Welcome to Shaw Family Practice,

We are so happy to have you here. Thank you for trusting us with your health.

On your first visit you will sit down with Dr. Shaw and discuss your goals, where you are now, how your life has shaped your current level of health. Dr. Shaw uses both naturopathic and chiropractic care to meet your needs. These healing techniques are based in preventive medicine and looking at the entire picture as a complete human being with physical, mental, and emotional health we address all of them here.

After you have shared what brought you in, Dr. Shaw will take you through a physical exam. She will talk with you so that you know what each test means, what she is looking for, and answer any questions you have along the way. With those results she will work with you to set goals, a timeline, and discuss a course of treatment to meet your goals.

This practice is a safe place for families. No need for babysitters, feel free to bring children, spouses, and friends. We invite you to bring your whole family to your visits at our office.

Should you feel the need to reach out, please do so. Dr. Shaw will reply as soon as she can.

We are glad you are here,

Shaw Family Practice

Dr. Shaw DC, ND

Harness the power of Nature

Shaw Family Practice

Adult Health History: Thank you for coming in, we are glad you are here. Please sit down and take your time with this detailed paperwork. The more information we review in your case the better care we can provide.

Name _____ Birthdate _____
Address _____City _____ State_____ Zip_____
Phone: (_____)_____ Email_____@_____.com
Would you like to receive online support through email or video with our office? Yes No

EMERGENCY CONTACT	
Name:	Address:
Phone:	
Relationship to patient:	

How did you hear about us? Many of our patients are referred by their friends, family, co-workers and doctors. These individuals are concerned for your health and have shown their trust and confidence in Dr. Shaw to provide you with the very best care possible. Please let us know how you heard about us so we can send them a "Thank You". Google Facebook Event Midwife_____ Referral:_____

Authorizing Consent for examination: Please Read Carefully

In order for Dr. Shaw to make a determination on the suitability of my case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by Dr. Shaw, or any party authorized to do so by that person. I understand that there may be risks with examinations and adjustments, as there are with any and all healthcare treatments. I understand that I may ask the doctor to stop the examination or treatment at any time. I understand by signing this form, the doctor continues to be obligated for best practices delivered in my interests.

Signature: _____ Date: _____

COLORADO SURPRISE/BALANCE BILLING DISCLOSURE

Surprise Billing – Know Your Rights: Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." **Provider: Dr. Shaw is out-of-network, you are responsible for the costs of services provided.** If you receive services from an out-of-network provider, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed. If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

ACKNOWLEDGEMENT OF RECEIPT OF COLORADO SURPRISE/BALANCE BILLING DISCLOSURE This document is to be signed by the patient or a person legally responsible for the patient's medical decisions relative to the treatment situation.I acknowledge that Shaw Family Practice has provided me with a copy of the Colorado Surprise/Balance Billing Disclosure. My signature below indicates that I understand that Shaw Family Practice is an out-of-network facility which does not participate with any insurance providers. I further understand that all of the services I receive at Shaw Family Practice will be performed by out-of-network providers.

Signature: _____ Date: _____

Naturopathic Care Disclosure

Dr. Shaw DC,ND was trained in naturopathic medicine at National University of Health Sciences. This practitioner received her degree after four years of graduate-level clinical and academic training, as well as the completion of rigorous basic science and clinical science board exams. This naturopathic doctor is registered, but not licensed, in the State of Colorado. The Division of Regulatory Agencies (DORA) is the regulatory board for naturopathic doctors in Colorado. Any complaints regarding our professional services should be submitted in writing to the Office of Naturopathic Doctor Registration. To obtain a complaint form, please contact the Division at (303) 894-7414 or www.dora.state.co.us.

As a Naturopathic Doctor, registered by the state to practice naturopathic medicine, under the "Naturopathic Doctor Act," I am not permitted to perform the following acts: • Prescribe, dispense, administer or inject any prescription medications or devices other than epinephrine for anaphylaxis and barrier contraceptives (not including IUDs). • Perform surgical procedures, including surgical procedures using a laser device. • Use general or spinal anesthetics, other than topical anesthetics. • Administer ionizing radioactive substances for therapeutic purposes. • Treat a child who is less than two years old without the family also seeing a pediatrician. • Treat a child who is two years of age or older, but less than eight years of age, unless: (1) this form is fully completed and signed; (2) the most recent immunizations schedule recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services is provided to the parent or guardian with this form; and (3) a release of information is provided to the parent or guardian requesting permission to exchange information with the child's licensed pediatric health care provider, if the child has one. • Practice medicine, surgery, or any other form of healing other than Naturopathic Medicine. Practice obstetrics. Recommend the discontinuation or counsel against a course of care, including a prescription drug that was recommended by another health care practitioner licensed in Colorado, unless the Naturopathic Doctor consults with the health care practitioner. Dr. Shaw is an active member of the Colorado Association of Naturopathic Doctors (www.coand.org). No license or registration has ever been revoked or suspended. The privacy of your medical information is important. This office complies with the United States HIPPA Patient Privacy Guidelines. Detailed information regarding these guidelines is available upon request. As a patient of Shaw Family Practice, you are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. You may seek a second opinion from another health care professional or may terminate therapy at any time. Dr. Shaw is not a medical doctor or physician licensed under Title 12, Article 36, of the Colorado Revised Statutes. I recommend that the patient named below have a relationship with a licensed physician, or if the patient is a child aged two to seven, with a licensed pediatric health care provider. If the patient is a child aged two to seven, we are required to recommend that the child's parent or guardian follow the immunization schedule that accompanies this form. If the patient has a relationship with a licensed physician or pediatric health care provider, we will attempt to develop and maintain a collaborative relationship with the physician or pediatric health care provider.

Signature: _____ Date: _____

Informed Consent for Chiropractic Spinal Manipulation, Authorization and Release

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition. **Possible risks:** Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy. Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer

and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury. **Other options** for the treatment of pain include: do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below for whom I am legally responsible) by the licensed Chiropractor, Dr. Jo Nell Shaw DC, ND.

Signature: _____ Date _____

FINANCIAL AGREEMENT

Shaw Family Practice is not a participating provider with any insurance companies. Our office does not file or submit claims to any health insurance plan. At your request, we can provide you with a receipt of services (SuperBill) that you can send to your insurance company for your reimbursement under your out-of-network plan. **Medicare:** Dr. Shaw is not a participating provider for Medicare. If you choose to use your Medicare plan we will happy to refer you to a participating provider. Workers Compensation: Dr. Shaw does not participate in workers compensation claims at this time. If you become injured on the job we would be happy to refer you for the appropriate care. **Payment:** Shaw Family Practice requires payment at the time of service. We currently accept debit and credit cards (Visa, MasterCard and Discover) cash, and checks. **Individual Consideration Contract:** If there is a financial hardship associated with receiving care in our office, payment arrangements can be negotiated with Dr. Shaw, and MUST be done prior to the time of service. Written agreements are required before treatment. **Past Due Accounts**: If your account becomes past due, we will take necessary steps to collect this debt. Outstanding balances will be billed monthly and considered past due 10 days after the invoice date. We will pass along the fee of $35 our bank charges us for any returned checks. Balances beyond 30 days will be charged an additional 1.5% of your total balance per month plus any additional costs necessary to collect the balance owed. If we have to refer your account to a collection agency, you agree to pay all of the collection agency fees or commissions that are incurred. We reserve the right to refuse future services until your account is in current status.

Signature: _____ Date _____

Cancellation and Missed Appointment Policy: We require a minimum of 24 hours notice when a patient cancels or reschedules their appointment. When a patient does not show up for an appointment and/or cancels / reschedules with less than 24 hours notice, a charge of 50% visit fee will be applied to the patient's account. If short notice cancellations or no-shows are frequent you will be asked for payment at the time of scheduling. I have read this agreement, understand it and agree with its provisions. I do clearly understand that I am ultimately responsible for the payment of fees for services rendered to me, or my family at this clinic. I authorize the doctors to administer such treatment as necessary. I do understand that no guarantees have been made as to the results of treatment. The ultimate financial responsibility remains with you, the patient. By signing this you are consenting to receive care.

Signature: _____ Date _____

Thank you for signing all of the spaces above, they are what is required by law, I appreciate your patience. Take a big breath, Now let's focus on you and why you are coming in today!

Dr. Shaw DC, ND

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Shaw Family Practice

WHY THIS FORM IS IMPORTANT: Our focus is on assisting people to function optimally, to become more self aware, stronger, healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body and contribute to other health problems. Please complete this form as thoroughly as possible and the doctor will review it with you. Information collected and discussed on this form is strictly confidential and can only be shared with your consent.

People seek care for a number of reasons and have certain expectations and perceptions.

___Improvement in function	___ Stress reduction	___ Improve fitness
___ Pain reduction/relief	___ Keep me moving	___ Longevity
___ Improved quality of life	___ Optimum function	___ Headache relief
___ Manage my crisis	___ Improved performance	___ Mental/emotional balance
___ Prevention	___ Overall Wellness	___ Brain health
___ Symptom management	___ Fertility	Other_____
___ Immune support	___ Pregnancy	_____

What goal, if you were to complete or accomplish it, would have the greatest impact on your life?

_____

_____

What do you hope to better enjoy as you improve your health_____

_____

What are you seeking help with? _____

What is your primary reason for seeking care at our office: _____

How long has this been a problem? _____

What do you believe the cause is? _____

What makes this worse?_____

What makes this better?_____

Is the problem worse during a certain time of the day? ▫ Yes ▫ No _____

Does this interfere with your sleep? ▫ Yes ▫ No Eating? ▫ Yes ▫ No Daily routine? ▫ Yes ▫ No

Is this becoming worse? ▫ Yes ▫ No

Have you ever received chiropractic care? Yes /No Have you ever seen a Naturopathic doctor? Yes/No

If yes, who is your previous Chiropractor or Naturopathic doctor?_____

Reason for visit _____ May we contact them? ▫ Yes ▫ No

In the last year have you had these tests done? ▫ Bloodwork ▫ Urine ▫ X-Rays

Circle your level of commitment to your health? (Bare minimum)-1 2 3 4 5 6 7 8 9 10- (Ultimate)

Personal Birth History

Birth weight _____lbs _____oz Were there any complications? ▫ No ▫ Yes_____

Where was your birth? ▫ home ▫ birth center ▫ hospital ▫ other _____

Assistances used during delivery: ▫ Forceps ▫ Vacuum extraction ▫ Episiotomy ▫ C-section

Childhood Diseases: Measles_____ Mumps_____ Chicken Pox_____ Other_____

Unusual Childhood Diseases:_____

Family Health History

Is there anyone in your family with any of the following medical conditions?

Condition	Who and type of illness	Condition	Who and type of illness
Cancer		Diabetes	
Arthritis		Stroke	
Autoimmune		Autism	
High blood pressure		Heart disease	
Lung disease/ asthma		Mental illness	
Kidney disease		Liver disease	

Trauma

Each person Dr. Shaw sees has a history, some events may have caused significant distress and even trauma. Please share any past/present events that have shaped your experience of the world (physical, mental, emotional) here: _____

_____

_____

_____

_____

Reproductive aged Females

When was your first period? _____ List the first day of your last period: _____

Are your cycles regular? yes/no/sometimes How many days are they (28-35 typically) _____

How many days of flow? _____ Date of last PAP smear:_____ Normal/abnormal?

Birth control methods: _____

Number of pregnancies:_____ Miscarriages? No/Yes How many deliveries?_____

Any complications during labor and delivery? _____

Any history of sexually transmitted infections or diseases?_____

Reproductive aged Males

Have you ever had a prostate exam (digital rectal exam)? No/Yes Have you ever had a PSA test? No/Yes

Date of last test: _____ Have you had altered urinary frequency, flow of urine stream?No/Yes

Do you have lessened ejaculation, arosal, or sexual performance? No/Yes History of STDs?No/Yes

Review of Systems: Please check items you have currently or have had in the last **3 months.**

Constitutional
__chills
__fatigue
__fever
__ night sweats
__weight gain/loss

Eyes
__blurred vision
__glasses/contacts
__sensitivity to light

Ears/Nose/Throat
__ear pain
__hearing problems
__ringing in ears
__nose bleeds
__dental disease
__tooth pain
__hoarseness
__thrush

Cardiovascular
__chest pain
__pain/leg cramp
__palpitations
__leg swelling
__fast heart beat
__varicose veins

Respiratory
__cough/wheezing
__difficulty breathing
__exposure to TB
__coughing up blood

Gastrointestinal
__abdominal pain
__acid reflux
__bloating
__difficulty swallowing
__heartburn
__nausea/vomiting
__vomiting blood
__constipation
__diarrhea
__red blood in stool
__hemorrhoids
__dark tar-like stools

Genitourinary
__painful urination
__blood in urine
__frequent UTI
__waking to urinate
__frequent urination
__urinary incontinence
__ discharge
__genital itching/ lesions
__sexually transmitted infections
__history of vaginosis
__irregular cycle
__excessive flow
__painful periods

Musculoskeletal
__joint pain
__joint stiffness
__pain in arms/legs
__muscle spasm/ache

Skin and Breast
__acne/mole(s)
__eczema/rashes
__breast mass
__tenderness
__nipple discharge

Neurological
__fainting/dizziness
__headaches
__memory loss
__numbness/tingling
__seizure/tremor
__vertigo
__weakness

Hematologic/ Lymphatic
__easy bruising
___excessive bleeding
___swollen lymph nodes
___hemophilia

Endocrine
__hair loss/hair growth
__heat/cold intolerance
__excessive thirst/ hunger
__excessive sweating

Allergic/ Immunologic
__seasonal allergies
__food allergies/ sensitivities
__frequent infections
__autoimmune disease

Psychiatric
__anxiety/stressed
__depression
__mood swings
__personality changes
__PMS (premenstrual syndrome)

Self Assessment

In this worksheet you will address many areas of your life, it will provide clues as to the areas you seek growth. Answer the questions based on the last 30 days of your life. This assessment will help with setting goals, developing habits, and be a tool for regular check-ins to see where you are in your journey.

Physical My overall physical health is optimal. I exercise and move often. I am able to move my body with ease. I feel energetic and strong everyday. I am happy with how I look and feel. My body is vibrant. I have more than enough stamina to face challenges, opportunities and enjoy life.	1 2 3 4 5 6 7 8 9 10
Mental and Emotional I am cultivating a sense of contentment in my life. I express my emotions in healthy ways. I experience a wide spectrum of emotions without being caught in one continually. My mind is sharp. I am mindful. I focus on one task at a time. I feel emotions and let them pass easily.	1 2 3 4 5 6 7 8 9 10
Nutrition I eat foods that make me feel good, I avoid those that do not. The foods I choose to eat fuel my body. I know eating processed foods effect my body and mind. I have a healthy relationship with food.	1 2 3 4 5 6 7 8 9 10
Sleep I get good quality sleep.I go to bed at the same time daily. I sleep 8-10 hours a night. My sleep environment is peaceful, dark, and comfortable. I wake up with energy.	1 2 3 4 5 6 7 8 9 10
Nature and Environment I am connected to the world around me. My home is a safe environment. I am present and know my behaviors and choices effect more than just me. I regularly connect with the outside world, with nature, and the earth. I spend enough time outdoors. I pay attention to the environment. I am in tune with the seasons and live by the cycles of nature.	1 2 3 4 5 6 7 8 9 10
Love and Intimacy I have loving intimate relationships with others. My significant other and I are trusting, respectful, and attentive to each other's needs. I am capable of loving others and being loved. I have the level of intimacy I want. I am as sensual and sexual as I desire. If single: I have compassion for others and walk through my day with loving kindness.	1 2 3 4 5 6 7 8 9 10
Family I am creating deep connections with family members that I keep in contact with. I am happy with the amount of time and attention I give my family. I love my family and connect often. I forgive their mistakes and am kind to members of my family.	1 2 3 4 5 6 7 8 9 10
Social Connection I am able to relate to other people and can form strong bonds with others. My social circle creates fun, positive energy and connection. I can make friends. I seek a balanced "give and take" with relationships. I spend enough time and energy on my friendships. I am a good friend.	1 2 3 4 5 6 7 8 9 10
Purpose and Mission I believe my day's effort adds to the world and is a reflection of me. I am fulfilled by the work I do and my contributions to the world. I am clear in the value I provide. I am engaged and excited by what I am doing, it feels like a calling, a mission, or purpose for me.	1 2 3 4 5 6 7 8 9 10

Experiences and Fun I enjoy life. I engage with hobbies, interests, adventures, and non-work related fun. I plan special experiences (time to connect, vacations, adventures, visits) that add to my experience of life. I give enough time to the things that light me up and bring me joy.	1 2 3 4 5 6 7 8 9 10
Values I know what values I stand for. I live in accordance to those values and it shows. I feel connected to others who share my core values. I am congruent with my beliefs.	1 2 3 4 5 6 7 8 9 10
Finances I am being responsible in how I earn and spend my money. I am saving money for my future. I am learning skills and developing my ability to provide for myself in a way that aligns with my values. I am happy with my current lifestyle, success, and financial choices.	1 2 3 4 5 6 7 8 9 10
Overall Health My overall health is ideal. I regularly care for my needs and have the vitality to heal from illness. My body functions as it should. I seek care of doctors before an illness becomes a crisis. I am healthy.	1 2 3 4 5 6 7 8 9 10
Self I am proud of the person I am. I show up in the world as an authentic version of myself. I allow myself to be seen and appreciated. I can accept a compliment. I am curious and ask questions to reflect on my life and experiences. I seek to discover new things about myself. I have created goals and a system/curriculum/plan so I can develop into the person I see as my best version of myself.	1 2 3 4 5 6 7 8 9 10

The results of this self-assessment should have brought to mind areas of your life you would like to work on improving. It may serve you to sit quietly with a journal and write any insights that came to mind and begin formulating a plan to achieve the life you want. Dr. Shaw is trained to see the whole picture and how all aspects of your life work synergistically allowing you to be at your best. Here's to your future!

Physical Stressors

These will show Dr. Shaw how much physical stress is showing up in your life today.

Allergies to food, environment, and medications: _____

Auto Accidents: _____

Any significant injuries, falls or traumas during infancy or childhood? ▫ Yes ▫ No _____

Any significant injuries, falls or traumas during adulthood? ▫ Yes ▫ No _____

Surgeries?_____

Any hospital visits? ▫ Yes ▫ No _____

Are you in prolonged postures (repetitive work, lifting, sitting) ▫ Yes ▫ No _____

Are your hobbies physically strenuous/repetitive movements? ▫ Yes ▫ No _____

What is your usual exercise routine? _____

Please list any other past medical conditions, serious illness, injury or fractures: _____

_____

_____

_____

_____

Psychosocial Stressors: As psychological stress has been shown to negatively affect many organ systems, please let us know how you are meeting and coping with the stresses of life. This is a judgement free office, Dr. Shaw meets you where you are.

Any difficulties at work or school? ▫ Yes ▫ No _____
Number of hours of screen time per week _____ Any concerns? _____
What are the areas of your life you are proud of? _____
What have you invested the most time and energy in over the last 6 months? _____
_____
What activities, events, interactions make you happy, light you up? _____
How do you measure your quality of life? _____
What milestones or markers are you using? _____
What values do you hold that shape your priorities in life? _____
If you are experiencing significant or ongoing stress please explain _____

Chemical Stressors: Our environment consists of what is outside and inside of our bodies, this is why Dr. Shaw wants to know about your environment and lifestyle to see how chemical stressors are showing up in your level of health.

Do you smoke? Yes No Quit (If yes, how much?) _____
Do you drink alcohol? Yes No (how much?) _____
Are you exposed to pollutants, strong smells, chemicals, aerosols? ▫Yes ▫ No ▫ Occasionally
What cleaning products do you use in your home?_____
Medications/supplements you are currently taking: _____
_____
_____

On a scale of 1-10, How do you rate your diet? Poor- 1-2-3-4-5-6-7-8-9-10- Amazing
Indicate any specific nutritional goals_____
Circle a label if thats helpful: Vegan Vegetarian Pescatarian Ketogenic Low Carb Plant Based
How often do you eat processed foods, white sugar, gluten (flour), dairy? ▫ Never ▫ Weekly ▫ Daily
Are you aware of the impact of nutrition on behavior and emotional health? ▫ Yes ▫ No
What diet or food choices make you feel best? _____
Which foods do you avoid? _____
If you try to follow a specific diet, please describe it and why you follow this type of diet? _____
_____

Are you happy with your diet? ▫ Yes ▫ No Do you want assistance with it? ▫ Yes ▫ No

Thank you for completing this form. If there are any other questions or concerns which you have, please discuss with Dr. Shaw.