



**PATIENT/CLIENT REGISTRATION FORM**

**PATIENT/CLIENT INFORMATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_F\_\_\_M

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email: \_\_\_\_\_ Best way(s) to reach you: \_\_\_cell\_\_\_home\_\_\_work\_\_\_email

Would you like to subscribe to our email newsletter (updates, supplement discounts, etc)? \_\_\_Y\_\_\_N

Insurance Carrier: \_\_\_\_\_ SS#: \_\_\_\_\_

Are you currently employed? \_\_\_Y\_\_\_N Occupation: \_\_\_\_\_

Are you a student at a university/college? \_\_\_Y\_\_\_N What is your current status? \_\_\_FT\_\_\_PT

Are you: \_\_\_Minor\_\_\_Single\_\_\_Married\_\_\_Partnered\_\_\_Separated\_\_\_Divorced\_\_\_Widowed

# of Children: \_\_\_\_\_ Names & Ages of Children: \_\_\_\_\_

Mother's Name (minors only): \_\_\_\_\_ Father's Name (minors only): \_\_\_\_\_

Emergency Contact Name & Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Last Physician Consulted: \_\_\_\_\_ Date: \_\_\_\_\_

Reason(s) for that visit: \_\_\_\_\_

Reason(s) for today's visit: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## OFFICE POLICIES

### APPOINTMENT CANCELLATION

You must call **24 HOURS in advance** (during office hours) prior to appointment to cancel an appointment. Otherwise, you will be considered a “no-show” and charged a \$100 fee for new patients and a \$50 fee for established patients. We value our time and want to ensure our patients receive the care they deserve.

### PAYMENT POLICY

- **Payment at Time of Service:** Payment for appointments, supplements, products, and lab tests is due in full at the time of service and/or purchase. For your convenience, we will provide you with a completed “superbill” for you to submit to your insurance company for reimbursement whenever services are rendered and paid for. **We do not bill for insurance in our office.**
- **Delinquent Accounts:** If a patient/client or guarantor’s check is returned due to non-sufficient funds, there will be a \$30 charge. In addition, if payment is not received within 30 days, finance charges will begin accruing at 1.5% per month. Excessively overdue accounts will be forwarded to an outside collection agency and the patient/client or guarantor will be responsible for any fees generated as a result of collection efforts.

### PRICING

#### Mary Shackelton, MPH, ND

New Patient (60 mins) - \$250  
Follow Up (45 mins) - \$145  
Follow Up (30 mins) - \$100  
Follow Up (15 mins) - \$65  
Nutrient IV Therapy – starts at \$110

#### Damiana Corca, LAc, Dipl OM

New Patient (90 mins) - \$125 + herbs  
Follow Up (60 mins) - \$75 + herbs  
Follow Up Stress Relief (45 mins) - \$45  
Follow Up Addiction (45 mins) - \$25  
Herbal Consultation Only (60 mins) - \$65 + herbs  
Facial Rejuvenation Initial Screening & Consultation (20 mins) - \$45  
Facial Rejuvenation (75 mins) - \$135  
Injection Therapy - \$45  
Private Qi Gong Classes - \$55 (packages available)

#### Terri Rebibo Fox, MD, ABHIM

New Patient (60-90 mins) - \$250-\$375  
Follow Up (40 mins) - \$185  
Follow Up (30 mins) - \$125  
Follow Up (15 mins) - \$65  
School Physical - \$125  
Sports Physical - \$100  
Nutrient IV Therapy – starts at \$110

*Note: Phone appointments are priced the same as in office visits.*

### RETURN POLICY

- **Supplements**  
Un-opened product within 30 days of the purchase date – 100% of the purchase price  
Opened product– No Refund (some exceptions may apply)
- **Skin Care Products** – returns decided on an individual basis; must have original receipt
- **Other Products** – must be unopened and come with the original receipt to receive a full refund.

**TELEPHONE CALLS**

**Call 911 for emergency situations**  
**Treatment Questions: call 303-449-3777 or email [info@holisticacare.com](mailto:info@holisticacare.com)**

*I hereby acknowledge that I have read and understand the above information and agree to the terms of payment.*

Patient/Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature (for minors only): \_\_\_\_\_ Date: \_\_\_\_\_

**FINANCIAL RESPONSIBILITY (GUARANTOR) – PARENT/GUARDIAN**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_F \_\_\_M

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*I hereby acknowledge that I am financially responsible for payment of all services rendered to the above named patient/client and that I am subject to all financial terms listed below.*

Guarantor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TERMS OF ADMISSION**

**Financial Terms:** I understand that I am responsible for all charges whether or not they are covered by my insurance. Holistica Integrative Care does not bill for insurance and accepts cash, check, VISA or MC for payment. I understand that payment for services, supplements, products, and lab tests are due in full at the time of service and/or purchase. I understand that a \$30 fee will be charged for returned checks (non-sufficient funds), and if payment is not received within 30 days, finance charges will begin accruing at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency, and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance, and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

**Privacy Terms:** We keep a record of healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to other unless you direct us to do so or applicable laws authorize or compel us to do so. Holistica Integrative Care is required to provide you, at your request, with a copy of it Notice of Privacy Practices and to obtain written acknowledgement that you have reviewed it. The notice outlines the types of uses and disclosures that may occur involving your protected health information and describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic and wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call our office at: 303-449-3777.

*I hereby acknowledge that I have reviewed a copy of Holistica Integrative Care's Notice of Privacy Practices. Should I fail to sign this form, I acknowledge that Holistica Integrative Care has made good faith effort to obtain my acknowledgement.*

X \_\_\_\_\_  
Patient/Client's Signature

Date: \_\_\_\_\_

X \_\_\_\_\_  
Guardian's Signature

Date: \_\_\_\_\_

# PATIENT/CLIENT INTAKE FORM

Patient/Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please indicate symptoms you've experienced in the last 6 months with an **X** and throughout your life with a **P** for past symptoms.

## FAMILY HISTORY

- Alcoholism
- Arthritis
- Cancer
- Diabetes
- Endometriosis
- Heart disease
- Other: \_\_\_\_\_
- Mental Emotional Disorder
- Osteoporosis
- Skin problems
- STD's
- Stroke
- Tuberculosis

## GENERAL

- Weight change
- Fever/Chills
- Weakness
- Fatigue
- Sweating/night sweats
- Fainting
- Dizziness
- Forgetfulness
- Hair/nail changes

## EYES

- Glasses/contacts
- Blurring
- Pain
- Double vision
- Discharge
- Floaters
- Glaucoma
- Cataracts
- Macular Degeneration

## PULMONARY

- Shortness of breath
- Wheezing
- Chronic Cough
- Coughing blood
- Sputum

## SKIN

- Itching
- Rashes
- Bruise easily
- Hives
- Athlete's Foot
- Eczema/psoriasis
- Change in moles
- Sores that won't heal

## MOUTH/THROAT

- Sores
- Bleeding gums
- Teeth
- Hoarseness
- Difficulty swallowing
- Taste

## CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Irregular heartbeat
- Murmurs
- Calf pain with Walking
- Heart attack
- Heart disease
- Edema
- Palpitations
- Chest pain/angina
- Varicose veins

## MUSCLE/JOINT/BONE

- Pain
- Numbness
- Swelling
- Bursitis/tendonitis
- Broken bones
- Sprains/strains
- Spasms/cramps
- Headache/head injuries
- Low back, hip, leg pain
- Neck/shoulder/arm pain
- Jaw pain/TMJ
- Arthritis
- Osteoporosis

## EARS

- Ringing
- Earache/discharge
- Loss of hearing

## NOSE

- Sinusitis
- Bleeding
- Discharge
- Obstruction
- Postnasal drip
- Nasal polyps

## GENITOURINARY

- Low back pain
- Painful urination
- Blood in urine
- Frequent/urgent urination
- Loss of bladder control
- Nighttime urination
- Recurrent Infections
- Kidney stones

**GASTROINTESTINAL**

- Poor appetite
- Constipation/diarrhea
- Indigestion/heartburn
- Ulcers
- Gas/bloating
- Lactose intolerance
- Bowel changes
- Nausea/vomiting
- Hemorrhoids
- Hernia
- Blood in stool
- Anal discomfort
- Excessive hunger
- Excessive thirst

**AUTO-IMMUNE**

- Lupus
- Rheumatoid Arthritis
- Crohn's Disease
- Fibromyalgia

**SEXUAL HISTORY**

- Syphilis
- Gonorrhea
- Chlamydia
- Sores/Discharge
- Herpes
- HPV
- Sexual/physical abuse

**FEMALE ONLY**

- Breast lumps
- Nipple discharge
- Bleeding after menopause
- Hot flashes
- Painful intercourse
- Hysterectomy total
- Hysterectomy partial (uterus only)
- Fibroids
- Vaginal infections
- Abnormal PAP smears
- Late Menstrual Period/Date: \_\_\_\_\_
- Infertility
- Low libido
- PMS

**MALE ONLY**

- Breast lumps
- Erection difficulties
- Lump/pain in testicles
- Penis discharge
- Sores on penis
- Infertility
- Low libido

**ENDOCRINE**

- Diabetes
- Thyroid
- Hypoglycemia
- Goiter
- Heat/Cold intolerance
- Hormone therapy
- Excessive thirst/hunger

**ALLERGIC**

- Drug/vaccination allergy
- Asthma
- Eczema
- Rhinitis
- Hay Fever
- Hives
- Post-nasal drip
- Itchy or water nose/eyes

**BLOOD/LYMPH**

- Anemia
- Transfusions
- Bleeding tendency
- Lymph node enlargement
- Lymph node pain

**NEUROLOGICAL**

- Fainting
- Convulsions
- Sensations
- Gait/coordination
- Speech
- Numbness/tingling
- Paralysis/weakness
- Migraines

**PSYCHOLOGICAL**

- Memory Loss
- Mood
- Sleep pattern
- Anxiety/depression
- Phobias
- Drug/alcohol abuse
- Eating disorder
- ADHD
- Bipolar
- Schizophrenia

**SLEEP**

- Difficulty falling asleep
  - Difficulty staying asleep?
  - Sleep problems during menstrual cycle?
- How many hours per night on average do you sleep? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**GENERAL INFO**

**Height:** \_\_\_\_ ft. \_\_\_\_ in.    **Weight:** \_\_\_\_ lbs.    **Frame size:** \_\_\_\_ Small \_\_\_\_ Medium \_\_\_\_ Large

**What are your top 3 health concerns?**

Health Concern #1: \_\_\_\_\_

Health Concern #2: \_\_\_\_\_

Health Concern #3: \_\_\_\_\_

**ALLERGIES** (please describe type of allergy and your symptoms):

| <b>Seasonal Allergies<br/>(e.g. pollen, hay fever)</b> | <b>Medication Allergies<br/>(e.g. penicillin, rashes)</b> |
|--|---|
|  |   |
|  |   |
|  |   |
|  |   |

**Besides the allergies listed above, are there any other substances to which you have had a bad reaction?**

\_\_\_\_\_

**SURGERIES/HOSPITALIZATIONS:**

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_

## SOCIAL HISTORY

Where did you grow up? \_\_\_\_\_

Highest level of education? \_\_\_ High School \_\_\_ Bachelors \_\_\_ Masters \_\_\_ Other: \_\_\_\_\_

What kinds of work have you done? \_\_\_\_\_

What kind of work do you do now? \_\_\_\_\_

How many hours do you work a week? \_\_\_\_\_

How would you rate your stress level at work? \_\_\_ Low \_\_\_ Medium \_\_\_ High

How would you rate your stress level at home? \_\_\_ Low \_\_\_ Medium \_\_\_ High

What are your hobbies? \_\_\_\_\_

What brings you the greatest joy in life? \_\_\_\_\_

## DRUG USE

*This section is relevant to your brain chemistry. You are not required to answer this section, but it will help us assess your overall brain chemistry. All information is kept confidential under the HIPPA Act.*

**Alcohol Use:** How long? \_\_\_\_\_ How often? \_\_\_\_\_

**Tobacco Use:** How long? \_\_\_\_\_ How often? \_\_\_\_\_

**Marijuana Use:** How long? \_\_\_\_\_ How often? \_\_\_\_\_

**Cocaine Use:** How long? \_\_\_\_\_ How often? \_\_\_\_\_ Mode? \_\_\_\_\_

**Psychedelic drug us (ecstasy, LSD, other):** How long? \_\_\_\_\_ How often? \_\_\_\_\_

**Other recreational drug use:** What type? \_\_\_\_\_ How long? \_\_\_\_\_ How often? \_\_\_\_\_

## SPORTS, HOBBIES, INTERESTS

**SPORTS, HOBBIES, INTERESTS (please include both current and past):**

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**NUTRITION**

**How many meals do you eat per day?**

- One
- Two
- Three
- Four or more

**How much water do you drink per day?**

- None
- 8 – 24 oz
- Quart to half gallon
- More than a half gallon

**Coffee:** Number of cups per day \_\_\_\_\_ Type \_\_\_\_\_

**Tea:** Number of cups per day \_\_\_\_\_ Type \_\_\_\_\_

**Soft Drinks/Diet Drinks:** Amount \_\_\_\_\_ Type \_\_\_\_\_

**Do you eat foods containing large amounts of sugar?** \_\_\_ Yes \_\_\_ No

**If so, what kinds of foods?** \_\_\_\_\_

**Do you use artificial sweeteners (Equal, Sweet 'n' Low or Sucralose)?** \_\_\_ Yes \_\_\_ No

**List any FOOD ALLERGIES that you have (be specific and be sure to include ALL food allergies:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List specific FOOD DISLIKES (be specific and include all foods you just won't eat:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## NUTRITION (con't)

**Typical Daily Food Intake:** List all the food consumed in the last TWO days. If these days are not typical, pick two days that are most typical of your eating patterns. Please be specific, including amounts of foods, beverages, and supplements.

### DAY 1

| Meal      | Time | Food & Amt | Beverage & Amt |
|-----------|------|------------|----------------|
| Breakfast |      |            |                |
| Snack     |      |            |                |
| Lunch     |      |            |                |
| Snack     |      |            |                |
| Dinner    |      |            |                |
| Snack     |      |            |                |

### DAY 2

| Meal      | Time | Food & Amt | Beverage & Amt |
|-----------|------|------------|----------------|
| Breakfast |      |            |                |
| Snack     |      |            |                |
| Lunch     |      |            |                |
| Snack     |      |            |                |
| Dinner    |      |            |                |
| Snack     |      |            |                |

## EXERCISE

**What type of exercise do you do?**

Aerobic     Resistance Training     Flexibility Training     None

**Please list your specific form(s) of exercise:**

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |

**How many times do you exercise each week?**

0     1-3     3-5     5-7     7+

**When you exercise, typically how long are your exercise sessions?**

|  |  |
|--|--|
| <input type="checkbox"/> 15-30 minutes | <input type="checkbox"/> 60-75 minutes |
| <input type="checkbox"/> 30-45 minutes | <input type="checkbox"/> 75-90 minutes |
| <input type="checkbox"/> 45-60 minutes | <input type="checkbox"/> 90+ minutes   |

**After exercising, is your energy better or worse?**  Better     Worse     Varies

**During your exercise sessions, is your energy level stable?**  Yes     No

## MEDICATION & NUTRITIONAL SUPPLEMENTS

**Please list the name(s), dosage, frequency, and duration of all MEDICATION and/or SUPPLEMENTS, VITAMINS, MINERALS, HERBS, or HOMEOPATHICS you are taking:**

| Name | Dosage | Frequency | Duration |
|------|--------|-----------|----------|
|      |        |           |          |
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