STENGLER CENTER FOR INTEGRATIVE MEDICINE

STENGLER

New Patient Registration

Please submit completed form no later than two business days prior to your appointment. EMAIL to patientcare@markstengler.com or FAX to 760-274-2381.

324 ENCINITAS BLVD · ENCINITAS, CA 92024
Tel: 760.274.2377 | www.markstengler.com | patientcare@markstengler.com

California Association of Naturopathic Doctors | American Association of Naturopathic Physicians | American Association of Integrative Medicine | The American College for Advancement in Medicine

Welcome to Stengler Center for Integrative Medicine. Please take time to fill out this new patient registration form. This form is very important for Dr. Stengler in analyzing your health history and making recommendations that treat the root cause of your illness. *All information will be kept strictly confidential and will become part of your medical record.*

Today's Date: _____ Patient Name: _____ Age: _____

Date of Birth: _____ Sex: M ☐ F ☐ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

How did you hear about our clinic? _____

PHONES: Home _____ Cell _____ Work _____ Fax _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

EMPLOYMENT INFORMATION

Employment status: ☐ Full time ☐ Part time ☐ Retired _____(date) ☐ Student (school)_____

Employer: _____ Phone: _____

Employer Address: _____

Spouse's name: _____ Spouse's Work Phone: _____

Spouse's Employer: _____

Credit Card Number _____ Exp _____ CVS (number on back) ____

Type: ☐ Visa ☐ Mastercard ☐ Discover

EMERGENCY CONTACT INFORMATION

Full Name(Printed) : _____

Telephone: _____ Relationship to patient: _____

OFFICE POLICIES

PAYMENT IS REQUIRED AT THE TIME OF SERVICE. Stengler Center for Integrative Medicine does not bill insurance for office visits. However, we will provide you with the necessary documentation so that you may do so. We are not a Medicare provider and therefore are unable to submit claims. These fees do not cover lab testing, although Dr. Stengler uses labs that insurance may cover, depending on individual plans. It is the patient's responsibility to understand their insurance coverage, including coverage of lab testing fees. Stengler Center is not responsible for any billing related to insurance claims. We do not give refunds for supplements that have been opened or returned over 30 days from date of purchase.

PAYMENT POLICY

We only accept MasterCard, Visa and Discover credit cards. Payments made in person at the clinic can be made by cash or credit card. We do not accept checks.

By signing below, I realize that I am responsible for payment at time of visit for all medical services rendered to me and/or my dependents, regardless of decisions of benefit coverage made by any insurance carriers.

Cancellation Policy: A two business day cancellation notice is required for appointment cancellations or the cost of the scheduled visit will be charged. The visit can be rescheduled and the original charge applied to this future visit. By signing below, I give permission to charge my credit card "on file" for any scheduled appointment that falls under the above cancellation policy knowing that the full amount of the visit charged will be applied toward my future appointment.

I further understand and acknowledge that:

Dr. Stengler is a licensed Naturopathic Medical Doctor in the State of California.

Serious ailments such as cancer and other chronic diseases or life threatening acute illnesses require the attention (or co-attention) of medical specialists.

There are studies that have indicated increased risk in connection with hormonal treatment. These studies generally involve synthetic hormones rather than bio-identical hormones. Dr. Stengler prescribes bio-identical hormones in appropriate cases. Nevertheless, in order to reduce uncertainties, patients who are prescribed hormones must agree to have adequate lab testing and physical examination from Dr. Stengler and their primary physician. For women, this includes a yearly exam by a licensed gynecologist. Patients being placed on bio-identical hormone replacement agree to follow-up office visits with Dr. Stengler as well as blood work every 3-6 months.

Signature: _____ Date: _____

Note: If the patient is a minor, the PARENT OR GUARDIAN must sign.

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STENGLER

Notice of Privacy Practices

324 ENCINITAS BLVD · ENCINITAS, CA 92024
Tel: 760.274.2377 | www.markstengler.com | drmark@markstengler.com
Contact Tudi Cabrera, Office Manager | Tel: 760-274-2377 x1619
patientcare@markstengler.com

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

We use these records to provide or enable other health care providers to provide quality health care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly.

MARKETING

This office will not use your health information for marketing communications without your written authorization.

APPOINTMENT REMINDERS

This office may use your health information to send appointment reminders via e-mail or phone and leave a message with a family member if you are not available, to remind you of your next appointment with one of the practitioners in this office.

DISCLOSURE

This office may use or disclose your Protected Health Information when required by law.

PATIENT RIGHTS

1. Upon your request, you have the right to access, review or receive copies of your healthcare records.
2. Upon written request, you have the right to receive a list of items this office disclosed about your healthcare information.
3. Upon written request, you have the right to request that we amend your Protected Health Information.
4. Upon written request, you have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
5. You have a right to receive all notices in writing.

If you have questions, complaints or would like more information, please contact this office (see above). You may also send a written complaint to the U.S. Department of Health and Human Services:

DHHS (Office of Civil Rights)
200 Independence Ave S.W., Room 509 F HHH Building
Washington, D.C. 20201

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the *Notice of Privacy Practices* for the office of ***Stengler Center for Integrative Medicine,*** detailing how my information may be used and disclosed as permitted under federal and state law.

Signed:_____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Patient: _____ Relationship: _____

STENGLER CENTER FOR INTEGRATIVE MEDICINE
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HEALTH HISTORY QUESTIONNAIRE

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COMPREHENSIVE HEALTH HISTORY QUESTIONNAIRE

The following pages are very important to complete as best you can so that Dr. Stengler can analyze your health history and make recommendations that treat the root cause of your illness.

Today's Date: _____ Patient Name: _____ Age: _____

When did you have your last health care visit? _____ Reason? _____

Height_____ Weight _____

Please list in order of importance your health problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Childhood illnesses: Scarlet Fever ☐ Diptheria ☐ Rheumatic Fever ☐ Mumps ☐ Measles ☐
German Measles ☐ Mononucleosis ☐ Chickenpox ☐ Polio ☐

Immunizations: Polio ☐ MMR Measles, Mumps, Rubella ☐ Pertussis ☐ Hepatitis A ☐ Hepatitis B ☐
Pneumonia ☐ Small Pox ☐ Anthrax ☐ Shingles ☐
Tetanus ☐ Last tetanus shot: _____ Other Vaccines: _____

Surgeries & Hospitalizations

Year _____ Reason _____ Hospital _____
Year _____ Reason _____ Hospital _____
Year _____ Reason _____ Hospital _____

EXAMS AND MEDICAL TESTS List the approximate date of your last exam or test as described below:

Physical Examination _____	By Whom? _____	Results? _____
Bloodwork _____	By Whom? _____	Results? _____
Bone Density Study _____	By Whom? _____	Results? _____
Spinal x-ray _____	By Whom? _____	Results? _____
MRI/CAT Scan _____	By Whom? _____	Results? _____
Mammogram _____	By Whom? _____	Results? _____
Pelvic Exam _____	By Whom? _____	Results? _____
Breast Exam _____	By Whom? _____	Results? _____
Digital Prostate Exam _____	By Whom? _____	Results? _____
EKG _____	By Whom? _____	Results? _____
Chest x-ray _____	By Whom? _____	Results? _____

Echocardiogram _____ By Whom? _____ Results? _____
Stool Test _____ By Whom? _____ Results? _____
Urinalysis _____ By Whom? _____ Results? _____
Other Tests _____ By Whom? _____ Results? _____

ALLERGIES

What drugs are you allergic to? _____

What foods are you allergic to? _____

What foods are you sensitive to (not life threatening)? _____

Environmental allergies? _____

Medications and dosages you are taking:

Medication _____ Dosage _____
Medication _____ Dosage _____
Medication _____ Dosage _____
Medication _____ Dosage _____
Medication _____ Dosage _____
Medication _____ Dosage _____
Medication _____ Dosage _____

Supplements and dosages you are taking:

Supplement _____ Dosage _____
Supplement _____ Dosage _____
Supplement _____ Dosage _____
Supplement _____ Dosage _____
Supplement _____ Dosage _____
Supplement _____ Dosage _____
Supplement _____ Dosage _____

CONDITIONS Indicate if you *currently have (C)* or have *previously had (P)* the following:

SKIN

Acne vulgaris (common type) C ☐ P ☐ Acne rosacea C ☐ P ☐ Dry Skin C ☐ P ☐
Color Changes C ☐ P ☐ Eczema C ☐ P ☐ Hives C ☐ P ☐
Itching C ☐ P ☐ Lumps C ☐ P ☐ Moles C ☐ P ☐
Rashes C ☐ P ☐ Scaling C ☐ P ☐
Easy to bleed/bruise C ☐ P ☐ Skin Cancer C ☐ P ☐

HEAD

Head injury C ☐ P ☐ Skull fracture C ☐ P ☐
Headaches C ☐ P ☐ If Yes, what type of headaches? _____

EYES

Eye pain C ☐ P ☐ Double vision C ☐ P ☐ Dryness C ☐ P ☐ Vision aids C ☐ P ☐
Glaucoma C ☐ P ☐ Impaired vision C ☐ P ☐ Tearing C ☐ P ☐

EARS

Discharges C ☐ P ☐ Earaches C ☐ P ☐ Dizziness C ☐ P ☐ Ringing C ☐ P ☐
Impaired hearing C ☐ P ☐ Trauma to ear C ☐ P ☐

NOSE AND SINUSES

Frequent colds C ☐ P ☐ Nose bleeds C ☐ P ☐ Sinus pain C ☐ P ☐ Stuffiness C ☐ P ☐
Persistent running C ☐ P ☐ Trauma to Nose or Sinus C ☐ P ☐ Polyps C ☐ P ☐

MOUTH AND THROAT

Bleeding gums C ☐ P ☐ Cavities C ☐ P ☐ Diagnosed with gum disease C ☐ P ☐
Sore tongue C ☐ P ☐ Hoarseness C ☐ P ☐ Frequent sore throat C ☐ P ☐
Ulcerations C ☐ P ☐ Difficulty speaking C ☐ P ☐

NECK

Goiter	C ☐ P ☐	Pain or stiffness	C ☐ P ☐	Swollen glands	C ☐ P ☐
Trauma to neck	C ☐ P ☐	Hypothyroid	C ☐ P ☐	Hyperthyroid	C ☐ P ☐

RESPIRATORY

Asthma	C ☐ P ☐	Cough	C ☐ P ☐	Emphysema	C ☐ P ☐
Pleurisy	C ☐ P ☐	Difficulty breathing	C ☐ P ☐	Pneumonia	C ☐ P ☐
Pain with breathing	C ☐ P ☐	Sputum	C ☐ P ☐	Shortness of breath	C ☐ P ☐
Tuberculosis	C ☐ P ☐	Wheezing	C ☐ P ☐	Blood in sputum	C ☐ P ☐

CARDIOVASCULAR

Angina	C ☐ P ☐	High Blood Pressure	C ☐ P ☐	Dizziness	C ☐ P ☐
Heart disease	C ☐ P ☐	Murmurs	C ☐ P ☐	Palpitations	C ☐ P ☐
Arrhythmia	C ☐ P ☐	Rheumatic fever	C ☐ P ☐	Ankle swelling	C ☐ P ☐

GASTROINTESTINAL

Belching	C ☐ P ☐	Change in appetite	C ☐ P ☐	Change in thirst	C ☐ P ☐
Heartburn	C ☐ P ☐	Gallbladder disease	C ☐ P ☐	Gas/bloating	C ☐ P ☐
Hemorrhoid	C ☐ P ☐	Liver disease	C ☐ P ☐	Jaundice/yellow skin	C ☐ P ☐
Vomiting	C ☐ P ☐	Vomiting of blood	C ☐ P ☐	Ulcers	C ☐ P ☐

Bowel movements: How often? _____ Is this a change? Yes ☐ No ☐

Do you feel symptoms if you don't eat often or every 3-4 hours? Yes ☐ No ☐

If Yes, what happens? _____

URINARY

Increased frequency	C ☐ P ☐	Inability to hold urine	C ☐ P ☐	Kidney stones	C ☐ P ☐
Kidney pain	C ☐ P ☐	Pain with urination	C ☐ P ☐	Urethral discharge	C ☐ P ☐

JOINTS AND MUSCLES

Muscle pain/stiffness	C ☐ P ☐	Swelling of joints	C ☐ P ☐	Muscle cramps	C ☐ P ☐
Arthritis	C ☐ P ☐	Weakness	C ☐ P ☐		

CIRCULATORY

Coldness of hands/feet	C ☐ P ☐	Deep leg pain	C ☐ P ☐	Spider veins	C ☐ P ☐
Numbness in hands/feet	C ☐ P ☐	Thrombophlebitis(blood clots)	C ☐ P ☐	Anemia	C ☐ P

NEUROLOGICAL

Dizziness	C ☐ P ☐	Numbness or tingling	C ☐ P ☐	Fainting	C ☐ P ☐
Memory loss	C ☐ P ☐	Seizures	C ☐ P ☐	Paralysis	C ☐ P ☐

MENTAL/EMOTIONAL

Anxiety or nervousness	C ☐ P ☐	Excessive fears	C ☐ P ☐	Depression	C ☐ P ☐
Mood swings	C ☐ P ☐	Excessive anger	C ☐ P ☐	Tension/stress	C ☐ P ☐

HAIR AND NAILS

Hair thinning or hair loss	C ☐ P ☐	Brittle hair	C ☐ P ☐		
Toenail fungal infection	C ☐ P ☐	Brittle nails	C ☐ P ☐	White spots on nails	C ☐ P ☐

SLEEP

Do you have trouble falling asleep? Yes ☐ No ☐ Do you wake up after falling asleep? Yes ☐ No ☐

What time do you wake up? _____ Do you awake rested? Yes ☐ No ☐

Do you snore? Yes ☐ No ☐ Average hours of sleep: _____

ENERGY

Do you have fatigue problems? Yes ☐ No ☐

On a scale of 1-10, with 10 being the highest, how would you rate your general energy level?___ (1 to 10)

BODY TEMPERATURE

Do you get warm easy? Yes ☐ No ☐ Do you get cold easily? Yes ☐ No ☐

Do you sweat easily? Yes ☐ No ☐

IMMUNE SYSTEM

Do you get sick easily? Yes ☐ No ☐

FOR WOMEN ONLY

[C = Currently have P = Previously had]

Age menses began: _____ Date of last menstruation: _____ Average number of days: _____

Type: Normal ☐ Heavy ☐ Light ☐ Length of cycle: _____ Are cycles regular? Yes ☐ No ☐

Painful menses C ☐ P ☐ Excessive flow C ☐ P ☐ PMS Symptoms: Mild ☐ Moderate ☐ Severe ☐

Are you sexually active? Yes ☐ No ☐ Sexual difficulties C ☐ P ☐ Pain with intercourse C ☐ P ☐

Difficulty conceiving? C ☐ P ☐ Are you pregnant or breastfeeding? Yes ☐ No ☐

Number of pregnancies: _____ Number of live births: _____ Number of miscarriages: ____

Number of abortions: _____ History of Sexually Transmitted Disease? Yes ☐ No ☐

Any hot flashes or sweating at night? Yes ☐ No ☐ History of uterus or ovary removal? Yes ☐ No ☐

If Yes , why? _____

Have you been on hormone replacement in the past? Yes ☐ No ☐

If Yes , what type of hormone? _____ Synthetic ☐ Bioidentical ☐

BREASTS: Do you do monthly or regular self breast exams? Yes ☐ No ☐

Lumps? Yes ☐ No ☐ Breast pain? Yes ☐ No ☐ Skin discoloration? Yes ☐ No ☐

FOR MEN ONLY

Hernias	Yes ☐ P ☐	Testicular Enlargement	Yes ☐ P ☐
Prostate disease	Yes ☐ P ☐	Discharges or sores	Yes ☐ P ☐
Venereal disease	Yes ☐ P ☐	Erectile Dysfunction or	
Testicular Pain	Yes ☐ P ☐	Sexual Difficulty	Yes ☐ P ☐

FAMILY HEALTH HISTORY

Has any family member had the following? If Yes, please identify family member.

Anemia	Yes ☐ No ☐	Family Member(s): _____
Asthma	Yes ☐ No ☐	Family Member(s): _____
Cancer	Yes ☐ No ☐	Family Member(s): _____
Diabetes	Yes ☐ No ☐	Family Member(s): _____
Epilepsy	Yes ☐ No ☐	Family Member(s): _____
Glaucoma	Yes ☐ No ☐	Family Member(s): _____
Heart Disease	Yes ☐ No ☐	Family Member(s): _____

High Blood Pressure Yes ☐ No ☐ Family Member(s): _____
Kidney Disease Yes ☐ No ☐ Family Member(s): _____
Mental Illness Yes ☐ No ☐ Family Member(s): _____
Pneumonia Yes ☐ No ☐ Family Member(s): _____
Stroke Yes ☐ No ☐ Family Member(s): _____
Tuberculosis Yes ☐ No ☐ Family Member(s): _____
Venereal Disease Yes ☐ No ☐ Family Member(s): _____
Were any of these a cause of death? If so, which family member and at what age?

LIFESTYLE AND DIET

EXERCISE

How often do you exercise?_____ What forms of exercise do you get? _____

DIET

What do you typically eat and what time?

Breakfast: _____ Time _____
Lunch: _____ Time _____
Dinner: _____ Time _____
Snack: _____ Time _____
Snack: _____ Time _____

Rank your salt intake: High☐ Medium☐ Low☐
Rank your fat intake: High☐ Medium☐ Low☐
What is your thirst like? High☐ Medium☐ Low☐
What is your appetite like? High☐ Medium☐ Low☐

What foods do you crave (such as salty, spicy, sweet, sour, bitter or other specific foods): _____

_____

Do you suffer from excessive hunger? Yes ☐ No ☐
Do you feel okay consuming gluten containing grains (wheat, rye, oats, barley)? Yes ☐ No ☐
If not, what symptoms do you notice? _____
Do you notice a reaction to dairy products, eggs, citrus fruit, chocolate, nuts, soy, artificial sweeteners, caffeine, sugar, or any other foods or food chemicals? Yes ☐ No ☐ *Please describe:* _____

_____

Caffeine None ☐ Coffee ☐ Tea ☐ Cola ☐ Number of cups/cans per day? _____
Alcohol Do you drink alcohol? Yes ☐ No ☐ If Yes , what kind? _____
How many drinks daily on average? _____ Are you concerned about the amount you drink? Yes ☐ No ☐
Drugs Recreational drugs? Yes ☐ No ☐ Drug dependence? Yes ☐ No ☐
Tobacco Do you use tobacco? Yes ☐ No ☐ Type: _____Quantity per day: _____
Have you previously smoked? Yes ☐ No ☐ How long ago did you quit? _____

WEIGHT CONCERNS

Are you overweight or underweight? Yes ☐ No ☐ How long have you been over/underweight? _____

What type of treatments have you tried? _____

What role do you think stress plays? _____

PERSONAL HABITS AND ENVIRONMENT

Do you enjoy your work? Yes ☐ No ☐ P ☐

Do you watch television? Yes ☐ No ☐ How many hours/day? _____

Do you work at a computer? Yes ☐ No ☐ How many hours/day? _____

Do you read? Yes ☐ No ☐ How many hours/day? _____ What time of day, typically? _____

What are your main hobbies/interests? _____

Spiritual/religious interests/preference? _____ Take vacations Yes ☐ No ☐

STRESS

How would you rate your general stress level on a scale of 1-10, with ten being the highest? _____

What causes you stress? _____

Do you have good stress coping mechanisms? Yes ☐ No ☐ Is your motivation level good? Yes ☐ No ☐

How committed are you to achieving better health? Low ☐ Medium ☐ High ☐

ENVIRONMENTAL/TOXINS

Do you have mercury (silver) fillings in your mouth? Yes ☐ No ☐ P ☐ If Yes , how many? _____

How long have you had them? _____ What other dental materials are in your mouth? _____

How often do you consume tuna, mackerel, shark, halibut, farm raised salmon, or sushi a week? _____

Do you drink tap water? Yes ☐ No ☐ P ☐ Do you live in a home with known mold? Yes ☐ No ☐ P ☐

Do you work with any known toxins in the workplace? Yes ☐ No ☐ P ☐ If so what? _____

Have you been on many antibiotics in the past? Yes ☐ No ☐ P ☐ What for? _____

Do you eat organic foods and hormone-free meats commonly? Yes ☐ No ☐ P ☐

Do you or have you lived in an area where pesticides/herbicides are commonly sprayed? Yes ☐ No ☐ P ☐

PERSONALITY TYPE

Do you like to be around people most of the time? Yes ☐ No ☐

Do you prefer to be by yourself most of the time? Yes ☐ No ☐

Do you prefer a relatively equal mixture of spending time around others and yourself? Yes ☐ No ☐

Do you prefer to be the leader or boss in group situations? Yes ☐ No ☐

Rate your confidence level: High ☐ Medium ☐ Low ☐

PATIENT INSIGHT

What do you think is the root problem(s) of your health issues? _____

When was the onset (when it first began)? _____ What was going on in your life just prior to the onset (eg. Illness, high stress, etc)? _____

Thank you for completing this comprehensive Health History Questionnaire. Please submit this for Dr. Stengler's review no later than two business days prior to your appointment. **EMAIL to patientcare@markstengler.com or FAX to 760-274-2381.**