# Enroute to Better Health

911 N. Hallett Cir.
Farmington, NM 87401
505.330.0727
www.christinatillia.com

enroutetobetterhealth@yahoo.com

## Client Health Intake Form

Name _____

Birth Date _____ Age _____ Sex _____

Email address _____

Address _____ City _____ State _____ Zip _____

Telephone (home) _____ Telephone (work) _____

Referred to us by: _____Health Care Provider _____

In emergency notify: _____ Phone _____

Have you been treated by Naturopathic Medicine or Asian Bodywork before? _____

I understand that the naturopathic medicine and therapeutic bodywork given here at Enroute is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation and energy flow. I understand that the Certified Traditional Naturopath or bodywork therapist does not prescribe medical treatment or pharmaceutical. It has been made very clear to me that this therapy is not a substitute for medical examinations and/or diagnoses and that it is recommended that I see a medical doctor for any ailment that I might have. I understand and accept that no guarantees or warranties are expressed with the naturopathic or bodywork treatments that are given here. I may also receive a form of Tuina Massage, which focuses on meridians, muscles, soft tissue, stretching, acupressure and supporting joint tissue. I understand that Tuina Massage may result in stretching, releases, and popping of certain parts of my body. I understand and accept such stretching, releases, and popping and understand that Tuina Massage is not a form of chiropractic care, but rather a form of naturopathic medicine and therapeutic bodywork. I agree to expressly state to Enroute in the Comments section below if I do not want to receive Tuina Massage.

Because a Certified Traditional Naturopath and/or bodywork therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the Naturopath and/or body work therapist updated on my physical health.

_____ _____

Client Signature Date

Main problem you would like us to help you with _____

How long ago did this problem begin? _____

Have you been given a diagnosis for this problem? _____ If so, what? _____

What kinds of treatment have you tried? _____

Are you currently receiving treatment for your problem? _____ If so, please describe _____

_____

Does anything improve your problem? _____

_____

### Past Medical History (please include date):

Illnesses: _____

_____

Surgeries: _____

_____

Significant Trauma (auto accidents, falls, etc.): _____

_____

## Past Medical History Continued (please include date):

Do you have, or have you ever had, any infectious diseases? _____ if so, please describe _____

_____

Do you or have you ever had MRSA (Methicillin-Resistant Staphylococcus Aureus)? _____

Medicines: (prescribed and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months) _____

_____

_____

_____

Average or typical blood pressure _____/_____ Pulse Rate _____

## Family Medical History (General Health)

Mother's side: _____

Father's side: _____

Siblings: _____

If above deceased, cause of death: _____

## Personal Health History

Birth (prolonged labor, forceps, deliver, etc.) _____

State of childhood health: _____ Location of upbringing: _____

Current emotional health: _____Current quality of life: _____

Current relationship quality: _____ Current predominant emotion: _____

Occupation: _____ Have you had any unusual stresses lately: _____

Favorite time of year: _____ Hobbies & Recreational habit: _____

Do you have a regular exercise program? _____ If so, please describe: _____

Please describe your average daily diet:

| Morning | Afternoon | Evening |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Proportion of raw food _____ to cooked food _____

Do you have any cravings? _____If so, what? _____

Preferred taste (circle one): bitter spicy sour salty sweet

Do you drink coffee? _____ If so, how much per day? _____ Do you drink tea? _____ If so, how much per day? _____

Do you smoke? _____ If so, how much? _____Do you drink alcohol? _____ if so, how often?

_____ How much water do you drink per day? _____

Do you, or your family, have a history of any of the following?

☐ Cancer ☐ Asthma ☐ High blood pressure ☐ Rheumatic Fever

☐ Diabetes ☐ Allergies ☐ Thyroid Disorders ☐ Addictive Disorders

☐ Heart disease ☐ HIV ☐ Herpes ☐ Mental Illness

☐ Seizures ☐ Hepatitis ☐ Stroke

## Personal Health History Continued:

Check any of the below if you have experienced it within the last three months:

☐ Fevers ☐ Dream disturbed sleep ☐ Tremors ☐ Poor balance
☐ Change in appetite ☐ Chills ☐ Depression ☐ Seizures
☐ Weight loss ☐ Peculiar tastes or smells ☐ Fatigue ☐ Mania
☐ Night sweats ☐ Weight gain ☐ Sudden energy loss ☐ Poor sleep/insomnia
☐ Emotional changes ☐ Day sweating _____ time of day ☐ Poor appetite
☐ Strong thirst ☐ Headaches ☐ Localized weakness ☐ Joint pain
☐ Bleeding or bruising ☐ Crave hot drink ☐ Crave cold drink

## General:

## Cardiovascular:

☐ High blood pressure ☐ Chest pain ☐ Cold sweats ☐ Difficulty in breathing
☐ Blood clots ☐ Low blood pressure ☐ Dizziness ☐ Swelling of feet
☐ Cold hands or feet ☐ Palpitations ☐ Irregular heartbeat ☐ Fainting
☐ Swelling of hands ☐ Phlebitis

## Respiratory:

☐ Cough ☐ Bronchitis ☐ Difficulty in breathing ☐ Shortness of breath
☐ Asthma ☐ Pain with deep breaths when lying down ☐ Coughing blood
☐ Easily winded with exertion ☐ Production of phlegm if so, what color? _____

## Gastrointestinal:

☐ Nausea ☐ Ulcers ☐ Belching ☐ Digestive disorders
☐ Blood in stool ☐ Vomiting ☐ Parasites ☐ Bad breath
☐ Constipation ☐ Hernia ☐ Indigestion ☐ Abdominal pain/cramps
☐ Diarrhea ☐ Hemorrhoids

## Genitourinary:

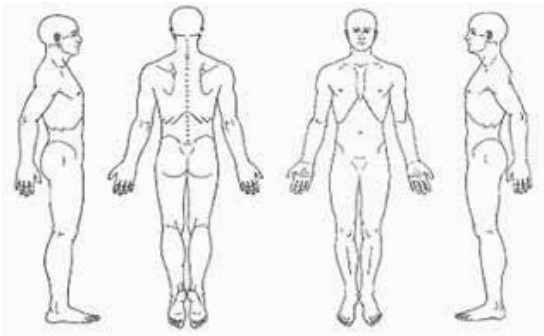
☐ Pain in urination ☐ Decrease in urine ☐ Genital sores ☐ Urgent urination
☐ Blood in urine ☐ Impotence/infertility ☐ Frequent urination ☐ Unable to hold urine
☐ Kidney stones ☐ Waking up to urinate if so, how often?_____

## Musculo-skeletal:

☐ General aches ☐ Arthritis ☐ Spasms ☐ Break
☐ Muscular atrophy ☐ Joint instability ☐ Recent sprains if so, where? _____
☐ Muscular weakness ☐ Muscle cramps ☐ Injuries or falls _____

On the diagrams to the right, please mark an "X" over those areas of concern.

Indicate old or new. Also, if it is a place of tension or pain, mark it.



Are there any other internal organ or systemic dysfunctions that I should be aware of?

_____

_____

_____

_____

## Ear, Nose, & Throat:

☐ Ringing in the ears ☐ Sinus problems ☐ Sores on lips or tongue ☐ Facial pain
☐ Poor hearing ☐ Nose bleeds ☐ Teeth problems ☐ Jaw clicks
☐ Ear aches ☐ Recurrent sore throat ☐ Grinding teeth

Any other ear, nose, or throat problems?_____

## Eyes & Vision:

☐ Glasses ☐ Cataracts ☐ Eye pain ☐ Floaters
☐ Poor vision ☐ Glaucoma ☐ Color blindness ☐ Spots in front of eyes ☐ Blurred vision ☐ Night blindness
☐ Eye strain

Any other eye or vision problems?_____

## Skin & Hair:

☐ Rashes ☐ Ulcerations ☐ Recent moles ☐ Change in hair
☐ Itching ☐ Hives ☐ Dandruff ☐ Change in skin texture
☐ Eczema ☐ Pimples ☐ Loss of hair

Any other skin or hair problems?_____

## Neuro-psychological:

☐ Seizures ☐ Migraines ☐ Fainting ☐ Easily angered
☐ Concussion ☐ Areas of numbness ☐ Disorientation ☐ Depression
☐ Dizziness ☐ Lack of coordination ☐ Irritability ☐ Mania
☐ Headaches ☐ Loss of balance ☐ Easily susceptible to stress ☐ Anxiety
☐ Poor memory ☐ Nervous habits ☐ Treated for emotional problems ☐ Contemplated suicide

Any other neurological or psychological problems?_____

## Pregnancy & Gynecology:

_____ Age of first menses _____ Number of pregnancies ☐ Birth control ☐ Fertility problems
_____ Period between menses _____ Number of births What type? _____ ☐ Vaginal discharge
Usual character of menses: _____ Miscarriages How long? _____ ☐ Vaginal soreness
☐ Heavy ☐ Irregular ☐ Light _____ Abortions ☐ Breast lumps
☐ Clots ☐ Painful _____ Difficult births

First date of last menses
____/____/____

Date of last pap smear
____/____/____

## Comments:

Please tell us of any other problems you would like to discuss: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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## ACKNOWLEDGMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my provider's **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such **Notice of Privacy Practices**. I understand that my provider has the right to change the **Notice of Privacy Practices** and that I may contact the holistic therapy clinic to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that the holistic therapy clinic restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that the holistic therapy clinic is not requires to agree to my requested restrictions, but if the therapy clinic agrees then we are bound to abide by such restrictions.

Client name: _____

Date: _____

Signature: _____

Relationship to Patient:

_____ Dependent family member also covered by this acknowledgment: _____

I have been informed of the holistic therapy clinics revised **Notice of Privacy Practices** on the following date(s):

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

We are unable to obtain the client's written acknowledgment of our Notice of Privacy Rights due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other _____

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## DISCLAIMER FORM

I understand that the naturopathic medicine and therapeutic bodywork given here is provided by licensed massage therapists and naturopaths who are unlicensed by the state of New Mexico. This treatment is complementary to, and not in lieu of, health care services provided by licensed health care practitioners.

The therapist may use nutrition, herbs, homeopathic, hydrotherapy, Tuina massage, stretching, acupuncture, and/or therapeutic bodywork to provide the clients with: relaxed muscles, relief of pain, and stiffness from tension, cramps and spasms; prevent muscle atrophy; lower blood pressure; stimulate blood and lymph circulation; aid in the elimination of toxins and wastes; increase nutrition to cells; expand physical, emotional and mental, and spiritual awareness; and facilitate the healing of injuries. I understand that the naturopath or bodywork therapists here are licensed massage therapists and unlicensed traditional naturopaths trained in hydrotherapies, herbology, homeopaths, nutrition, Tuina massage, and therapeutic bodywork. As such, they do not diagnose illness, disease or any other physical or mental disorder.

The naturopath or bodywork therapist does not prescribe medical treatment or pharmaceuticals. It has been made very clear to me that this therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I immediately see a medical doctor for any ailment that I might have. No guarantees or warranties are implied or expressed with the naturopathic or bodywork treatments that are given here. You may also receive a form of Tuina Massage, which focuses on meridians, muscles, soft tissue, stretching, acupressure and supporting joint tissue. Tuina Massage may result in stretching, releases, and popping of certain parts of your body. By submitting to therapy at Enroute, you understand and accept such stretching, releases, and popping and understand that Tuina Massage is not a form of chiropractic care, but rather a form of naturopathic medicine and therapeutic bodywork.

Because a naturopath and/or bodywork therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the naturopath and/or bodywork therapists updated on my physical health.

As a patient, I have the right to complete a current information concerning the practitioner's assessment and recommended services that are provided, including the expected duration of the services to be provided, the method of billing for the fees listed below and that I have the right to reasonable notice of changes in services and/or charges, and that I be allowed access to my record and any written information from my records. All my records and transactions are confidential unless the release of these records are authorized in writing by me or otherwise provided by law. I have the right to a coordinated transfer when there is a change in therapists.

I understand that I may file complaints with:

New Mexico Practitioners of Natural
Medicine c/o Peer Review Board 12 James
Sanchez Lane Belen, NM 87002

My signature below acknowledges that I have been provided with a copy of this information.

Client Signature: _____ Date: _____

# Enroute to Better Health

Christina Tillia CTN, LMT
Lic #5048
911 N. Hallett Cir
Farmington NM
87401
505.330.0727

## Cancellation Policy Acknowledgment

I fully understand that things come up at the last minute, and therefore I offer a one-time cancellation within a 24 hour time frame of the appointment. After that the first cancellation within 24 hours will be charged a $25.00 cancellation fee. Any appointments thereafter cancelled within 24 hours will be charged a full appointment fee. A full appointment fee will also be charged for any no-show appointments.

Sign: Date:

Sincerely,
Christina Tillia CTN, HHP, LMT

# COVID-19 Health Information & Informed Consent

Client Name: _____

Date: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

## COVID-19 Information

Please answer these COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐

2. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? Yes ☐ No ☐

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐

4. Have you traveled anywhere outside of the state in the last two weeks? Yes ☐ No ☐ Location:

_____

5. Have you had a new loss of sense of taste or smell? Yes ☐ No ☐ The following questions are specific to a new aspect of COVID-19 involving blood coagulation.

6. Can you exercise to get your heart rate and respiratory rate up without any problem? Yes ☐ No ☐

7. Have you had a new onset of muscle aches and pain since the emergence of the virus? Yes ☐ No ☐

8. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? Yes ☐ No ☐

**Consent for Treatment**

*To proceed with receiving care, I confirm and understand the following (Initial in all places provided)*

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I have been offered a copy of this consent form. _____

***I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.***

Client Signature: _____ Date: _____ Parent or Guardian Signature (in case of a minor): _____ Date: _____