Welcome to Natural Healing of Tampa Bay! We look forward to meeting you and also working with you towards your wellness goal. We have enclosed a new patient packet which should be filled out prior to your appointment. We will also need your driver's license in order to make a copy for your chart.

If you should have any questions or concerns prior to your visit please contact our office. Our staff is eager to help and make your visit as comfortable as possible.

PHONE: (813) 655-2829
FAX: (813) 655-2848

NATURAL HEALING OF TAMPA BAY

PATIENT INFORMATION RECORD

The following information is needed is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist.

PLEASE PRINT.

PERSONAL INFORMATION

Last Name:_____ First Name:_____ MI:_____
Birth Date:_____ Age:
Gender: M F Marital Status: Married Single Separated Divorced Widowed Other
No. of Children: _____
Driver's License # & State: _____
Home Phone:_____ Cell Phone:_____
Email Address:_____
Home Address:_____

Mailing Address (IF DIFFERENT FROM ABOVE):

Employer Name:_____
Occupation:_____
Employer Address:_____
Employer Phone:_____

FINANCIAL/GUARANTOR/PARENT INFORMATION:(If guarantor is "self", skip this section)

Last Name:_____ First Name:_____ MI:_____
Birth Date:_____ Age:_____
Social Security #: _____
Home Phone:_____ Cell Phone:_____
Email Address:_____
Home Address:_____

Mailing Address (IF DIFFERENT FROM ABOVE):

Employer Name:_____ Occupation: _____
Employer Address:_____
Employer Phone:_____

EMERGENY CONTACT INFORMATION

Last Name:_____ First Name:_____
Relationship to Patient:_____
Home Phone:_____ Cell Phone:_____
Email Address:_____

Home Address:_____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it CAREFULLY.

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and/or providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment to you.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health care information may be used as necessary to support the day-to-day activities and management of Natural Healing of Tampa Bay. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement investigations and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo and use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information.

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information About your Treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Institute Duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. WE also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information. You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office at. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints. If you would like to submit a comment or complaint about our privacy practices or you believe that your privacy rights have been violated, you can send a letter outlining your concerns to:

Dr. Heath Lambert D.C.
342 E Bloomingdale Ave
Brandon, FL 33511

MEDICAL RELEASE FORM

Authorization to Obtain or Release of Medical Records From Medical Providers

I, _____, hereby authorize Natural Healing of Tampa Bay and all of its participating practitioners within the practice to obtain any and all medical records concerning my care from any physician, hospital, pharmacy, or other health care professions that have provided medical care in my past. I also authorize the practice to release any and all medical records concerning my care to any physician, hospital, or other health care providing care to me at any time. Additionally, I authorize the practice to release any and all medical records concerning my care to Medicare and any other insurance or third party administrator.

Authorization to Release Medical Information to Individual/Family Members

In accordance with Federal government privacy rules implemented through the Health Care Portability and Accountability Act of 1996 (HIPAA), in order for your physician or staff of the practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. IN THE EVENT OF A CITICAL EPISODE OR IF YOU ARE UNABLE TO GIVE YOUR AUTHORIZATION DUE TO THE SEVERITY OF YOUR MEDICAL CONDITON, THE LAW STIPULATES THAT THESE RULES BE WAIVED.

_____ I DO NOT authorize Natural Healing of Tampa Bay to release any information concerning my medical care to any individual except as set forth above.

_____ I authorize Natural Healing of Tampa Bay to release any information concerning my medical care to any individual except as set forth above.

Name/Relationship:_____Date of Birth:

Name/Relationship:_____Date of Birth:

Patient Signature:_____Date:

Witness:_____Date:

HIPAA COMPLIANT RELEASE OF INFORMATION FORM
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Print Patient's Full Name _____Patient's Date of Birth _____

Physician of healthcare facility records requested from:

_____ Fax#

Send requested health record information to:

_____ Fax#

The following information is to be released (Check all that apply):

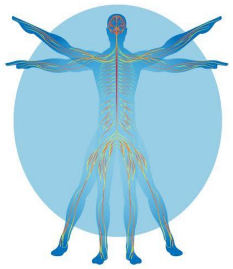
_____ All Records
_____ Records of treating physician _____(only)
_____ Initial Evaluation
_____ Follow-up Notes
_____ Medication Report
_____ Discharge Summary
_____ Hospital Admission, History & Physical
_____ Radiology Report(s)
_____ Lab Report(s)
_____ Other:

The purpose for which the release is being requested: _____

This authorization expires 12 months from date of signature of specified date: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that I have the right to revoke this authorization in writing at any time

Patient (or Parent/Guardian) Signature_____ Date_____



NATURAL HEALING
OF TAMPA BAY

Dr. Heath Lambert D.C.

HEALTH HISTORY

Name:_____ Date:_____

Referred by:_____

Describe the Major Complaint(s) that Bring You to Our Office:

All Current Health Problems:

List Any Other Doctors Seen, Diagnoses, Treatments & Results Obtained:

Your Current Physician(s) /Therapist(s):

List All Hospitalizations or Surgeries & Their Dates:

List Any Traumas and Their Dates:

List Any Medication You Are Taking:

List Any Food or Medication Allergies:

Tobacco or Prior Drug Abuse:

_____

_____

Alcohol Use:

_____

_____

History of Domestic Violence:

_____

_____

Describe Your Exercise & Activity Habits:

_____

_____

Height:_____ Weight: _____ High Blood Pressure: Y N

Glasses of Water Each Day: _____ Diet: _____

FAMILY HISTORY:

Father: Age_____ Deceased_____Health?_____

Mother: Age_____Deceased_____Health?_____

Sister(s): Age_____Deceased_____Health?_____

Brother(s): Age_____Deceased_____Health?_____

Children: Age(s)_____Health?_____

PLEASE CHECK ALL THAT APPLY:

MUSCULOSKELETAL SYSTEMS

HEAD

( ) Frequent headaches
( ) Severe Headaches
( ) Head feels heavy
( ) Injury/Concussion
( ) Dizziness
( ) Light headedness
( ) Loss of taste
( ) Loss of smell
( ) Loss of hearing
( ) Loss of balance
( ) Loss of grip strength

ARMS & HANDS

( ) Pain in upper arm
( ) Pain in forearm
( ) Pain in hands
( ) Pain in fingers
( ) Tingling in fingers
( ) Tingling in arms
( ) Cold Hands
( ) Swollen fingers
( ) Swollen feet

HIPS, LEGS, AND FEET

( ) Pain in buttocks
( ) Pain in hip
( ) Pain down leg
( ) Knee pain
( ) Leg Cramps
( ) Tingling in legs
( ) Numbness in legs
( ) Numbness in toes
( ) Cold feet
( ) Swollen ankles

NECK
( ) Pain in neck
( ) Pain w/movement
( ) Swelling in neck
( ) Stiffness in neck
( ) Pinched nerve in neck
( ) Neck feels out of place
( ) Muscle spasms in neck
( ) Grinding sounds in neck
( ) Popping sounds in neck
( ) Previous neck injury
( ) Masses

SHOULDERS
( ) Pain in shoulders
( ) Pain across shoulders
( ) Muscle spasms
( ) Can't raise arm:
( ) *Above shoulder*
( ) *Above head*

MID-BACK
( ) Mid-back pain
( ) Pain between shoulders
( ) Sharp stabbing pain
( ) Dull ache
( ) Pain from front to back
( ) Pain over kidney area

LOWER BACK
( ) Limited back movement
( ) Lower back pain
( ) Shooting pain down the legs
( ) Lower back feels out of place
( ) Muscle spasms
( ) Numbness/Tingling down t he legs

OTHER
( ) General body aches
( ) Passing out
( ) General weakness
( ) Osteoporosis

SYSTEMIC CONDITIONS
( ) AIDS/HIV
( ) Anemia
( ) Arthritis
( ) Cancer
( ) Chronic fatigue
( ) Parkinson's disease
( ) Diabetes
( ) Epilepsy/seizures
( ) Fibromyalgia
( ) Hypoglycemia
( ) Multiple sclerosis
( ) Polio
( ) Rheumatic fever
( ) Rheumatic arthritis
( ) Tuberculosis
( ) Depression

CARDIOVASCULAR
( ) General swelling
( ) Swelling in legs
( ) Swelling in face
( ) Swelling around eyes
( ) Chest pain
( ) Pounding heartbeat
( ) Rapid heartbeat/palpitations
( ) Irregular heartbeat
( ) Blue or purple skin
( ) Stroke
( ) Hypertension
( ) Angina/MI
( ) Double Vision
( ) Loss of coordination
( ) Loss of memory
( ) Ringing in ears
( ) Heart attack
( ) High blood pressure
( ) Muscle weakness
( ) Dizziness
( ) Blurred vision
( ) Fainting
( ) Area of numbness
() Chronic heart failure
( )Inability to form words
( )Burning sensations
( ) Blindness
( ) Previous head injury
( ) Previous neck injury
( ) Taking birth control pills
( ) Family history of stroke
( ) Blood vessel disease
( ) Blue or purple nail beds
( ) Cold hands/feet
( ) High cholesterol
( ) Stroke

( ) TIA (mini-stroke)

SKIN, HAIR, NAILS
( ) Eczema
( ) Itchy skin
( ) Rough, scaly skin
( ) Dry skin
( ) Oily skin
( ) Yellow skin
( ) Bruise easily
( ) Baldness
( ) Paper thin nails
( ) Nail biting

RESPIRATORY
( ) Shortness of breath
( ) Dry cough
( ) Coughing up blood
( ) Wheezing
( ) Productive cough
( ) Asthma
( ) Bronchitis
( ) COPD
( ) Sleep apnea
( ) Tuberculosis
( ) Chronic cough

OB/GYN (WOMEN)
( ) Painful periods
( ) Spotting
( ) Premenstrual symptoms
( ) Irregular periods/menses
( ) Lumps in breast
( ) Vaginal discharge
____Age at menses
____Age at menopause
____# of pregnancies
____# of deliveries
( ) Hot flashes
( ) Uterine fibroids
( ) Polycystic ovarian syndrome
( ) Breast discharge
( ) Breast enlargement

( ) Breast pain
( ) Prior breast biopsy

EYES
( ) Blurred vision
( ) Double vision vision changes
( ) Eye fatigue
( ) Excessive tearing
( ) Lack of tearing
( ) Light bothers eyes
( ) Excessive itching
( ) Pain in eyeball
( ) Cataracts

EARS
( ) Loss of hearing
( ) Not sufficient
( ) Pain in ears
( ) Discharge from ears
( ) Vertigo
( ) Ringing in ears

NOSE & SINUSES
( ) Nose bleeds
( ) Pressure over eyes
( ) Nose obstruction
( ) Frequent colds
( ) Sinusitis
( ) Loss of smell
( ) Allergies

MOUTH & THROAT
( ) Pain in throat
( ) Bleeding gums
( ) Abscessed tooth
( ) Difficulty swallowing
( ) Lesion in mouth
( ) Frequent sore throats
( ) Hoarseness

STD'S
( ) Syphillis
( ) Gonorrhea
( ) Other

GASTROINTESTINAL
( ) Poor appetite
( ) Constant nibbling
( ) Difficulty swallowing
( ) Indigestion/ulcers
( ) Nausea & vomiting
( ) Abdominal pain
( ) Change in bowel habits
( ) Diarrhea
( ) Constipation
( ) Hemorrhoids
( ) Gallbladder disease
( ) Vomiting blood
( ) Blood in stool
( ) Hepatitis
( ) Pancreatitis

GENITOURINARY
Urination is:
( ) Frequent
( ) Not sufficient
The amount is:
( ) High
( ) Moderate
( ) Low
( ) Frequent urination at night
( ) Intense desire to urinate
( ) Difficulty urinating
( ) Lack of control
( ) Pain in urination
( ) Dribbling/Leaking
( ) Bloody urine
( ) Cloudy urine
( ) Chronic UTI's
( ) Prostatitis
( ) Kidney failure
( ) Erectile dysfunction

ENDOCRINE/HORMONAL
( ) Hot or cold intolerance
( ) Thyroid problems
( ) Fatigue (not alleviated by sleep)
( ) Increased susceptibility to infection
( ) Hair thinning
( ) Dry skin
( ) Weight loss
( ) Diabetes
( ) Easy bruising
( ) Weight gain
( ) Cravings for sweets

SOCIAL/PSYCHOSOCIAL
( ) Smoking
( ) Other tobacco use
( ) Alcohol use
( ) Drink coffee or tea
( ) Nervousness
( ) Irritability/mood swings
( ) Fatigue
( ) Depression
( ) Panic attacks
( ) Insomnia/problems sleeping
( ) Generally feel run down
( ) Anxiety
( ) Reduced tolerance for stress
( ) Low sex drive

Diet is:
( ) Balanced
( ) Not balanced

Family Stress is:
( ) Severe
( ) High
( ) Moderate
( ) Minimal
( ) None

Rest it:
( ) Sufficient
( ) Not sufficient

My job stress is:
( ) Severe
( ) High
( ) Moderate
( ) Minimal
( ) None