Patient Acceptance Policy

Thank you for your interest in becoming a member at Sana Vida Wellness Center. To give you clear a picture of what to expect and to avoid any misunderstandings please read the below steps. Please sign that you agree to and accept this policy. These next steps are necessary to get the best results. A good working relationship will help us to get you as close as possible to reaching your health goals.

1. **Complete of the following forms:**
    - ❑ **The Health Questionnaires**
    - ❑ **The Diet Diary**

To get the most out of your consultation and treatment program, complete all these forms and questionnaires diligently prior to your first consultation. Please provide me with copies of all lab work or diagnostic testing you can get a hold at least one day before your first visit so I can study them. The questionnaires will help me zero in on the probable causes of your health problems.

2. Once I have received all your completed questionnaires and copies of all your medical records, we will schedule a 60-minute appointment for an Initial Assessment, which includes a consultation and examination. Based on your history and exam findings, it may be necessary to order additional lab tests.

3. Then we will schedule another appointment for the Report of Findings. On this appointment, I will give you a report about what I found and give you my recommendations. This appointment usually takes approximately 45 minutes. You will be given a written report explaining the results of your examination, lab tests, and information about your health problems and the recommended treatment program. It is a good idea that you bring your spouse or a supportive family member to this appointment.

4. Your treatment program will most likely involve several phases of care. You will need a series of follow up visits, depending on your condition and severity. There is no "quick fix" or "magic bullet". The best results are only achieved with good patient commitment and follow through. Your treatment will consist of a combination of supplements, dietery and lifestyle changes, stress management, and integrative health care. Follow up consultations can be done by phone, text, or video conferencing via the platform app you will download to your phone or computer. This is available for those who live in and out of the area. The results of the treatment will vary.

5. As described above, the Initial Assessment and Report is a two-step process that requires two visits and additional study and preparation time by me. The fees for each of these two visits, and all other visits, are included in your annual membership fee. Insurance is not accepted for any services provided under my Direct Primary Care model. Patients need to understand that successful management of any complicated case requires time, in-depth testing, diagnosis and treatment. This cannot be achieved through insurance plans.

6. Some of the lab tests may need to be repeated at a later date and I will perform them at my discretion. You may also need further specialty lab and imaging testing, depending on your condition. These are not covered under your membership and will be discussed prior to ordering. The success of your treatment is not only measured by the reduction or elimination of your symptoms, but also on abnormal laboratory tests returning to a normal or optimal level.

7. With good patient commitment and follow through, I have had good success helping people with a variety of health concerns.

I, ____ have read and fully understand the **Patient Acceptance Policy.**

Patient Signature:__________________________________

Date:___________________________________

Sana Vida Wellness Center, PLLC

GENERAL INFORMATION

Name ____

Preferred Name ______________________________________ Date _____________

Address __________________________ City _____________ State ____ Zip Code ___

Home Phone _________________________ Work Phone _______________________

Cell Phone _______________________ Email _______________________________

Age ________ Date of Birth ________ Place of birth____________ Gender: female __ male___

Married ______ Separated ______ Divorced _____ Widowed _____ Single ____ Partnership ______

Number of Children _____ Right Handed: ____ Left Handed: ____ Mixed Dominance: _____

Occupation _____________________________ Hours per week ________ Retired _______

Nature of Business____

Who referred you to my office? ____

Next of Kin or other to reach in an emergency _____________________________________

Relationship ______________________________ Phone _______________________

Address ____

Who is your primary medical physician?____

Primary medical physician address & office phone # __________________________________

Have you ever lived or traveled outside the United States? Yes ____ No ____

If so, when and when:

____

____

____

____

Have you or your family recently experienced any major life changes? Yes____ No____

If yes, please comment:

____

____

Functional Diagnosis Questionnaire

Please write a detailed story of your health problem in a time line sequence from the beginning to now. In other words, tell me: about all your symptoms, when and how your problem started, what you did to try get over the problem, what medicines and supplements you took and who you saw for the problem. Or better yet, type this whole section below on separate sheet of paper.

Please list all diagnosis or explanations that have been given to you from the beginning to the present.

Did something trigger your change in health? What do you think caused your health problem?

List any treatments, medicines or supplements that have caused any reactions or made you worse.

List any treatments, medicines or supplements that have made you better.

Please list any history of infections (excluding common colds)

Please list in time line sequence any significant exposure to molds, industrial or toxic compounds.

PAST MEDICAL & SURGICAL HISTORY

ILLNESSES	Date	Date	Date	Comments
Chicken Pox				
German Measles				
Measles				
Mononucleosis				
Mumps				
Whooping cough				
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic Fatigue				
Crohn's Disease or Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				
Gout				
Heart attack/Angina				
Heart failure				
Hepatitis				
High blood pressure				
Irritable bowel				
Kidney stones				
Mononucleosis				
Pneumonia				
Rheumatic fever				
Sinusitis				
ILLNESSES	**Date**	**Date**	**Date**	**Comments**
Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				
INJURIES	**Date**	**Date**	**Date**	**Comments**
Head Injury				
Neck Injury				
Back Injury				
Fracture				
Other (describe)				
DIAGNOSTIC STUDIES			**Date**	**Results**

Chest X-ray				
Mammogram				
EKG				
Sigmoidoscopy				
Colonoscopy				
Upper GI Series				
Barium Enema				
CAT scan of Abdomen				
CAT scan of brain				
CAT scan of spine				
Liver scan				
Bone scan				
Neck X-rays				
Back X-rays				
MRI				
Bone Density Test				
Carotid Artery Ultrasound				
Blood Tests				
Other (describe)				
OPERATIONS	**Date**	**Date**	**Date**	**Results**
Tonsillectomy				
Tubes in Ears				
Appendectomy				
Gall Bladder				
Hernia				
Hysterectomy				
Dental Surgery				
Other (describe)				
Other (describe)				

Other major illnesses that required hospitalization.

If yes, please explain your illness;____

ALLERGIES

Are you allergic to any foods, medicines, supplements, pollen, dust etc? If so, please list the substances and your reactions.

____

Are there any foods that you avoid because they give you symptoms? Yes____ No_____

If yes, please name the food and symptom example: wheat – gas and bloating

Food	Symptom	Other comments

If you could only eat a few foods a week, what would they be? _________________________________

____

____Do you feel you have **delayed** symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes _____ No _____

One Day Diet Diary

In the spaces below please list everything you eat, drink or take each on a typical day. Include everything “you put in your mouth”. This includes: glasses of water, juice, sodas, vitamins or other supplements, medicines and drugs, alcoholic beverages, food, snacks, teas, coffee, fruits and vegetables. Please include everything.

Morning:

Midday:

Evening:

FAX to 210-455-6287