARE if Dan O. Harper, M.D. were an authorized provider for TRICARE.
- I (the TRICARE beneficiary) or my legal representative understand that I have the right to obtain TRICARE-covered items and services from a physician and/or practitioner who is an authorized provider for TRICARE.
- I (the TRICARE beneficiary) or my legal representative will receive a copy of this form upon request, before items or services are furnished to me under the terms of this contract.

Please sign below to acknowledge your agreement:

Patient Name (print): _____

Patient Signature: _____

Date: _____

If applicable:

Patient's Legal Representative (print): _____

Patient's Legal Representative Signature: _____ Date: _____

Patient's Legal Representative Phone:

Home_____ Work_____ Cell_____

Relationship to Patient: _____

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Physician Specialist Consent

Be Well Associates, Inc., APC, is a specialty medical clinic and Dan O. Harper, M.D. is serving as a specialist at this clinic for complementary/integrative medical care and nutritional consultation, as well as an advisor for chronic and complicated medical cases.

Dan O. Harper, M.D. is board certified in Family Medicine, Holistic Medicine, Integrative Medicine, and Lipidology, as well as a certified Nutritional Specialist with a doctorate in Homeopathy.

As such, Be Well Associates/Dan O. Harper, M.D. does not provide primary medical care.

We require all patients to continue a relationship with a primary medical provider for ongoing routine care, as well as urgent medical problems which may arise during the time period that you are being treated at our facility. Your primary care provider would be responsible for any routine lab work, vaccinations, annual physical examinations, and any other routine care normally provided by a primary care physician.

Primary care physicians typically have hospital admitting privileges and 24-hour coverage for their patients. As a specialty provider, Dan O. Harper, M.D. is not affiliated with and does not have admitting privileges at any area hospital. You should contact your primary care provider for any after-hour emergencies, medical needs, or urgent questions. You are welcome to leave non-emergency messages at any time that will be addressed during the next business day.

I fully understand and concur with the above statements. I have taken adequate time to consider my decision to seek evaluation and treatment with Dan O. Harper, M.D.

Please sign below to acknowledge your agreement:

Patient Name (print): _____

Patient Signature: _____

Date: _____

If applicable:

Patient's Legal Representative (print): _____

Patient's Legal Representative Signature: _____ Date: _____

Patient's Legal Representative Phone:

Home_____ Work_____ Cell_____

Relationship to Patient: _____

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Medical Disclaimer

I,_____, have read and agree to the following statements:

- I fully understand that there are no warranties, assurances, or guarantees of successful outcomes.
- There are no claims made of healing or cures.
- Some of the treatments given at the clinic may not be FDA approved, but careful investigation has been done regarding these treatments. I may choose to have some of these treatments after reading the appropriate informed consents and after I have had all have my questions answered by Dr. Harper.
- I am free to stop any treatments at any time without reprisal or condemnation from the clinic staff, or Dr. Harper. I may resume any treatments in the future if I so choose. Such decisions are mine to execute.
- My possessions that I bring to the clinic during evaluation and treatments are my responsibility to care for, and the clinic will not be responsible for any lost or damaged items.
- I will provide supervision for any young children that may accompany me to the clinic and I will be responsible for any items damaged.
- I will carefully follow the instructions given to me concerning any equipment used in my treatments, and any injuries resulting from not following those instructions will be my responsibility I will not hold the clinic liable in any form.
- I understand that many of the clinic's staff and clients are chemically sensitive. **I will refrain from wearing colognes, perfumes, fragrances or scented hair products on the days I enter Be Well Associates.** If I unknowingly forget this, my appointments may have to be rescheduled for another day and the full charge for the scheduled appointment may be charged to me.
- I have also been informed that the World Health Organization has declared Cell Phone use to be a Class 2B carcinogen. The harmful microwave frequencies generated by my cell phone, even if on vibration or airplane mode, may be harmful to others in the clinic. The cell phone frequencies may also interfere with treatments given in Be Well Associate's treatment room. **I will turn off my cell phone before entering the clinic building.**

Please sign below to acknowledge your agreement:

Patient Name (print): _____

Patient Signature: _____

Date: _____

If applicable:

Patient's Legal Representative (print): _____

Patient's Legal Representative Signature: _____ Date: _____

Patient's Legal Representative Phone:

Home_____ Work_____ Cell_____

Relationship to Patient: _____

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Consent for Treatment by Dan O. Harper, M.D.

I have sought medical care from Dan O. Harper, M.D. I have chosen to do this of my own free will. I am aware that Dr. Harper is board certified as both an allopathic family practice physician and as an integrative/holistic physician. He is also licensed as a homeopathic physician. Allopathic medicine refers to medicine as it is commonly practiced in the United States, a system that uses pharmaceuticals and surgery as the primary modes of therapy. Integrative/holistic medicine refers to a system which uses naturally derived substances such as homeopathic remedies, herbs, vitamins, enzymes, etc. to promote and restore a healthy balance to the body. Since Dr. Harper is dually trained and board certified in both systems, he is fully qualified to determine whether the use of allopathic treatments, homeopathic treatments, integrative/holistic treatments or a combination of some or all are applicable. Dr. Harper emphasizes the importance of nutrition, exercise, attitude, and non-toxic remedies and supplements as the therapeutic mainstays for restoring a patient to his or her optimal state of health.

I realize that Dr. Harper's integrated approach to medical therapy may not be as rapid as pharmaceutical or surgical therapy. It may require more effort from me than the simple administration of a symptomatic medication for each complaint. Some medical authorities consider such treatment to be unproven and/or ineffective. I also understand that every patient is unique. Dr. Harper cannot warrant or guarantee that his treatment programs will always result in an improvement of the condition being treated.

I also understand that many insurance plans have clauses which limit coverage to usual and customary fees for necessary services. I realize that some of the integrative/holistic medical services provided by Dr. Harper will not fall under this description. I do not hold Dr. Harper responsible for the possible decisions by insurance companies to deny coverage for any of the medical services I may receive at Bell Well Associates.

I am consulting with Dr. Harper solely for the reasons concerning my own health. I am not consulting Dr. Harper in order to provide any information to any enforcement, regulatory, or investigative agency of any kind.

I release and forever discharge Dr. Dan Harper and his heirs, successors, and administrators from any and all claims, loss, damages, and injuries, present and future, in any manner arising out of my consultations or treatments with him. This release covers all damages, whether or not contemplated at the present time and includes situations undeveloped and unknown at the present time, as well as those now known.

If I choose at any time **not** to have any integrative/holistic medical treatments or any other type of treatment or medical test at Be Well Associates, I will notify Dr. Harper immediately. If explanations for any treatments or tests are not fully understood by me, I will also inform Dr. Harper.

By my signature below I state that I have had adequate time to read and understand the above information.

Please sign below to acknowledge your agreement:

Patient Name (print): _____

Patient Signature: _____Date: _____

If applicable:

Patient's Legal Representative (print): _____

Patient's Legal Representative Signature: _____ Date: _____

Patient's Legal Representative Phone:

Home_____ Work_____ Cell_____

Relationship to Patient: _____

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Acknowledgment of Receipt of HIPAA Privacy Practices

We at Be Well Associates Inc., APC are required by law to maintain the privacy of individuals and provide individuals with our Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our Office Manager in person or by phone at our number above. If you would like a copy of our entire HIPAA Privacy Practices, please ask. Our Privacy Policy is also on our website at www.drdanharper.com.

Patient Name (print): _____

Patient (sign): _____

Patient Date of Birth: _____

Today's Date: _____

If applicable:

Patient's Legal Representative (print): _____

Patient's Legal Representative (sign):_____

Relationship to Patient: _____

Today's Date: _____

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NOTICE TO CONSUMERS

Medical doctor, Dan O. Harper, M.D. of Be Well Associates, is licensed and regulated by the Medical Board of California. (800) 633-2322 www.mbc.ca.gov

By signing this document, I hereby acknowledge that I have read and understand the above-referenced notice.

Patient name (print): _____

Patient Signature: _____

Date: _____

If applicable:

Patient's Legal Representative (print): _____

Patient's Legal Representative (sign): _____

Relationship to Patient: _____

Date: _____

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Health Appraisal Questionnaire

Name: _____

Date of Birth: _____

Medication allergies (if none, please write in none): _____

_____

_____

Reason for this health consultation: _____

_____

_____

_____

_____

_____

_____

_____

1. Please check (√) all of the conditions which you now have or have been treated for in the past:

	Diabetes mellitus		Pneumonia		Parkinson's Disease
	Hypo/ hyperglycemia		Glaucoma		Diverticulitis/ diverticulosis
	Elevated cholesterol		Macular Degeneration- wet/ dry		Inflammatory Bowel Disease
	Elevated triglycerides		Food intolerances/ allergies		Irritable Bowel Syndrome
	Emphysema/ COPD		Hayfever/ airborne allergies		Ulcerative Colitis
	Asthma/ Reactive Airway Disease		Headaches- tension/ migraine		Crohn's Disease
	Angina—chest pains		Sleep Apnea		Lupus
	Cardiac arrhythmias- A.fib/ PVC's		Insomnia/ sleep disorders		Rheumatoid Arthritis
	Heart Attack/ coronary artery dis.		Depression		Osteoarthritis
	Heart Valve –aortic/ mitral/tricuspid		Anxiety		Other Autoimmune Disorders
	High blood pressure		Bipolar		Cancer:_____
	Stroke/ TIA (mini-stroke)		Obsessive compulsive disorder		HIV/ AIDS
	Varicose Veins		Alzheimer's / dementia		Lyme Disease
	Anemia— type:_____		Osteoporosis / osteopenia		Recurrent Infection:_____
	Chronic Fatigue Syndrome		Paget's Disease		Females: Endometriosis
	Fibromyalgia		Thyroid disease—hyper/ hypo- -		Post-partum blues
	Multiple Chemical Sensitivities		Gallbladder disease/ gallstones		Fibroids
	Mold Sensitivity/ Infection		Liver Disease		Polycystic Ovary Disease
	Electromagnetic Field Sensitivity		Kidney failure		Hormonal Imbalance

	Obesity		Kidney stones		Males: Erectile Dysfunction
	Epilepsy/ Seizures		Multiple sclerosis		Benign Prostatic Hypertrophy
	Meningitis/ Encephalitis		ALS		Other:_____

2. Do you have any close relatives with any of the following health conditions? Please check (√) if "yes".					
	Asthma/ severe hay fever		Drug/ Alcohol Addiction		Diabetes: __childhood /__ adult onset
	Eczema/ psoriasis		Emphysema/ COPD		Multiple Sclerosis/ Parkinson's
	Arthritis/ Rheumatism		Cystic Fibrosis		Autism
	Thyroid disease		Heart Disease		Autoimmune diseases
	Depression/ mental disorder		Stroke/ TIAs		Cancer: type_____
	Alzheimer's dementia		Thrombophlebitis /blood clots		Other:_____
Did any of these relatives have a heart attack (myocardial infarction) or stroke before age 65? ( ) yes / Before age 55? ( ) yes					

3. Have you been hospitalized in the last five years?	For surgery? Type-
For Infections? Type-	For illness? Type-
For injuries? Type-	For mental health?

4. Pregnancy / Delivery: (Females only)	Complications of pregnancy or delivery (please list)_____
Number of pregnancies :___ / How many: term births___, premature births___, still-born___ miscarriages___, surgical abortions___	
Number of living children:_____	Number of children still at home:_____

5. Types of known infections from past—check (√) those that you know you have had or been treated for--									
	Mono/ EBV		Hepatitis A		Mycoplasma		Lyme: Bartonella		Anthrax
	Herpes simplex		Hepatitis B		Chlamydia		H. pylori		Mumps
	Her. zoster /shingles		Hepatitis C		Gonorrhea		Giardiasis or Ameba		Malaria
	CMV		HIV		Lyme: Borrelia		Rocky Mt. Spot Fever		Candida (yeast)
	Coxsackie virus		Polio		Lyme: Babesia		Q Fever		Tuberculosis
	West Nile Virus		Strep throat		Lyme: Ehrlicia		Brucellosis		Other:

6. Types of surgeries you have ever had performed: (check (√) all that apply). Also indicate year of surgery if known.									
	Tonsillectomy		Bilateral Tubal Ligation		Fibroid removal		Stomach Banding		Bone Plate or ORIF
	Appendectomy		Vasectomy		Hysterectomy- ?ovary		Stomach Stapling		Neck Surgery
	Gallbladder		Knee Replacement		Hemorrhoidectomy		Thyroid Nodule		Lumbar surgery
	CABG (heart)		Hip Replacement		Vein Stripping		Thyroidectomy		Harrington Rod
	Heart stent		Laser Eye Surgery		Stomach Ulcer Surgery				Breast Augmentation

	Cataract—R / L		Lasix Eye Correct		Whipple Procedure		Vessel Bypass or Stent in artery not ♥		Other:

7. Significant Traumas: (check (√) all that apply). Also indicate year of trauma if known—such as " '04"					
	Motor Vehicle Accident		Head injuries		Gunshot Wound
	Motorcycle Accident		Bicycle Accident		Stabbing
	Significant fall		Sports Injury		Molestation/ Rape
	Second or third degree burns		Physical Assault / Abuse		Other:

8. Stress Questions: In the last year, have you had any of the following? (check (√) all that apply).					
	Death of a spouse		Change in Level of Faith		Troubles with spouse
	Divorce		Loss of Job		Foreclosure of a loan
	Marital Separation		Retirement		Change in job description
	Legal Troubles		Illness of a Family Member		Child leaving home
	Molestation/ Rape		Pregnancy		Trouble with in-laws
	Death of a Family Member		Sexual Difficulties		Teenager problems
	Loss of Self-Confidence		Addition of a new family member		Change in sleep habits
	Personal Injury or Illness		Loss of a close friend		Change in residence
	Marriage		Changed Line of Work		Tension at workplace

9. Stress Reduction: What do you do to reduce the above stress? (check (√) all that apply).					
	Exercise		Comfort foods/ binge eating		Laughter/ joking around
	Biofeedback		Gardening		Massage
	Crying		Hiking		Music—listening or playing
	Dancing		Rest/ get lots of sleep		Reading
	Talking to friend or fellow employee		Hobby:		Prayer
	Eating healthy		Hot tub or hot shower		Other:

10. Immunizations: check (√) all that you have been vaccinated for and list approximate date:					
	MMR-measles/mumps/rubella		Hepatitis A		Pneumococcal Date
	Polio		Hepatitis B		Influenza
	Smallpox		Yellow Fever		Tetanus
	Chickenpox/ shingles		Dengue Fever		Cholera
	Meningococcal		Typhoid		Other:

11. Examinations: (please write in the year of last exam in the blank---i.e. 1997)		
____Complete Physical Examination	____Ultrasound	____Dental Exam
____EKG	____C.T. Scan	____Eye Exam
____Lab panel	____MRI or PET scan	____ Other:
____Chest X-ray	*If female*: ____PAP	
____Colonoscopy	____Mammogram	*If male:* ____PSA blood test
____Cardiac Stress Test	____Thermography of Breasts	____Prostate Exam

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12. Environment Influences: (check (√) all that apply). Circle all that are problematic.									
	Mold/ black fungus		Dental Implants		Printing press fumes		Near high power lines		Remodeling home
	Loud noises		Chlorine		HVAC ducts-old		Near cell phone tower		Remodeling work
	Pesticides		Fluoride		Solvents		Near drilling well		Pets indoor home
	Radiation from X-ray		Dust		Paint / varnish fumes		New carpets		Cigarette smoke
	EMFs/ wi-fi-- microwave		Car Exhaust		Asbestos		Cleaning solutions		Air /car fresheners
	Mercury Amalgams		Diesel Exhaust		Mining operations		Concussion		Others:
	Root Canals		Gasoline fumes		Lead pipes/ paints		Post-Traumatic Stress		
List any specific chemicals at work or home that you know are causing reactions:									

14. Residence: (check (√) all that apply).							
	Live in single family home		Dwelling in suburban area		Dwelling is over 25 years old		House has central air
	Live in mobile home		Dwelling in rural area		Use humidifier in home		House has central vacuum
	Live in condo		Dwelling newly built		Use air conditioner in home		Heating system is oil
	Live in rental apartment		Dwelling is newly remodeled		Use air conditioner work		Heating system is coal
	Live in car or tent		Dwelling 3-10 years old		Use air conditioner in bedroom		Heating system is electric
	Dwelling in city		Dwelling is 11-25 years old		Use air conditioner in car		Heating is wood burning

15. Bedroom Environment: (check (√) all that apply).							
Mattress is:		Pillow is:		Flooring:		Items near head at night while sleeping:	
	Feather		Feather		Hardwood		Cell phone
	Memory foam		Dacron		Carpet		Plugged in alarm clock/ lamp near bed
	Horse hair		Memory Foam		Stone or tile		Computer or wi-fi equipment
	Organic cotton/wool		Foam rubber		Linoleum		TV or stereo speakers- ---corded or remote
Do you have allergy control products on the pillows, mattress and box springs? ( ) yes / ( ) no							

16. Tobacco Exposure: (check (√) all that apply).							
a. Have you been exposed to tobacco smoke? ( ) at home, ( ) at work, ( ) in stores, ( ) while in car, ( ) place of worship b. Did you experience second hand cigarette or cigar smoke while growing up? ( )yes, number of years_____; ( )no c. Do you personally smoke cigarettes now? ( ) yes, number of packs per day___/ number of years_____; ( ) no d. Do you personally smoke cigars? ( ) yes, __ years ( ) no; smoke pipe? ( ) yes, ___# times/day, ___years, ( ) no e. Do you currently use or have you used chewing tobacco? ( ) yes, ___cans per week, ___#years; ( ) no, never have ☺							
With smoke fumes you experience: (check (√) all that apply).					Headache		Nausea
	Fast Heart Beat		Shortness of breath		Wheezing		Other:_____

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17. Mold Exposure: If you have any symptoms in the presence of mold, please indicate below: (check (√) all that apply).							
	Muscle Aches		Headache		Irritability		Laryngitis
	Joint Pains		Bloating/ gas		Visual Changes		Nausea
	Fatigue/ Weakness		Heartburn/Indigestion		Chest tightness		Skin Rashes
	Memory Issues		Shortness of Breath		Insomnia		Tremors
	Cognitive Dysfunction		Anxiety		Dizziness		Heart Palpitations
	Sinusitis		Depression		Numbness/tingling		Onset of Fibromyalgia

18. Electro-Magnetic Field Exposure: If you have symptoms in the presence of EMF's: (check (√) all that apply).							
	Localized tingling		Swollen mucous membranes		Tachycardia		Sensitivity to light/ glare
	Localized heat		Dry eyes		Dizziness on rising		Burning Skin
	Headache		Muscle Aches		Ringing in the ears		Tremors
	Brain fog		Joint Aches		Insomnia		Blushing/ red face
	Nausea		Heart Palpitations		Sensitivity to Noise		Other:

19. Chemically Sensitive: please indicate which of the following are true today in your present condition: (check (√) all that apply).	
	a. Symptoms are reproducible with repeated (chemical) exposures.
	b. The condition has persisted for a significant period of time.
	c. Low levels of exposure (lower than previously or commonly tolerated) result in manifestations of the syndrome (i.e. increased sensitivity).
	d. The symptoms improve or resolve completely when the triggering chemicals are removed.
	e. Responses often occur to multiple chemically unrelated substances.
	f. Symptoms involve multiple-organ symptoms (runny nose, itchy eyes, headache, scratchy throat, ear ache, scalp pain, mental confusion or sleepiness, palpitations of the heart, upset stomach, nausea and/or diarrhea, abdominal cramping, aching joints).

20. If the issues are predominately related to the skin, please answer the following: (check (√) all that apply).					
	Skin itches—worse ( )night, ( ) heat, ( ) under stress, ( ) in EMFs,( ) other____		Things are pushed out through skin— ( ) fibers, ( ) crystals, ( ) 'critters', ( ) plastic threads, ( ) black beads, ( ) pus-like material, ( ) other_____		Skin sloughing or peeling
					Skin cracking and bleeding
	Feel things crawling under skin or organs				Brain fog with itching or worse rash
	Have tracks or streaks under or on skin				Insomnia from itch or skin pain
	Have seen organisms under or on skin		Others in room begin to itch, sneeze, or get rash		Co-infections: ( ) yeast, ( ) skin fungus, ( ) intestinal parasites, ( ) insect bites, ( ) recent travel illnesses, ( )other-_____
	Skin burns or stings or has numbness		Lint floats off skin—color--_____		
	Skin forms red blisters or hemangiomas		Skin ulcerations		

Give brief description of when and how problems in #17, #18, #19 or #20 occurred and how they have progressed to this point—may finish writing on back, if necessary:

_____

_____

_____

_____

_____

21. If your problems are mostly allergic in nature, please indicate which conditions make them worse: (check (√) all that apply).

	Indoors		Windy Day		Smoke from wood		Milk products		Vegetables
	Outdoors		Hot day		Cigarette smoke		Eggs		Wine
	At Home		Cold Day		Soap powder		Soy products		Beer
	At Work		Air Conditioning		Insecticides		Wheat/gluten		Hard liquor
	In car		In Barns		Paint fumes		Nuts		Cheese
	Morning		Damp Areas		Perfumes		Beans or seeds		Mushrooms
	Afternoon		Hay, mown grass		Cosmetics		Chocolate		Other food:
	At Night		Dusty areas		Wave sets		Fish		Aspirin
	Weather changes		High Air Pollution		Newspapers/print		Shellfish		NSAIDS
	Wet Weather		Animals		Wool		Meats		Drug:
	Dry Weather		Cooking Odors		Road Dust		Fruit		Other:

Is there a specific month or months it is worse?
( ) Jan; ( ) Feb; ( ) Mar; ( )Apr; ( ) May; ( )Jun; ( )Jul; ( )Aug; ( )Sep; ( )Oct; ( )Nov; ( )Dec; ( )Year round

22. If symptoms are related to the mouth and throat, please indicate which you are experiencing: (check (√) all that apply).

	Mouth pain or burning		Denture/ plate problem		Bleeding / swollen gums		Hoarseness of voice
	Mouth sores/ ulcerations		Pus on/ or swollen tonsils		Gum abscess/infection		"Belchy" taste in mouth
	Sore tongue		Dry mouth		Loss of taste		Trouble swallowing
	"Geographic"/white tongue		Toothaches		Metallic taste		Other:_____

23. If symptoms are related to the nose or nasal passages, please indicate which you are experiencing: (check (√) all that apply).

	Nasal discharge		Nasal dryness		Nasal polyps		Change in sense of smell
	Sinus pain		Nasal ulcerations or sores		Septal deviation		Snoring at night
	Nasal congestion		Nosebleeds		Septal perforation		Other:_____

24. If symptoms are related to the ears or hearing, please indicate which you are experiencing: (check (√) all that apply).

	Earaches		External ear discharge:		Vertigo (room spinning)		Pressure at elevations
	Tinnitus/ ear ringing		-Blood from ear		Mold growing in ear canal		Pulsation in ears
	Decrease in hearing		-Pus from ear		Popping in ears		Other:_____

25. If symptoms are related to the eyes / vision, please indicate which you are experiencing: (check (√) all that apply).

	Blurred vision		Glaucoma		Eye redness		Recent change in vision
	Double vision		Cataracts		Eye irritation		Trouble seeing to read
	Floaters in visual fields		Lazy eye		Eye discharge		Wear glasses/ contacts

	Blind spots in visual fields		Crossed eyes		Blindness: ( )R/ ( ) L eye		Other:_____

26. If symptoms are related to the brain /nervous system, please indicate which you are experiencing: (check (√) all that apply).							
	Seizures/ epilepsy		Nervous/ anxious		Inappropriate fears/phobia		Burning/ pain in nerves
	Syncope/ blackouts		Emotional outbursts		Disorientation		Mini-strokes (TIA's)
	Tremors		Panic attacks		Rapid mood swings		Stroke (CVA)
	Twitching/ tics		Compulsive thoughts or acts		"Seeing things"		Weakness of extremity
	Memory loss- short term		Depression/ blues		Hallucinations		Paralysis
	Memory loss- long		Seasonal Affective Disorder		Numbness/ tingling		Spinal/ nerve damage
	Cognitive issues		Brain fog		Migraines		Restless leg syndrome
	Focus issues/ ADD / ADHD		Insomnia/ sleep issues		Headaches		Other:_____

27. If symptoms are related to the blood or hematological system: (check (√) all that apply) and _____type							
	Bleeding tendency		Anemia_____		Hemangiomas		Platelet disorders
	Leukemia _____		Required transfusion		Heavy menses		Bone marrow problems
	Easy bruising		Reynaud's phenomena		Low white count		Other:_____

28. If symptoms are related to the endocrine system, please indicate which you are experiencing: (check (√) all that apply).							
	Heat intolerance		Fatigue		Abnormal thyroid tests		Bone density loss
	Cold intolerance		Excessive thirst/ urination		Goiter/ thyroid nodules		Mano/Menopause
	Hair loss for no reason		Loss of outer eye brows		Abnormal adrenal studies		Excessive/ unusual sweating
	Abnormal hair distribution		Lack of endurance		Loss of libido		Insatiable appetite
	Undesired weight gain		Undesired weight loss		Inches not desired		Other:_____

29. If your symptoms are related to the musculoskeletal system, please indicate which you are experiencing: (check (√) all that apply).							
	Sore joints		Gouty attacks		Sciatica /pain into legs		Stiff neck
	Swollen joints		Muscle weakness		Scoliosis/ spinal curve		Headache coming from neck
	Deformed joints		Painful muscles/fascia		Frozen shoulder		Trigger finger
	Stiff joints/limited motion		Loss of coordination		Rotator cuff tear		Bursal swelling on elbow
	Muscle spasms/cramps		Herniated discs		Grinding/clicking joints		Other:_____

30. If your symptoms are related to the kidneys or bladder, please indicate which you are experiencing: (check (√) all that apply).							
	Burning on urination		Urinary urgency		Too little urine		Kidney stones

	Frequent urination		Interstitial cystitis		Dark or colored urine		Dribbling urine
	Trouble starting urination		Voiding at night		Flank or mid back pain		Foul smelling urine
	Urinary incontinence		Too much urine		Blood in urine		Other:_____

31. If your symptoms are related to the stomach or intestines, please indicate which you are experiencing: (check (√) all that apply).							
	Change in appetite		Food not digesting		Jaundice or yellow eyes		Vomiting
	Heartburn		Mal-absorption		Blood seen in / on stools		Nervous stomach
	Belchy taste in mouth in a.m.		Abdominal distention/bloating		Rectal bleeding		Frequent bowel movements
	Vomiting blood		Black, tarry stools		Food sticking in esophagus		Worms in stool
	Flatus/ extra gas		Food intolerances		Trouble swallowing		Hemorrhoids
	Constipation		Pain after eating		Abdominal pain		Rectal pain after BM
	Diarrhea		Nausea		Gallbladder problems		Rectal itching
	Change in bowel habits		Stomach ulcers		Abdominal cramping		Other:_____

32. If you have symptoms of the heart or blood vessels, please indicate which you are experiencing: (check (√) all that apply).							
	Chest pain at rest		Low blood pressure		Heart murmur		Arm or leg numbness
	Chest pain with exertion		High blood pressure		Heart valve problem		Thrombophlebitis /clots
	Shortness of breath laying		Dizziness on standing		Exertional shortness of breath		Reynaud's phenomena
	Leg swelling/ edema		Palpitations		Coldness of feet or hands		Leg sores / ulcers
	Rapid heart beats		Hardened arteries in heart		Discolored feet or hands		Other:_____

33. If you have any symptoms of sleep disturbances, please indicate which you are experiencing: (check (√) all that apply)*							
	Snore loudly		Someone observed you stop breathing during sleep		Overweight		Neck circumference 15 3/4" (40cm) or larger
	Feel tired		High blood pressure		Over 50 years old		Male
*If more than three are checked, a sleep apnea monitor test should be arranged.							

34. If you have symptoms related to the lungs or your breathing, please indicate which ones you are experiencing: (check (√) all that apply).							
	Wheezing		Cough		Can't take a deep breath		Shortness of breath
	"Rattle" in chest		Chest pain with deep breath		Exposure to tuberculosis		Periods of apnea
	Change in sputum		Coughing up blood		Coughing up mucous		Other:_____

35. <u>For females only:</u> please indicate which of the symptoms you might be experiencing: (check (√) all that apply).

	Painful periods		Mood changes near period		Dry vaginal area		Fibroids
	Headaches around period		Painful intercourse		Bloating at time of period		Breast lumps
	Vaginal discharge		Abnormal PAP in past		Vaginal itching		Fibrocystic Breasts
	Pain on ovulation		Endometriosis		Hot flashes		Hx of rape or molestation
	Breakthrough bleeding		Loss of libido		Ovarian cysts		Other:_____

Use this area to further explain any of the symptoms in numbers #24 to #34:

_____

_____

_____

_____

_____

	36. Exercise: Do you exercise at least 4 days a week?( )-no ( )-yes			Type of exercises:	
	Walking _____miles		Swimming/ Surfing		Tennis
	Jogging _____miles		Free weights		Pilates
	Hiking _____miles		Treadmill		Aerobics
	Biking _____miles		Golf		other:_____
Do you exercise to:					
	Lose weight		Reduce stress		Increase motivation/ feel good
	Gain weight		Increase strength		Increase flexibility
	Cardiovascular conditioning		Maintain health		Condition for sports
What limits your physical activity? ( ) injuries listed below, ( ) lack of time, ( ) fatigue, ( ) just not my thing					
	Arm / elbow injury		Nerve damage		Groin injury
	Shoulder injury		Wrist / hand injury		Hamstring pull
	Ankle / foot injury		Hip / pelvis injury		Bone spurs
	Recent fracture/ stress fracture		Tennis elbow		Joint disease
	Low back pain		Neck injury		Abdominal pain
	Arthritis		Upper back injury		Dizziness
	Bursitis /calcium deposit		Knee / thigh injury		Chest pain

	37. Foods and Beverages: Think of the meals and snacks that you have had in the last week—indicate in the box how many portions of each you had in that week. Example: for five helpings of brown rice last week-- 5 -brown rice				
	Potato—baked, mashed		Ice cream		Beef
	Dry cereals		Butter		Pork
	Brown rice		Milk		Chicken/ turkey
	White rice		Margarine / Veg. Oil		Candy bars/choc.
	Rolls / biscuits		Eggs		Chips
	White bread		Nuts / nut butter		Sweet snacks
	Whole wheat bread		Oatmeal		Soda pop / lemonade
	Pasta		Fresh vegetables		Fruit juice
	Cakes / pies / pastries		Fresh fruits		Beer
	Cottage cheese		Fresh salads		Liquor
	Yogurt		Shellfish		Wine

	Cheese		Fish		other:_____

Food preparation: total % needs to add to 100% --

Frozen foods-___% +Canned foods-___% +Fresh foods-____% +Dehydrated foods-___% = to 100% of foods

Most meals are: ( ) at home; ( ) on the road; ( ) fast foods- eat out; ( ) fast foods- take home/delivered; ( ) mooch off family/ friends

38. Life Style Choices: (check (√) all that apply).

	Drink the fluoridated tap water		Live within ½ mile of high power lines	For Women:	
	Drink Reverse Osmosis Water-trace minerals added		Live with a mile of cell phone tower		Acrylic nails- non-toxic
	Drink Bottled or Delivered Water		Cell phone receivers on work place		Use wireless bras
	Drink Filtered Water		Cell phone receivers church/mosque		Skin lotions/ natural --non-paraben
	Drink at least 6 glasses of plain water		Use artificial air fresheners at home		Use bio-identical hormone
	Use a microwave to heat food or water		Use artificial car air fresheners		Use hair dyes that are natural
	Use a cell phone or cordless phone		Use scented detergents/fabric softener		Use all natural make up
	Use a router/ wi-fi on home computer		Use artificial cologne or perfume		Use natural hair spray/ mousse
	Sleep with computer router still on		Use antiperspirant: type_____		Avoid talking on cell /texting in car
	Have plugged in alarm clock near head		Use seat belts in car		Use non-synthetic vitamins/minerals
	Sleep with cell phone on		Have a central vacuum in home		Use non-PABA sunscreen
	Have SDGE Smart Meter on home		Have an air filtration unit in home		Use non-sugar/non-fluoridated tooth paste
	Get eight hours or more of sleep/night		Spray pesticides in or near home		Choose non-toxic products
	Get 30+minutes of exercise 4-5days/week		Meditate or relax daily		Recycle when possible
	Focus on positive things		Choose to eat healthy		Have a loving pet/ mate/ friend
	Have 1-2 daily bowel movements		Choose to shop for natural foods		Enjoy the sunshine often

What have you done in the last few years to try to improve your health (e.g. other doctors, treatments, massages, acupuncture, craniosacral therapy, chiropractors, etc.)?

_____

_____

_____

_____

_____

_____

What areas of your lifestyle are likely involved with your condition and you would like to have improved: (please prioritize #1, 2, 3, etc.)

___my level of anxiety
___my pace of living
___not enough peace and quiet
___my diet and nutrition program
___my exercise program
___not enough time spent in nature
___my creative expression
___my feelings about my career
___my social and family life
___my communications skills

What obstacles could prevent you from changing those things in your lifestyle that are undermining your health?

Other issues or concerns you want addressed:

List your special interests and passions in life:

I understand that there are no guarantees in the field of health. I realize that if I am not willing to work towards my health or the health of my loved ones seeking consultation with Dr. Harper, that none of the suggestions made will correct improper diet, unhealthy lifestyle, or years of bad habits. The work is up to me, with Dr. Harper as a consultant and educator.

List the name of any doctors or practitioners you are currently seeing with brief reason (please list your primary care physician):

List the name of doctors or practitioners you have seen in the past with brief reason:

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_____

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_____

_____

_____

Patient Name (print): _____

Patient Signature: _____

Date: _____

If applicable:

Patient's Legal Representative (print): _____

Patient's Legal Representative Signature: _____ Date: _____

Patient's Legal Representative Phone:

Home_____ Work_____ Cell_____

Relationship to Patient: _____