Magnolia Personalized Medicine P.C

Magnoliapersonalizedmedicine.com

Dr. Wright

6237342473

Which of the following treatments are you interested in?

_____ Bone health: osteoarthritis, Osteoporosis, Rheumatoid arteritis

_____ Heavy metal detox: oral

_____ Natural approach to autoimmune: Hashimoto, AK, MS, RA, ALS

_____ Build up the immune system defense: Lymphatic drainage and liver detox

_____ Food sensitivity tests and diet modification

_____ Natural Weight loss programs with amino acids and lipotropics

_____ Hormonal balance with plants or bioidentical hormones

_____ European Homeopathic injection: mild depression, sciatic pain, lymphatic drainage, hepatic detox

_____ Anxiety: Hypnosis, Acupuncture, Nutrition

_____ Specialized Testing for Allergies, Deficiencies, Cholesterol, GI Issues, etc.

_____ Natural treatments for digestive issues: ulcer, IBS, fatty liver

_____ Natural Treatments for joint pain, fatigue, degenerative disease, etc.

_____ Alternative to Mammogram= Thermography

_____ Natural treatments for adrenal fatigue, sleep, hypertension, cholesterol

_____ Mental health: stress, anxiety, focus, memory

_____ Clinical hypnotherapy for emotional release, anxiety, weight loss

_____Acupuncture: for pain, anxiety, stress

_____Personalized diet: anti fatigue, anti-estrogenic, anti-inflammatory, anti-stress

Patient Name: _____ Date: _____

Dr. Ellie Wright NMD

www.magnoliapersonalizedmedicine.com

MEDICAL INTAKE FORM

Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____(H) _____(C) _____(other)

Date of Birth: _____ Age: _____ Sex: M / F (circle one)

Email address: _____

How did you learn about Magnolia Personalized Medicine?

□ Already a Client □ Advertisement _____□ Website □ Groupon

□ Web Search □ Referred by: _____

□ Walk-In/Sign □ Other: _____

In case of emergency, who should we contact:

Name: _____ Phone: _____

In the event that we cannot speak to you directly do you wish for us to leave medical information on your voicemail or message system?

Yes_____ No _____

If yes, what number may we leave medical information?

(c) _____ (h) _____ (w) _____

Do you wish to receive newsletters in the form of e-mails from our office?

Yes _____ No _____

Do you wish to receive text messages about appointment reminders?

Yes _____ No _____

Please list with whom, other than yourself, we may discuss and/or release your personal medical information:

1.) Name:

Tel:

2.) Name:

Tel:

3.) Name:

Tel:

Signature:_____

List, in order, of importance what your health concerns are:

1.

2.

3.

Current Medication and supplements:

1.

2.

3.

4.

5.

Primary Physician name & contact info:

List all surgeries & hospitalizations, including date occurred:

1.

2.

3.

Please note when & why you have had each of the following:

X-Rays:

Accidents:

MRI/Cat Scans:

Ultrasounds:

TB Test: HCV: _____ HIV:

Last Dental Visit:

Last Eye Exam:

Did you have any of the follow Disease (D), Get Immunized (I), or Neither (N):

Measles: D I N Chicken Pox: D I N Mumps: D I N Rubella: D I N Tetanus: D I N Whooping Cough: D I N Hemophilus (Hib) D I N Hepatitis B: D I N German Measles: D I N

Any vaccination reactions: _____

List Yes (Y), No (N), or Past (P) regarding use of the following:

Antacids: Y N P Steroids: Y N P Analgesics: Y N P Laxatives: Y N P

Smoking: Y N P Packs per day & number of years: _____

Coffee: Y N P Cups per day if Yes/Past: _____

Soda: Y N P Ounces per day if Yes/Past: _____

Alcohol: Y N P How often & how much if Yes/Past: _____

Any alcohol addiction: Y N P Any alcohol treatment: Y N P

Recreational drugs: Y N P Any drug addictions: Y N P

Any cancer treatment: Y N P

Review of Systems

Present weight: Weight one year ago: Height:

Maximum weight & when: Minimum weight & when:

Ideal weight:

Family History

FATHER MOTHER SIBLINGS GRANDPARENTS SPOUSE CHILDREN

Parents Age, if living/died: _____ _____ _____ _____ _____ _____

Siblings Age, if living/died: _____ _____ _____ _____ _____ _____

Reason for death: _____ _____ _____ _____ _____ _____

Cancer type: _____ _____ _____ _____ _____ _____

Diabetes_____

Heart diseases_____ _____

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Current medical history:

High Blood Pressure? YES NO **HeartAttack/Stroke?** YES NO **Heart Disease?** YES NO
Asthma/Allergies? YES NO **Mental Illness?** YES NO **TB?** YES NO **Auto-Immune Disease**? YES NO

Diabetes Mellitus? YES NO **Osteoporosis?** YES NO

REGARDING THIS NEXT SECTION: Please circle Yes (Y) if your have a problem NOW, circle Never (N) if you never had the problem, or (P) if you had the problem in the past.

Good Energy: Y N P **Fatigue:** Y N P If you have fatigue, when is it the worst? (Morning, afternoon, evening)

If you have fatigue, can you do what you need to do during the day?

HEAD

Headache: Y N P **Migraine:** Y N P **Dandruff**: Y N P **Head Injury:** Y N P

Oil/dry hair: Y N P **Hair loss:** Y N P

NOSE

Frequent Colds: Y N P **Nosebleeds:** Y N P **Congestion:** Y N P **Post Nasal Drip**: Y N P

Polyps: Y N P **Seasonal Allergies:** Y N P

EYES

Dry/Watery: Y N P **Blurry Vision**: Y N P **Double Vision:** Y N P **Cataracts:** Y N P **Glaucoma:** Y N P

Sties: Y N P **Strain**: Y N P **Discharge:** Y N P **Itchy:** Y N P **Dark Circles** Y N P

MOUTH/THROAT

Canker Sores: Y N P **Cold Sores:** Y N P **Sore Throat:** Y N P **Gum disease:** Y N P **Dentures**: Y N P
Cavities: Y N P **Loss of taste:** Y N P **Hoarseness**: Y N P

NECK

Stiffness: Y N P **Swollen Glands**: Y N P **Full Movement**: Y N P **Tension:** Y N P

RESPIRATORY

Cough: Y N P TB: Y N P **Shortness of breath with exertion**: Y N P **Bronchitis**: Y N P

Shortness of breath sitting: Y N P **Pneumonia:** Y N P **Shortness of breath while lying:**Y N P

Asthma: Y N P **Wheezing:** Y N P **Painful breathing**: Y N P

CARDIOVASCULAR

High Blood Pressure: Y N P **Rheumatic Fever:** Y N P **Low Blood Pressure**: Y N P **Murmurs**: Y N P

Arrhythmias: Y N P **Palpitations:** Y N P **Edema:** Y N P **Chest Pain:** Y N P

URINARY TRACT

Incontinence: Y N P **Pain with Urination:** Y N P **Frequent infections:** Y N P **Kidney Stones**: Y N P

Urgency: Y N P **Discharge/Blood:** Y N P

GASTROINTESTINAL

Heartburn: Y N P **Bowel Movement Frequency:** **Indigestion:** Y N P **Recent BM Change:** Y N P

Bloating: Y N P **Diarrhea/Constipation:** Y N P **Nausea:** Y N P **Hemorrhoids:** Y N P **Vomiting:** Y N P

Gall Bladder Disease: Y N P **Change in Appetite**: Y N P **Liver Disease:** Y N P

Pancreatitis: Y N P **Ulcer:**Y N P **Rectal discharges/bleeding:**

MUSCULOSKELETAL

Weakness: Y N P **Arthritis:** Y N P Stiffness: Y N P Leg Cramps: Y N P Tremors: Y N P Pain: Y N P

NERVOUS

Paralysis: Y N P **Sciatica:** Y N P **Tingling/numbness:** Y N P **Carpal tunnel syndrome:** Y N P

Seizures: Y N P **Fainting** Y N P

MENTAL/EMOTIONAL

Depression: Y N P **Anger/irritability:** Y N P **Suicidal:** Y N P **High-strung/tense:** Y N P

Anxiety: Y N P **Fear/Panic:** Y N P **Eating disorder:** Y N P **Psych Hospitalization:** Y N P

MALE HEALTH

Testicular pain/swelling: Y N P **Prostate Disease/Symptoms:** Y N P **Hernia:** Y N P

Sexually Active: Y N P **Discharge:** Y N P **S.T.D.:** Y N P **Impotency:** Y N P

Sexual Orientation: Heterosexual Homosexual Bisexual

FEMALE HEALTH

Age began period: _____ How often period occurs: _____

How long period lasts: _____ Heavy menstrual bleeding: Y N P

Menstrual cramping: Y N P **Menstrual Pain**: Y N P

PMS: Y N P **Food cravings:** Y N P

Times Pregnant: _____ How many births _____

Miscarriages: _____ Abortions: _____

Last Pap Smear: **_____ Diagnosis: _____**

Any abnormal paps: Y N P **When was abnormal: _____**

Menopausal since what age: ___ Use of hormones: Y N P **Types of hormones used:_____**

Healthy libido: Y N P **Dry vagina:** Y N P **Sexually Active:** Y N P **Pain with intercourse:** Y N P

Vaginitis: Y N P **S.T.D.:** Y N P **Mammography:** Y N P **Dexa Scan:** Y N P **If Yes, what were results:** _____

Sexual Orientation: Heterosexual Homosexual Bisexual

Please list any birth control used and ages used:

EXERCISE

How often do you exercise? What type of exercise?

For how long? Hobbies:

SLEEP

How long per night?____ If you wake up frequently, what is the reason?_____

Nightmares: Y N P **Wake Refreshed:** Y N P **Must nap during the day:** Y N P

Sleep walk: Y N P **Grind teeth**: Y N P **Snore** Y N P

TOXIN EXPOSURE

- Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?
- Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials?
- Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing?
- Are you particularly sensitive to perfumes, gasoline or other vapors?
- Do you use pesticides, herbicides or other chemicals around your home?

SOCIAL LIFE

Do you enjoy your job? Y N P Hours worked per week: Highest level of education:

Active spiritual practice: Y N P Quality of significant relationship:

History of sexual, mental/emotional, physical abuse: Y N P If so, at what age and by whom:

What is your greatest health concern:

How does it limit you the most:

How committed are you toward making valuable changes? Little Moderately Very

TYPICAL DAY'S DIET

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

ALLERGIES

List all known allergies (food, drugs, environment, etc):

I give my consent for examination and treatment by doctor Ellie Wright at the Magnolia Personalized Medicine. Please, sign below that this information is true and correct.

Signature/ Date:

Patient or Guardian Signature/ Date:

PATIENT AND PHYSICIAN ARBITRATION AGREEMENT

Please read each item below and initial in the space next to it if you understand and agree to the item. Please ask any questions regarding anything that needs to be clarified before initialing or signing this form.

THIS CONTRACT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES AND WHICH WILL ELIMINATE YOUR RIGHT TO HAVE A JURY OR A JUDGE DECIDE ALL ISSUES AND CLAIMS THAT MAY ARISE AS A RESULT OF YOUR AGREEMENT AND DECISION TO REQUEST AND RECEIVE THE ADMINISTRATION OF THE FOLLOWING TREATMENT(S), INCLUDING BUT NOT LIMITED TO CLAIMS OF NEGLIGENCE AND INTENTIONAL ACTS THAT RESULT IN INJURY TO YOU.

PATIENT NAME:_____DATE: _____

Article 1: Agreement to Arbitrate: It is understood that any claim of malpractice, including any claim that health care services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered or omitted, will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. The patient has the right to seek legal counsel concerning this agreement prior to signing.

Both parties to this agreement, by entering into it, have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury**.**

Initials: _____

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all patient claims that may arise out of or relate to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the health care provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the health care provider, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Initials: _____

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issue of liability and damage upon written request to the proper additional party in a court action, and upon such intervention and joiner any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, whether applicable, establishing the right to

introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the arbitration conducted pursuant to this Arbitration Agreement shall be final and binding. The prevailing party shall be entitled to reasonable fees incurred due to the arbitration, including arbitration fees, counsel fees, witness fees, or other expenses incurred by the prevailing party**.**

Initials: _____

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence**.**

Initials: _____

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 90 days of signature and if not revoked will govern all professional services received by the patient.

Initials: _____

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. Effective at the date of first professional services.

Initials: _____

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this

Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION RATHER THAN BY A JURY OR COURT TRAIL - SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ By: _____

Patient or Patient's Representative's Signature Date

Physician's or Authorized Representative's Signature Date

(Indicate relationship if signing for patient)

Dr. Ellie Wright NMD

www.magnoliapersonalizedmedicine.com

Office Policies & Fees

- No Refund Policy: It is the policy of *Magnolia Personalized Medicine* PCthat no refunds will be issued once an initial purchase has been made. If treatment is declined, the purchaser may receive the full amount in house credit toward alternative treatments. Only the amount paid is redeemable towards house credit taking into account discounts that were taken at the time of original purchase. When treatment packages are used the full cost of each treatment will be deducted from the amount paid and the remaining balance can be redeemed toward house credit if other treatment options are pursued.
- Cancellation Policy: There is a 48-hour cancellation policy. Any cancellations less than 48 hours before a scheduled appointment will be subject to a $40 cancellation fee.
- Weight-Loss Policy: To keep our costs low, we are unable to provide any exchange or refunds of all diet programs or products.
- Injectables: A product is considered compromised and no longer usable after it leaves the office. There will be no refund offered for products of this nature.
- Updated Information: It is the patient's responsibility to notify *Magnolia Personalized Medicine* of any changes to health, insurance, address, phone number and email.

By signing below you acknowledge that you fully understand and accept the policy of *Magnolia Personalized Medicine* regarding the refunding of purchases.

Name: _____ Date: _____