Colleen Gagliardi ND LLC **Located within Notaro Chiropractic** **Phone: 716-688-8815**
Naturopathy, Acupuncture **4754 North French Rd.** **Text: 716-534-8885**
Hypnosis **East Amherst, NY 14051** **drcolleen@drcolleennd.com**

These questions may be used to further assess options to improve your overall nutritional wellness.

Your reason for coming in today:

1. What is your primary concern today?
2. How is this impacting you?
3. When/how did this condition occur?
4. Is this issue constant in nature or does it come and go?
5. Problem/pain scale from 1-10, with 10 "worst"
6. Is this issue new, or has it occurred in the past?
7. Any prior injury, trauma or event associated with this?
8. How have you tried to address this in the past?
9. What makes this issue better?
10. What makes this issue worse?
11. Has this issue been medically evaluated in the past? If so, by who?
12. Do you have other concerns that you'd like to discuss? If so, what?
13. Which natural therapies are you most interested in?
14. On a scale of 1-10 with 10 being the highest, how committed are you in wanting to address these issues?
15. What are your 3 top health goals that you would like to accomplish in the next 4-5 months?

Medications/Supplements:

1. Please list out all current medications (and over the counter medications) that you take, along with the doses, and please note when you started taking each:
2. Please list out all current supplements and dose:

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3. Have you taken any of these medications in the past? (circle all that apply):

anti-anxiety meds antacids antibiotics anticonvulsants antidepressants
antifungals aspirin/ibuprofen asthma inhaler beta blocker
chemotherapy meds cortisone (oral or topical) diabetic meds
diuretics estrogen/progesterone heart medications
high blood pressure meds pain killing medications/muscle relaxers, opioids, analgesic medication
hormone therapy laxatives insulin birth control pills or IUD
radiation exposure - treatment, xrays, CT scans, MRI recreational drugs muscle relaxers
sleeping pills thyroid medication tylenol/acetaminophen
heartburn meds ulcer medication

Health History:

1. Who is your Primary Care Provider?
2. When was your last physical exam with your PCP?
3. When were your last labs done?
4. Any history of abnormal labwork?
5. List all surgeries/hospitalizations and year:
6. Please list (include dates) of all accidents/physical traumas/serious illnesses/broken bones/motor vehicle accidents, etc.:
7. Have you had imaging, MRI, CT, Ultrasound - if so, please list year and reason for imaging:
8. Please list out any medication, food or environmental allergies:
9. Your blood type if known:
10. Women - date of last pap?
11. Women - date last mammogram?
12. Women - any history of abnormal pap/mammogram?
13. Father's significant health issues:
14. Mother's significant health issues:
15. Sister's significant health issues:
16. Brother's significant health issues:
17. Children's significant health issues if any:

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Overall Wellness:
If any of these have been a significant issue for you, please mark P for past or C for current.

Eyes:

Eye pain	Vision problems	Wear glasses/contacts
Red eyes	Dry eyes	Itchy eyes
Watering eyes	Dark circles under eyes	Blurry vision
See floaters	Dry eyes	Glaucoma
Cataracts	Other:	

Ears:

Ear pain or soreness	Itchy ears	Ear pressure	Meniere's
Frequent ear infections	Ear ringing high pitched sound		
Ear ringing low pitched sound		Itchy ears	Hearing loss
Other:			

Nose:

Hay fever	Sinus pressure	Recurrent sinus infections
Loss of smell	Runny nose	Nose congestion
Nose itching	Nose bleeds	Other:

Mouth:

History of, or currently have silver fillings		Root canals	Cold sores	Tooth
pain	Dental implants	Canker sores	TMJ	
Tongue sores	Gum pain	Gum disease		
Bleeding gums after brushing teeth		Teeth grinding		
Dry mouth	Cavities			

Throat:

Frequent strep infections	Hard to swallow	Hoarseness
Swollen neck lymph nodes	"Feels like a lump in throat"	Sore throat
Tightness in throat	Itchy mouth or throat	
History of anaphylactic reaction (throat closing)		Have an Epi Pen

Head:

Headaches	Migraines	Past head injury
Loss of consciousness		

Lungs:

Shortness of breath	Asthma	Bronchitis
Seasonal allergies	Emphysema	Pneumonia
Positive TB test	Hard to breathe in sometimes	
Hard to breath out sometimes		Sigh a lot
Dry cough	Cough with mucous	
Tight chest	Chest pain with breathing	
Chest pain with movement	Chest pain with coughing	
Wheezing		

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Cardiovascular:

Chest pain | Varicose veins | Heart disease
Sleep apnea | Air hunger | Yawn frequently
Need to use an extra pillow to elevate your head at night
Shortness of breath with moderate exertion
Ankles swell, especially at the end of the day
Cough at night | Face turns red for no reason
Dull pain or tightness in chest that radiates into left arm
Heart attack | TIA's | Blood clots/DVT
Elevated triglycerides | Anemia | Swelling hands/feet
Stroke | Poor circulation | Snoring
Bleeding disorder | High blood pressure | Low blood pressure
Elevated cholesterol | Heart palpitations | Irregular heartbeat
Bleed/bruise easily | History of blood transfusion

Digestive- Upper GI:

Belching or gas within 1 hour of eating meal | Heartburn or acid reflux
Bloating shortly after eating | Food seems to just sit in stomach after eating
Get full fast while eating | Vegan diet (no dairy, meat, fish or eggs)
Not hungry in general | Bad breath | Diet frequently
Frequent tickle in throat, need to cough | Lost taste for meat
Sweat has strong odor | Stomach upset by taking vitamins
Sense of excess fullness after | Feel like skipping breakfast frequently
Feel better when you don't eat | Sleepy after meals
Fingernails chip, peel or break easily | Stomach pain or cramps
Chronic diarrhea | Diarrhea shortly after meals
Black or tarry stools | Abdominal pain upper abdomen
Food cravings: circle all that apply – sweet, sour, salty, bitter, spicy

Liver/Gallbladder:

Frequent pain between shoulder blades | Stomach upset by greasy foods
Nausea | Sea, car or airplane sickness/motion sickness
History of morning sickness | Dry skin, itchy feet and/or skin peels on feet
Headache that occurs over the eyes | Gallbladder attacks
Gallbladder removed | Bitter taste in mouth | Become sick with drinking wine
Easily intoxicated | Drink more than 3 alcoholic beverages /week
History of drug or alcohol abuse | History of hepatitis
Long term use of prescription medications
Sensitive to chemicals (perfumes, cleaning solvents, insecticides, exhaust etc)
Exposure to diesel fumes, solvents | Sensitive to tobacco smoke
Pain under right side of rib cage | Hemorrhoids or varicose veins
Chronic fatigue or fibromyalgia | History of blood transfusion
Abdominal surgery

Small Intestine:

Food allergies/sensitivities | Abdominal bloating 1-2 hours after eating
Specific foods make you tired or bloated | Pulse speeds up after eating
Environmental allergies (hayfever) | Hives
Sinus congestion | Crave bread, noodles or carbs

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Alternating constipation/diarrhea Crohn's disease
Wheat or grain sensitivity Dairy sensitivity
Are there foods you feel that you could not give up eating?
Use over the counter pain medications
Feel spacey, unreal or have brain fog
Abdominal pain mid abdomen

Large Intestine:

Abdominal pain lower abdomen Rectal itching Coated tongue
Constipation Recurrent fungus or yeast infections
Have taken any antibiotic for more than 10 days on more than 2 occasions
Ring worm, jock itch, athlete's foot, nail fungus
Eating sugar, starch or drinking alcohol makes you feel worse
Stools hard or difficult to pass Feel like you never fully evacuate stool
History of parasites (by testing) Less than one bowel movement per day
Stools are loose and not well formed Diagnosed with IBS or colitis
Diverticulitis Diverticulosis Ulcerative Colitis
Blood in stool Mucous in stool Excessive foul smelling gas
Painful to press along outer sides of thighs (IT Band)
Significant history of right lower abdominal pain

Urinary:

History of bladder or kidney infections Dark circles under eyes
Cloudy, dark or bloody urine Kidney stones
Interstitial Cystitis Blood in urine Urinate more than once per night
Frequently urinate more than once per hour Trouble stopping/starting urine
Burning pain with urination Frequent urination
Urgent urination Urinary Incontinence Smelly urine

Gynecological:

Hormonal Imbalances Endometriosis
Breast Lumps Breast pain Fibroids
Ovarian cysts PCOS Menopausal symptoms
Bleeding between cycles Currently sexually active
Currently using birth control Pain during intercourse
Recurrent yeast infections
Diagnosed with bacterial vaginosis in past History of HPV
History of STD Genital herpes History of abnormal pap
Abnormal vaginal discharge Vaginal soreness/burning
Vaginal itch Hot flashes Night sweats
Vaginal dryness Low libido PMS
Excess sex drive
Associated with menstrual cycle- cramps
Associated with menstrual cycle-headaches
Associated with menstrual cycle-fluid retention
Associated with menstrual cycle-chocolate cravings
Associated with menstrual cycle-weight gain
Associated with menstrual cycle-irritability/anger
Associated with menstrual cycle-depression
Associated with menstrual cycle-fatigue

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Concerns regarding fertility
Date of last menstrual cycle: _____
Menstrual cycle usually occurs every _____ days
Menstrual cycle usually lasts for how many days _____
During your heaviest flow, how frequently do you need to change protection? _____
How many days does your heavy flow last?_____
Are your menstrual cycles are regular or irregular?_____
Number of pregnancies?_____
Could be pregnant now?_____

Male:

Erectile Dysfunction	Prostate issues	Dribbling or difficult urination
Low libido	Excess sex drive	
Genital itching, pain, burning, discharge, redness or irritation		

Musculoskeletal:

Generalized aching all over	Muscle pain or soreness	Muscle cramps
Joint Pain	Neck pain	Shoulder pain
Arm pain	Upper back pain	Mid-back pain
Lower back pain	Sciatic pain	Hip pain
Knee pain	Calf pain	Foot pain
Restless legs	Muscle weakness	Muscle jerks or twitching
Muscle stiffness	Tight muscles	Numbness/tingling
Arthritis	Scoliosis	Osteopenia
Osteoporosis	Paralysis	Fibromyalgia
Gout	Parkinson's	Cold hands/feet
Muscle spasms	Muscles feel tired often	
Problems with urination or bowel movements		
Carpal Tunnel Syndrome		

Endocrine:

Hypothyroid	Hyperthyroid	Adrenal fatigue
Diabetes	Blood sugars > 100	Blood sugar < 80
Excessive thirst	Excessive hunger	Excessive sweating

Immune:

Hashimoto's	Lupus	Rheumatoid arthritis
Connective tissue disease	Catch colds/flu easily	Chronic sinus infections
Chronic yeast infections	Mononucleosis	Swollen glands
Chronic Fatigue	AIDS/HIV	Hepatitis
Lyme disease	Venereal disease	Cancer
West Nile Virus	EBV/CMV	Chronic/frequent infections
History of low Vitamin D status on lab		History of positive autoimmune markers on lab
History of cancer		

Hair/Skin/Nails:

Rash	Eczema	Psoriasis
Acne	Change in mole	Hair loss
Dandruff	Itchy skin	Hives
Herpes		

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Neuro:

Seizures Dizziness Fainting
Loss of consciousness from injury Have had a blow to the head in the past
Have had blackouts before Falls/Loss of Balance
Poor memory Learning disability
Difficulty with speech Trouble concentrating
Trouble thinking clearly Tremors
Hyperactive

Mood:

Anxiety Depression Lack of motivation
Sadness History of psychiatric illness
Irritability Stress Worry a lot
Have phobias/specific fears Panic attacks

General:

Appetite increased Appetite decreased
Unexplained weight gain in past year Unexplained weight loss in past year
Unexplained fatigue Hard to get to sleep Hard to stay asleep
Get less than 7 hours of sleep nightly
Feel as though you need more sleep then you currently get
Poor quality of sleep Frequent chills/fevers
Other:

Diet & Lifestyle:

1. History of or current use of alcoholic beverages: (circle):
   none social drinking more than 2 drinks per most evenings

2. Tobacco use (circle):
   none history of tobacco use currently smoke/chew tobacco vape/e-cigarette

3. Amount of daily water intake:

4. Amount of coffee or tea per day:

5. Amount of soda per day:

6. Exercise-amount & type per day/week:

7. Amount of time per day spent outside in nature:

8. Mood in general?

9. Number of hours of sleep per night?

10. Sleep quality (circle all that apply): good hard to get to sleep hard to stay asleep
Interrupted sleep difficulty waking up trouble staying awake I snore
use CPAP diagnosed with sleep apnea stay up too late get up too early
don't feel like I get enough sleep tired most of the time

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11. Do you feel supported by your current relationships?

12. Type of work you that you do currently?

13. Do you work over 50 hours per week?

14. Types of jobs you've held in the past?

15. Job satisfaction: please rate 0 – 100

16. What gives you joy in life - what do you like to do in your free time?

17. Stress level (0 is none, 10 is alot)

18. Major stressors?

19. Energy level in general (10 is great energy)?

20. Spirituality: Do you have a spiritual practice that supports you?

21. Environment: If you had to describe the "health" of your current residence and work place, how would you describe each of them? Also include any locations where you might spend a great deal of time:

22. Any travel outside of the US or Canada? If so where?

23. Have you served in the armed forces? If so, where?

24. Any significant exposure to (circle all that apply): lead paint asbestos chemicals

solvents herbicides/pesticides mining house remodeling mold
welding automotive repairs new carpet well water farming
gardening dry cleaning breast implants dental implants/root canals
silver fillings

25. Any history of a tick bite?

26. Current weight? If this is not a comfortable weight for you, what is your ideal weight goal?

27. Please describe what you typically eat for your first meal and beverage of the day and what time?

28. What is your typical next meal/beverage of the day and usual time?

29. What is your next typical meal/beverage and time that you eat it?

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30. Do you typically snack? If so what time and what do you snack on?

31. Do you eat 3 meals per day?

32. Do you eat a little protein with each meal?

33. Do you drink tap water, reverse osmosis, filtered or well water?

34. Do you frequently eat out at restaurants or eat fast food?

35. Do you eat your evening meal before 6 PM?

36. Do you use artificial sweeteners? This includes sucralose (Splenda), aspartame (equal, nutrisweet), saccharin (sweet n low), xylitol or sorbitol?

37. Do you eat candy or other sweets more than 3 times per week? If so, what?

38. Do you eat 5 servings of vegetables and fruit per day?

39. Do you use margarine?

40. Do you use milk products regularly?

41. Do you take a daily multivitamin?

42. Do you take calcium/magnesium daily?

43. Do you take some form of essential fatty acid daily (fish oil, flaxseed oil, EPO or borage oil?

44. Have you dieted often in the past? If so, what diet worked the best for you?

45. After you eat, do you generally feel satisfied and nourished?

46. Last time you had a real vacation?

47. What activities "give" you energy?

48. What activities "take" your energy - what do you feel drained by?

49. Describe your "ideal" wellness state – what you would like to have happen as a result of your visit here today:

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Naturopathic Disclosure:

I have chosen to consult with Dr. Colleen Gagliardi, a Naturopathic doctor, to discuss natural wellness options.

I understand that Dr. Colleen Gagliardi, ND, LAc, CCH is not a Medical Doctor (MD), or an Osteopathic Doctor (DO) and is not licensed to practice medicine in New York State, nor did she represent herself as such.

I understand that Dr. Colleen Gagliardi, ND, LAc. CCH, received her Doctorate in Naturopathic Medicine from Bastyr University in Kenmore, Washington and holdscurrent Naturopathic licensesto practice Naturopathy in the states of Montana (license #84), and Washington (license # NT 60840493). I also understand that in New York, Dr. Gagliardi, as a Naturopathic Doctor, cannot, and will not, prescribe, diagnose or treat medical conditions, as New York does not license Naturopathic Doctors.

I acknowledge that Iam recommended to maintain regular medical care with my licensed medical provider, and to discuss all natural therapies and recommendations with my regular medical provider.

Client or guardian name (please print)

_____

Client or guardian signature

_____

Date

_____

**All patients are advised under New York State Law to consult a physician regarding the condition or conditions for which they are seeking acupuncture, naturopathy and hypnosis treatment. In addition, patients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or should a new condition arise.

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles,

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as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

I authorize my insurance benefits to be directly paid to the acupuncturist. I understand that I am financially responsible for any balance. If my insurance carrier sends payment to me for services incurred in this office, I agree to send or bring those payments to this office upon receipt. I authorize Dr. Colleen Gagliardi, ND, LAc, CCH, or the insurance company to release any information required to process my claims. I agree that I will pay the reduced fee of $99 for an initial treatment and $75 for each follow-up treatment due to financial difficulties if my insurance does not cover acupuncture. For naturopathic and hypnosis services, all clients are asked to pay in full at the time of service

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE

DATE_____

PRACTITIONER SIGNATURE

CANCELLATION POLICY

I understand that there is a 24-hour cancellation policy. I agree to pay $50 fee if I cancel less than 24 hours within the scheduled appointment time.

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE

DATE

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INFORMED CONSENT

I consent to any treatments and related procedures, associated with any services, by Dr. Colleen Gagliardi, ND, LAc, CCH I have discussed the nature and purpose of my treatment with her and I understand that the methods of treatment may include but are not limited to acupuncture, naturopathy and hypnosis, herbal medicine, moxibustion, cupping, gua sha, and electrical stimulation.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, tingling, numbness or mild pain near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and gua sha. An unusual risk of acupuncture includes spontaneous miscarriage, nerve damage, and organ puncture. Infection is another possible risk, although this office uses only sterile, disposable needles while maintaining a clean and safe environment. Burns and scarring are potential risks of using moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgments during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time.

Since everyone responds to acupuncture, naturopathy and hypnosis treatments differently, outcome of the treatment cannot be guaranteed. Some individuals may experience total or partial relief of their pain or symptoms after the first few treatments, while others may notice a steady, gradual improvement. In some cases, no relief may be felt at all until after several days go by. Some people may notice that their pain actually seems to be worse before it gets better.

I will notify the acupuncturist, who is caring for me, if I become pregnant.

By voluntarily signing below, I show that I have read or have had read to me, this consent to treatment. I have been told about the risks and benefits of acupuncture and other procedures and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for both the present condition and for any future conditions for which I seek treatment(s).

Dr. Colleen Gagliardi, ND, LAc, CCH., is a separate independent business not affiliated with Notaro Chiropractic. Dr. Colleen Gagliardi, ND, LAc, CCH. is a separate business operating located within the building space of Notaro Chiripractic only and Notaro Chiropractic is not responsible for any liability concerning the treatment of services under Dr. Colleen Gagliardi, ND, LAc, CCH.

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Signature of patient or patient representative **Date**

NOTICE OF HIPAA PRIVACY PRACTICE

I have received the HIPAA privacy notice of Dr. Colleen Gagliardi, ND, LAc, CCH.

Signature of patient or patient representative **Date**

NOTICE OF PRIVACY PRACTICES

This notice summarizes how the health data about you may be used and shared and how you can get access to this data.

I. How we may use and share health data about you:
- a) Treatment – To give you medical treatment or other types of health services.
- b) Payment – To bill you or a third party for payment for services provided to you.
- c) Health Care operations – For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
- a) To you
- b) As required by a federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal

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activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:
a) Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care – We may share your health data with your family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to health data we keep about you:
a) Right to inspect your health record and to receive a copy upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

NOTIFICATION CONSENT:

*By signing this form, you agree to receive text messages, phone calls and emails regarding appointments and promotions.

Thank you.

Signature:_____

Date:_____