GOODNESS FOR LIFE CENTER
HEALTH QUESTIONNAIRE

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

Personal Information

Last Name_____ First Name_____ MI____ Age_____

Date of birth____/____/_____ Gender ___Phone to leave messages (____) _____

Address_____ City_____ State _____Zip_____

Email address _____May we email you clinic info? _____

Person to Notify in Emergency _____Phone (_____) _____

Primary Care Doctor:

Name_____ Practice Name_____

City_____ State____ Phone _____ Fax _____

Specialists:

Name_____ Practice Name_____

City_____ State____ Phone _____ Fax _____

Health History

Chief health concern: _____**Date of onset**: _____

What happened 6 mos. prior to the onset of your chief health concern, or what decisions did you make in your life prior (if you feel a narrative will help, please feel free to provide separately):

_____

Location of concern (the more specific, the better): _____

List any other health concerns: _____

What have you already tried: _____

Past Medical/ Surgical History: List your current medical conditions and any previous surgery.

Diagnosis:	**Date of onset**
Surgery:	**Date: Month/Year**

Childhood Illnesses

List illnesses, age occurred, any birth trauma/defects/premature: _____

_____Blood Type: _____

List any known **allergies** (environmental, food, drug) and reaction:

1)_____Reaction: _____2) _____Reaction: _____

List any sensitivities (i.e., light, smell, touch, food, sounds):

_____

Medications/Supplements/Herbs

List all medications (prescriptions), vitamins, herbs and other supplements you are taking currently or have taken in the past year (attach additional sheet if needed):

Meds/Supplements	Dose	Frequency	Dates (start-end)	Reason	Doctor or Self -Prescribed

Antibiotic use and when: _____ Take probiotics afterwards? ___

Nutrition

How many meals do you eat per day? _____ Do you eat snacks between meals? _____

Food Diary: Name what you ate yesterday and the approximate time.

Food item (s)	**Time eaten**

Oz. of water/day (1 cup = 8 oz): _____ ounces; Coffee_____/day; Soda_____/day;

Tea_____/day; Juice_____/day; Other drinks_____/day

Vegetarian/vegan/other: _____Foods that trigger heartburn/bloating/gas: _____

Sweeteners/gum use (brand): _____; Sugar in diet: low ____med _____high_____

Dairy in diet: low ____medium _____high____ No dairy_____ Salt in diet low ____ high ____

Foods excluded from diet: _____; Foods/drinks you crave _____

Review of Systems

Please check, if you are experiencing 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___ live births___ miscarriages___ abortions___

Date of last pap____/____/_____ any abnormalities? Y/N If so, how resolve_____

Cycle Length (average 28 days)_____ Last menses____/____/_____ Age perimenopause_____

Ovulation day (average is day 14) _____ Ovulation Symptoms_____

PMS Symptoms_____

Color of menses_____ Flow heavy ___ light ___ Clots ___

Cramping ____ If spotting, when_____ List all birth control in use_____

If fertility, fertility work-up results, including sperm analysis_____

Men only:

Prostate results _____

Diagnostic Tests

Please fill in known information, add other procedures if needed:
Date latest labs: _____ Date thyroid tested: _____

Procedure	Reason	Date	Outcome	Procedure	Reason	Date	Outcome
X-Ray				Mammogram			
Bone scan				MRI			
Endoscopy				CT Scan			
Colonoscopy				EKG			
Rectal Exam				Echocardiogram			
Ultrasound				EEG			

List any serious trauma you have had, such as accident or fall _____
_____

Social History

Marital status_____ No. Children_____ Occupation_____

What do you LOVE to do the most? _____

With whom do you live? (List all members of household) _____-

_____

Alcohol: ____drinks/week; wine/liquor/beer? _____ Social/Stress _____

Tobacco ____packs/cigars/chew/day

Do you want help to quit? ___ Recreational drug use (past or present):_____

Exercise _____hours/week what types? _____

Most common thought that crosses your mind _____

Any limiting beliefs _____

How do you take time to relax? _____ Hobbies: _____

Major life changes in the last year_____

List top 3 stressors or most stressful events in life: 1)_____

2)_____3)_____

Height_____ Weight_____ lbs. Significant change in weight? ___ Blood pressure_____

Times low energy: _____ Times high energy: _____

Time you go to bed _____Sleep hours/night _____Is this enough? Y/N Sleep apnea Y/N

Trouble: Falling asleep ___Staying asleep __ (what times awoken: _____)

What causes sleeping issues: _____

Are you able to walk up & down stairs? _____

Family History

List health conditions immediate family members have or what conditions run in the family:

_____

_____

_____

Payment is required immediately following each visit. An invoice will be sent to you via PayPal. Cancellations require 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.
- Public benefit: 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 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. 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.

I have read and understand the above-stated information.

_____	_____
Patient's Name	Legal Guardian (under 16 years old)
_____	_____
Patients Signature	Date

Dr. Tauheedah Bronner, ND
Goodness for Life Center
Newark, DE 19702
Email: tbronner@gflc.org

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

Goodness for Life Center™
The Health & Wellness Specialty Plaza

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 Patient

If the patient is a minor or is unable to consent, please complete the following: Age_____

Name of Guardian_____Relationship_____Signature_____