

Synchronicity Health Centre

Carolyn Humphreys, ND

206 N. Acacia Ave Solana Beach, CA 92075 P: 858.847.0922 F: 858.847.0923

The 7 Principles of Naturopathic Medicine

1. The Healing Power of Nature (Vis Medicatrix Naturae)

The healing power of nature is the inherent self-organizing and healing process of living systems. Naturopathic medicine recognizes this healing process to be ordered and intelligent. It is the naturopathic physician's role to support, facilitate and augment this process by identifying and removing obstacles to health and recovery, and by supporting the creation of a healthy internal and external environment.

2. First Do No Harm (Primum Non Nocere)

Naturopathic physicians utilize methods and medicinal substances which minimize the risk of harmful effects, and apply the least possible force or intervention necessary to diagnose illness and restore health. Whenever possible the suppression of symptoms is avoided as suppression generally interferes with the healing process.

3. Treat The Cause (Tolle Causam)

Every illness has an underlying cause, often in aspects of the lifestyle, diet or habits of the individual. A naturopathic physician is trained to find and remove the underlying cause of a disease.

4. Doctor as Teacher (Docere)

The original meaning of the word "doctor" is teacher. A principal objective of naturopathic medicine is to educate the patient and emphasize self-responsibility for health. Naturopathic physicians also recognize and employ the therapeutic potential of the doctor-patient relationship.

5. Treat The Whole Person

Health or disease comes from a complex interaction of mental, emotional, spiritual, physical, dietary, genetic, environmental, lifestyle, and other factors. Naturopathic physicians treat the whole person, taking these factors into account.

6. Preventive Medicine

The naturopathic approach to health care can prevent minor illnesses from developing into more serious diseases. Patients are taught the principles with which to live a healthy life and by following these principles, they can prevent major illnesses.

7. Wellness

Establishing and maintaining optimum health and balance. Wellness is a state of being healthy, characterized by positive emotion, thought, and action. Wellness is inherent in everyone no matter what dis-ease(s) are being experienced. If wellness is really recognized and experienced by an individual, it will more quickly heal a given dis-ease than direct treatment of the dis-ease alone.

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Office Policies

Welcome to SHC!

Please review and initial each paragraph, then sign and date below.

Missed Appointment Policy

Appointments are a commitment on the part of both client and practitioner. Because we reserve a specific time in our schedule just for you, please provide at least 24-hour notice if you need to reschedule or cancel your appointment. Any appointment cancelled with less than 24 hours notice or is missed altogether is subject to a \$75 dollar charge.

_____Initials

Notice of Privacy Policy

Initial below to acknowledge you have received a copy of the Notice of Privacy Policy that explains in detail the policy regarding how your health information can be used and disclosed.

_____Initials

Our Practitioners

SHC is made up of a group of legally separate practitioners who share space. Your care and the results of your care are the responsibility of the practitioner who provided that care. All other practitioners and the entities of Inner Wisdom Wellness Center/Synchronicity Health Centre are not responsible for any issues, financial or otherwise, that may arise with the practitioner who provided the services.

_____Initials

Consent

I have read the information above and fully understand my responsibilities. I understand that my express consent is required to release any information relating to testing, diagnosis or other health care. I also understand that a photocopy of this form is as valid as the original. Please sign below that you understand and agree to the above office policies and willingly give your consent for treatment.

Patient Signature

Date

Patient's Name (printed)

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Exchange Agreement

Fees & Payment

All payment is due at the time of service, in the form of cash, check, VISA or MasterCard.

Naturopathic Medical Care

First appt	\$245	90 mins
Follow up	\$195	60 mins

Craniosacral Therapy

\$90 1 hr session

NAET – Allergy Elimination Technique

First appt	\$155	60 mins (includes treatment)
Follow up	\$75	30 mins

NAET: Children rates are \$125 and \$65

B-12 Injections

\$25 Other vitamin combos available; prices vary

Insurance

Naturopathic services may be covered by your insurance as an out-of-network benefit verses an in-network benefit. To find out if you have out-of-network benefits, call the customer service number on the back of your insurance card.

If you are eligible and desire the option of submitting to your insurance company, please let me know *before* your appointment. For 'insurance appointments', specific criteria must be met during the appointment in order to be compliant with insurance specifications.

Please note that even if you do have out of network benefits, insurance companies have chosen **not** to provide coverage for all services offered here at SHC. This includes but is not limited to Kinesiology, NAET (allergy treatments) and nutritional counseling.

Submitting to insurance is the responsibility of the individual, not that of SHC. At the end of an 'insurance appointment' you'll be given a 'superbill' with the insurance codes that you may submit to your insurance company for reimbursement.

Insurance is known for being a little confusing at times, so if you have any questions, just ask!

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Patient Information

Patient Profile

Date: ___/___/___

Name:		Date of Birth:	Age: <input type="checkbox"/> M <input type="checkbox"/> F
Address:		Apt:	
City:		State/Zip:	
How did you hear about this clinic?	<input type="checkbox"/> Ad: Nat'l Health Guide Other:	<input type="checkbox"/> Friend: Who?	<input type="checkbox"/> Other: Please indicate
	<input type="checkbox"/> Practitioner: Who?	<input type="checkbox"/> Search Engine: Which one?	

Contact Information

Phone Numbers: Check the box next to the phone number(s) below where a message can be left that may contain confidential health information. If none, please mark here _____ (initials)		
<input type="checkbox"/> Home #:	<input type="checkbox"/> Work #:	<input type="checkbox"/> Cell #:
E-mail address: _____ (used minimally for announcements)		
Occupation:	Employer:	
Emergency Contact:	Relationship to you:	
Emergency Contact Phone #:		

Other

Have you ever seen a naturopathic doctor?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you seen any kind of alternative practitioner?	<input type="checkbox"/> Y <input type="checkbox"/> N

OFFICE USE ONLY

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Name _____ Date of Birth _____ Today's Date _____

Please state the main reason(s) for today's visit:

1. _____
2. _____
3. _____

Health Concern 1

- When did the condition begin?
- Describe the area of the body affected (i.e. head):
- Does it radiate to any other areas?
- How would you describe the problem (i.e. dull, achy pain?)
- How would you rate the severity on a scale of 1 to 10 with 10 being the worst?
- When does it occur (i.e. constantly, only the morning etc)?
- Does it only occur with certain activities (i.e. sleep)?
- What makes it better?
- What makes it worse?
- Any other associated symptoms (i.e. fatigue, runny nose etc)?

Health Concern 2

- When did the condition begin?
- Describe the area of the body affected (i.e. head):
- Does it radiate to any other areas?
- How would you describe the problem (i.e. dull, achy pain?)
- How would you rate the severity on a scale of 1 to 10 with 10 being the worst?
- When does it occur (i.e. constantly, only the morning etc)?
- Does it only occur with certain activities (i.e. sleep)?
- What makes it better?
- What makes it worse?
- Any other associated symptoms (i.e. fatigue, runny nose etc)?

Health Concern 3

- When did the condition begin?
- Describe the area of the body affected (i.e. head):
- Does it radiate to any other areas?
- How would you describe the problem (i.e. dull, achy pain?)
- How would you rate the severity on a scale of 1 to 10 with 10 being the worst?
- When does it occur (i.e. constantly, only the morning etc)?
- Does it only occur with certain activities (i.e. sleep)?
- What makes it better?
- What makes it worse?
- Any other associated symptoms (i.e. fatigue, runny nose etc)?

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Name _____

Date of Birth _____

Who is on your health care team?

Practitioners	Name	City	Clinic Name or Hospital Name	Prescribes you medication?	Happy with care overall?
Family Doc				Y / N	Y / N
Pediatric Doc				Y / N	Y / N
GYN / OB				Y / N	Y / N
Psychologist				Y / N	Y / N
Psychiatrist				Y / N	Y / N
Counselor				Y / N	Y / N
Chiropractor				Y / N	Y / N
Acupuncturist				Y / N	Y / N
Physical Therapist				Y / N	Y / N
Dermatologist				Y / N	Y / N
Neurologist				Y / N	Y / N
Rheumatologist				Y / N	Y / N
Energetic Healer				Y / N	Y / N
Massage Therapist				Y / N	Y / N
Other(s):				Y / N	Y / N
				Y / N	Y / N
				Y / N	Y / N

List most recent date of the following care:

Exam	Date	Repeat	Exam	Date	Repeat
Physical Exam			Prostate Exam PSA		
Cholesterol			Vision & glaucoma		
PAP / pelvic exam			Chest XR		
Mammogram			EKG		
Colonoscopy			TB test		
DEXA/bone density			STD screen		

Labs & Imaging Tests – ordered from this office

Date reviewed	Lab Test	Repeat Date	Date reviewed	Lab Test	Repeat Date

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Name _____ Date of Birth _____ Today's Date _____

Family History

Mother:	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	Cause/Age:
Father:	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	Cause/Age:
Siblings:	# living:	# deceased:	Causes/Ages:
Children:	# living:	# deceased:	Causes/Ages:
Do any of your blood relatives have the following?	Y	N	Which Relative(s) Age:
			Dad's side (D), Mom's side (M)
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Stroke or heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Gall bladder removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Drinking or drug problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Other cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Depression / Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)
Other(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (D) <input type="checkbox"/> (M)

Health History – include dates

Allergies to (medications, environment or foods): <input type="checkbox"/> none			
Organs removed? <input type="checkbox"/> tonsils <input type="checkbox"/> appendix <input type="checkbox"/> uterus <input type="checkbox"/> ovaries <input type="checkbox"/> gall bladder <input type="checkbox"/> wisdom teeth			
Other Surgeries:	<input type="checkbox"/> none		
Injuries:	<input type="checkbox"/> none		
Head trauma(s):	<input type="checkbox"/> none		
Major illness:	<input type="checkbox"/> none		
Accidents (car, falls):	<input type="checkbox"/> none		
Have you had mercury filling? <input type="checkbox"/> Y <input type="checkbox"/> N			
Have you had mercury fillings removed? <input type="checkbox"/> Y <input type="checkbox"/> N If so, when?			
Immunization			
Flu Shot (influenza vaccine)	<input type="checkbox"/> Y date:	Hepatitis B vaccine	<input type="checkbox"/> Y date:
Tetanus booster	<input type="checkbox"/> Y date:	Tuberculosis (TB) skin test	<input type="checkbox"/> Y date:
Hepatitis A vaccine	<input type="checkbox"/> Y date:	Other:	<input type="checkbox"/> Y date:

Life Style

Work Related	Yes	No	Notes
Number of hours you work per week:			
Do you feel job satisfaction?	<input type="checkbox"/>	<input type="checkbox"/>	
Health hazards: work/ home; past/current	<input type="checkbox"/>	<input type="checkbox"/>	What?

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Name _____ Date of Birth _____ Today's Date _____

Life Style

Relationships			
Are you happy in your relationship?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Do you have a good support network of friends and family?	<input type="checkbox"/> Y <input type="checkbox"/> N	What is your predominant emotion? (e.g. happy, sad, angry):	
Are you currently in counseling?	<input type="checkbox"/> Y <input type="checkbox"/> N		
Habits			
Tobacco use	<input type="checkbox"/> Y <input type="checkbox"/> N	Packs per d:	Date quit:
Alcohol	<input type="checkbox"/> Y <input type="checkbox"/> N	Drinks per d:	Drinks per wk:
Recreational Drug use	<input type="checkbox"/> Y <input type="checkbox"/> N	What?	
Stress			
Stress level (1-10)			
What do you do to relieve stress?			
Exercise			
What?	Cardio: Y <input type="checkbox"/> N <input type="checkbox"/> Weights: Y <input type="checkbox"/> N <input type="checkbox"/> None, since? _____		
Time, Frequency:	_____ minutes _____ days/wk		
Do you consider yourself:	<input type="checkbox"/> religious <input type="checkbox"/> spiritual <input type="checkbox"/> neither		
Diet Profile			
Do you follow any particular diet?	<input type="checkbox"/> Y <input type="checkbox"/> N	Which?	
Do you have any food allergies?	<input type="checkbox"/> Y <input type="checkbox"/> N	What?	
Are you lactose intolerant?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, does lactaid work? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> I don't know	
Do you eat red meat? (beef, lamb) If no, why not? Since when? _____	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how often?	
Meals – please list typical meals AND the times you generally eat			
Breakfast: Time _____		typically eat Bkfst? <input type="checkbox"/> Y <input type="checkbox"/> N	
Lunch: Time _____		typically eat Lnch? <input type="checkbox"/> Y <input type="checkbox"/> N	
Dinner: time _____		typically eat Dn'r? <input type="checkbox"/> Y <input type="checkbox"/> N	
Snacks /time(s) _____			
Caffeine (cola, coffee, black tea,):	<input type="checkbox"/> Y <input type="checkbox"/> N	How often? <input type="checkbox"/> daily <input type="checkbox"/> 5d/wk <input type="checkbox"/> 2-3d/wk <input type="checkbox"/> wkly	
Chocolate	<input type="checkbox"/> Y <input type="checkbox"/> N	How often? <input type="checkbox"/> daily <input type="checkbox"/> 5d/wk <input type="checkbox"/> 2-3d/wk <input type="checkbox"/> wkly	

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Name _____ Date of Birth _____ Today's Date _____

Review of Systems

Condition	Current	Past	Never	Doctor's Notes
Generals				min wt: max wt: ideal wt:
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	amt: duration: steady: y / n
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	amt: duration: steady: y / n
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fever / chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Change in height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin				
Dry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema or psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bumps on skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Slow healing times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nail irregularities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes				
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Poor night vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Red eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Visual disturbances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> floaters <input type="checkbox"/> lights <input type="checkbox"/> flashes
Blepharitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ears				
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> Both ears
Nose / Sinus				
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> drippy <input type="checkbox"/> stuck <input type="checkbox"/> alternates
Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> recurrent
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lose of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	date:
Mouth / Throat				
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> cold sores <input type="checkbox"/> canker sores
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TMJ concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Name _____ Date of Birth _____ Today's Date _____

Condition	Current	Past	Never	Doctor's Notes
Respiratory				
Asthma / wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> chronic <input type="checkbox"/> bloody
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis /pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular				
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of hands/feet/ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations / racing heart rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal				
Poor or excessive appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Excessive burping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach-ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart burn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> stomach <input type="checkbox"/> duodenum
Foods 'sits' in stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea / vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gas / bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation <1/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea or loose stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colitis or Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Irritable bowel syndrome (IBS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> painful <input type="checkbox"/> painless
Anal itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Any in the stool?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> blood <input type="checkbox"/> mucous <input type="checkbox"/> food particles
Blck tarry/coffee ground stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequency:
Gallbladder stones, pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary				
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency to urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Involuntary loss of urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loss urine w/cough or lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal				
Muscle pain / sprain / strain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Joint pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	type:
Osteoporosis / osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Condition	Current	Past	Never	Doctor's Notes
Endocrine				
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> type I <input type="checkbox"/> type II
Poor temp regulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hot <input type="checkbox"/> cold <input type="checkbox"/> day <input type="checkbox"/> night
Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cold hands / feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gynecological				
Fibrocystic breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Menopausal / perimenopausal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood / Lymph				
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lymph node concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> painful <input type="checkbox"/> swollen <input type="checkbox"/> hardened
Allergy/ Immune				
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> foods <input type="checkbox"/> drugs <input type="checkbox"/> environmental
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	type:
Neurological				
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness / vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headache or migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lack of mental alertness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> voluntary <input type="checkbox"/> involuntary
Epilepsy / seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric				
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mood changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> alcohol <input type="checkbox"/> drugs

Patient's Signature

Date

Doctor's Signature

Date reviewed with patient