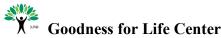


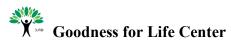
# GOODNESS FOR LIFE CENTER HEALTH OUESTIONNAIRE

HEALTH QUESTIONNAIRE
Fax (302) 832-9472 | Website: http://drbronnernd.org | Email: tbronner@gflc.org

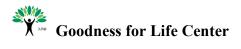
Personal Information					
Last Name		First N	ame		MIAge
Date of birth//	Gende	erPhor	ne to leave mes	sages () _	
Address			_ City	State	Zip
Email address			May	y we email you	clinic info?
Person to Notify in Emerge	ency			_Phone (	)
Primary Care Doctor:					
Name		P <sub>1</sub>	ractice Name		
City	_State	_ Phone _		Fax	
Specialists:					
Name		Pı	ractice Name_		
City	_State	Phone _		Fax	· · · · · · · · · · · · · · · · · · ·
Chief health concern:			Date	of onset:	
What happened 6 mos. prior make in your life prior (if y	or to the or	nset of you	ır chief health c	concern, or wha	
Location of concern (the m	ore specif	ic, the bett	eer):		
List any other health conce					
What have you already trie					
Past Medical/ Surgical Hi					
Diagnosis:					Date of onset
Surgery:					Date: Month/Year



Childhood Illnesses					
List illnesses, age occurre	ed. anv birth t	trauma/defects	/premature:		
					pe:
List any known allergies					
1)Reac	ction:	2)		Reaction:	
List any sensitivities (i.e.					
Medications/Supplemen	its/Herbs				
List all medications (pres					are taking
currently or have taken in Meds/Supplements		Frequency		Reason	Doctor or
		1	(start-end)		Self -Prescribed
Antibiotic use and when:			-	Γake probiotics	s afterwards?
Nutrition				•	
How many meals do you	eat per day?	D	o vou eat sna	cks between m	neals?
Food Diary: Name what	t you ate yest	erday and the	approximate	time.	
Food item (s)					Time eaten



Oz. of water/day (1 cup =	8 oz): ounces;	Coffee/day;	Soda/day;		
Tea/day; Juic	e/day; Oth	ner drinks/da	y		
Vegetarian/vegan/other: _	Foods that tr	rigger heartburn/bloating	g/gas:		
Sweeteners/gum use (brar	nd):	; Sugar in diet: low _	medhigh		
Dairy in diet: lowme	ediumhigh	No dairy Salt in	diet low high		
Foods excluded from diet	:	; Foods/drinks y	ou crave		
Review of Systems					
Please check, if you are ex	speriencing any of the	following:			
Frequent headaches	Migraines	Change in Vision □	Sinus problems		
Weight loss □	Weight gain □	Nervousness	Appetite problems		
Painful stiff neck □	Thyroid issue □	Bronchitis	Emphysema □		
Coughing blood □	Pneumonia	Heart murmur	Angina □		
Indigestion □	Gallstones	Pain in abdomen	Hemorrhoids		
Liver problems □	Bladder infections	Freq urination	Slow urine stream □		
Arthritis □	Seizures	Anemia □	Easy bruising □		
Migraines □	Glaucoma 🗆	Ear problems	Sleep problems		
Heavy night sweats □	Depression	Fevers	Coughing blood □		
Sore throat	Diff swallowing □	Short of breath □	Chronic cough □		
Chest pain □	Palpitations □	Rapid heartbeat □	Nausea/vomiting □		
Diarrhea	Constipation	Blood in stool □	Back pain □		
Kidney infections □	Blood in urine	Prostate problems	Pain/stiff joints □		
Stroke/TIA's □	Vision loss □	Bleeding easily	Mole changes □		
Skin rashes □	Weakness	Chronic fatigue □	Hypertension □		
Diabetes	Sarcoidosis	Sickle cell anemia	Numbness/tingling		
Autoimmune disorder	HIV □	Covid-19 □	Vaccine reaction □		
Women only Number of pregnancies Date of last pap/	/ any abnormali	ties? $\underline{Y/N}$ If so, how res	solve		
Cycle Length (average 28					
Ovulation day (average is					
PMS Symptoms					
Color of menses Flow heavy light Clots					
Cramping If spotting, when List all birth control in use					
If fertility, fertility work-u	p results, including spe	erm analysis			
Men only: Prostate results					



## **Diagnostic Tests**

Please fill in know	n information	, add oth	er procedure	es if needed:			
Date latest labs: Date thyroid tested:							
Procedure	Reason	Date	Outcome	Procedure	Reason	Date	Outcom
X-Ray				Mammogram			
Bone scan				MRI			
Endoscopy				CT Scan			
Colonoscopy				EKG			
Rectal Exam				Echocardiogram			
Ultrasound		. 1	.1	EEG			
List any serious tra	auma you nav	e nad, su	ch as accidei	nt or fall			
Social History							
Marital status		_ No. Ch	nildren	Occupation			
What do you LOV	E to do the m	ost?					
With whom do yo	u live? (List a	ll membe	ers of househ	old)			
Alcohol:drin	ks/week; wine	e/liquor/b	oeer?	Social/S	tress		
Tobaccopacl	ks/cigars/chew	/day					
Do you want help	to quit? F	Recreation	nal drug use	(past or present):			
Exerciseho	urs/week what	types?					
Most common tho	ught that cros	ses your	mind				
Any limiting belie	fs						
				Hobbies:			
Major life changes	s in the last ye	ar	· · · · · · · · · · · · · · · · · · ·				
List top 3 stressors							
2)			3)				
				nge in weight?			
Times low energy	:		Time	es high energy:			
				Is this enough?			
-		_		mes awoken:			
Are you able to wa							

## **Family History**

List health conditions immediate family n	members have or what conditions run in the family:
	lowing each visit. An invoice will be sent to you via 24 hours' notice to avoid a \$25 cancellation fee.
Patient's Signature	Date

#### Goodness for Life Center 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.

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. HIPAA 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, health care operations, health care reminders, and for public benefit. Any other disclosure requires your written authorization.

- Treatment: providing or managing health care and related services by one or more health providers.
- Payment: billing or collection activities and utilization review.
- Health care operations: running the clinic, quality assessment, and certification or credentialing activities.
- Reminders: appointment reminders or to inform you of changes in the hours by such means as postcards, voicemail messages or letters.
- <u>Public benefit</u>: 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 create and distribute de-identified health information by removing all references to 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 unless we have already taken actions relying on your authorization.

You have the following rights, which you can exercise with a written request to the office.

- 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 <u>must be in writing</u> 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.

I have read and understand the above-stated 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. You have recourse if you feel your privacy protections have been violated by a written complaint to the US Department of Health and Human Services about violations of this notice.

Patient's Name	Legal Guardian (under 16 years old)
1 attent 5 Name	Legal Guardian (under 10 years old)
Patients Signature	Date
Dr. Tauheedah Bronner, ND Goodness for Life Center	For more information about HIPAA or to file a complaint The US Department of Health & Human Services
Newark, DE 19702 Email: tbronner@gflc.org	Office of Civil Rights 200 Independence Avenue, SW
Email toronner wight-org	Washington, DC 2020 Phone: 202-619-0257, Toll Free: 877-696-6775



### Fax (302) 832-9472 Email: tbronner@gflc.org

#### INFORMED CONSENT FOR RECOMMENDATIONS

Name:	· · · · · · · · · · · · · · · · · · ·	 · · · · · · · · · · · · · · · · · · ·	 
Date of Birth: _		 	

I hereby authorize the Naturopathic Doctor at Goodness for Life Center to perform the following specific procedures as necessary to facilitate recommendations:

- **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, crèmes, 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, bodywork, manipulation

Practitioner of Goodness for Life Center has explained the risks and benefits of the care I am receiving, and I have been given the opportunity to ask questions about the procedures. I recognize the 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 herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, and possible drug interactions with natural supplements or products. Physical medicine may result in temporary pain or discomfort.

**Potential benefits and purpose:** restoration of health and the body's maximal functional 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 alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the practitioner 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. I consent to additional procedures from those described herein that are deemed necessary.

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 I may request to view my medical record and can request a copy by paying the appropriate copying fee.

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 understand that Dr. Tauheedah Bronner is a naturopathic doctor, and registered nurse, not a medical doctor. I further understand that Dr. Tauheedah Bronner does not diagnose, treat or prescribe for any particular symptom, disease or condition. I understand that she will work on increasing my general vitality and constitutional strength in effort to prevent illness and help reverse the progression of disease.

Date	Signature of F	Signature of Patient		
If the patient is a minor or is	s unable to consent, please complete the fol	llowing: Age		
Name of Guardian	Relationship	Signature		