SECOND NATURE HEALTH

"First we treat you,

The rest is Second Nature"

Dr. Veronica E. Hayduk – Naturopathic Medicine

620 Hungerford Dr., Suite 15, Rockville, MD 20850

Office: (301) 395-9118 ♦Fax: (240) 404-0389

www.secondnaturehealth.com

Welcome to Naturopathic Medicine!

We are delighted to meet you and be assisting you in achieving your health care goals using natural medicine to gently restore your body back to its optimal health.

The address to the office is: ***620 Hungerford Dr. Suite 15,*** (Hungerford Drive is Rockville Pike or Route 355 - different names for the same street) next to downtown Rockville in the Washington Square Office Park.
We are about a mile north of the Rockville Metro and Town Square.

We are directly across the street from a Giant grocery store and next door to the Rockville Post Office.
The office is the second entrance, just past GW Asian Supermarket & Cathay Bank on the right.

There is ample free street parking in the front and sides of the building. We are handicapped accessible.
We are on the first floor and face the street, there are also two signs on the exterior for 'natural medicine'.

Do not go upstairs or to the back of the building.

Naturopathic doctor's appointments are not your typical doctor's appointment. You have some *homework to do before you get to the appointment*. To get started, I have attached an extensive **health history summary – fill it out;** it is long, but having it completed before we meet ensures a more productive visit. You don't have to type your answers or send it back prior to us meeting. I like to think of us as partners in health and I encourage you to be complete and as detailed as possible. If any of the questions are confusing or uncomfortable, please skip them. However, the more I can learn about you, the better we can meet your health goals. The first two pages and last page to read and sign is the most important. These questions are not to judge you or your lifestyle!

Naturopathic medicine is individualized and is especially tailored for your needs. The questions on the health summary form ask about past medical history, current prescription drugs, diet & exercise habits, as well as other lifestyle questions.
Most find the form needs about an hour to complete.

Please obtain as much of your medical history as possible, including past lab work (blood tests) of the past year and results of all diagnostic tests (x-rays, CT/MRI, if applicable) from the last year. Bring copies. ***Also, bring all the pharmaceutical drugs & supplements you take with you.***

We cannot help you achieve your best health if you come to the appointment unprepared or late.

I'm looking forward to meeting with you. Please call no later ***than 48 hours before your appointment*** to reschedule if needed. *Your appointment with me is set for you alone, you are the only patient at your scheduled time. Please call if you are running late, we cannot hold appointments, and* read the informed consent page carefully for important information. Do arrange for childcare, we do not offer this service. Should you have any questions or concerns, don't hesitate to call or e-mail us at any time. I am excited to meet you and assist you towards better health – naturally!

Be well,
Dr. Veronica Hayduk

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Health History Summary

Please bring all prescription medication and supplements, along with pertinent lab work to appointment.

Name ________________________________ Date____________________________

Address ____Age_____________ Birth date: __________________

City ____________________________________, State __________________ Zip code _____________________

Cell phone number _________________________ Alt. number _______________________________________

How did you hear about this office? *If Internet, which website?* We'd love to know the exact website please or whom we can thank for referring you.
____

E-mail address ______________________________ Alt email address _________________________________

Occupation _____________________________Employer____
Last physician or health practitioner seen? __________________________ When? ______________________
Why? ____
Have you ever seen a naturopathic physician before? If yes, when? __________________________________

When was your last lab blood test? ____

******BRING COPIES OF RECENT LAB TESTING WITH YOU TO THE APPOINTMENT*****

Any allergies to drugs, foods, herbs, animals or other?
Explain____

List all prescription medication and the amount and why you are taking it? Use the reverse of this sheet if you should need additional space.

Drug	Amount taken & when	Why prescribed?	How long?
1			
2			
3			
4			

List all over the counter medication (like Tylenol, Benadryl), all supplements, herbal (botanical) preparations, homeopathics and the like *that you take regularly (most days)*, including the amount taken and why you are taking it, and if applicable, who suggested it? Use the reverse of this sheet if you should need additional space. ***Bringing the bottles with you is more important than writing them down.*** Yes you can take a photo of the front and back of the bottles instead. *Let's not spend our appointment time looking these up on the Internet.*

Bring bottles with you

Supplement/Herb/Product	Dose & duration	Prescriber	Manufacturer & Purpose
1			
2			
3			

YOUR CURRENT HEALTH CONCERNS

What is the main reason for your visit today? Please be as detailed as possible. How long has it troubled you? When did you first notice the condition? What have you tried already for treatment? What has helped? What has made it worse? Use reverse of this sheet for more room if necessary.

____
____
____
____
____

Are there any other health concerns? List in order of importance:

1)____ & length of time ________________

2)____ & length of time _______________

YOUR HEALTH HISTORY

What childhood illnesses have you had? (check all that apply)

__ measles
__ diphtheria
__ polio
__ mumps
__ small pox
__ typhoid fever
__ chicken pox
__ scarlet fever
__ mononucleosis
__ rheumatic fever
__ tuberculosis
__ whooping cough
__ (other?) _______

Any recent vaccines? __________________________________Travel outside USA?____________

Any recent surgeries?____

Hospitalization? Be specific ____

****

The general state of your health is: (excellent___), (good ___), (avg. ____), (fair____), (poor___)

Your state of health a year ago? ____________ Five years ago? ______________ Ten? __________

Metabolic Assessment Form

Please circle the appropriate number. 0 as the least/never to 3 as the most/always.

Category I	(Least to Always)				Comments
Feeling that bowels do not empty completely	0	1	2	3	
Lower ab pain relief by passing stool or gas	0	1	2	3	
Alternating constipation and diarrhea	0	1	2	3	
Diarrhea	0	1	2	3	
Constipation	0	1	2	3	
Hard, dry, or small stool	0	1	2	3	
More than 3 bowel movements daily	0	1	2	3	
Use laxatives frequently	0	1	2	3	
Category II					
Excessive belching, burping, or bloating	0	1	2	3	
Gas immediately following a meal	0	1	2	3	
Offensive breath	0	1	2	3	
Sense of fullness during and after meals	0	1	2	3	
Difficulty digesting fruit, veggies, cold food.	0	1	2	3	
Category III					
Stomach pain, burning, 1- 4 hrs after eating	0	1	2	3	
Feel hungry an hour or two after eating	0	1	2	3	
Heartburn when lying down, bending forward	0	1	2	3	
Temporary relief from antacids, food, milk, beverages . .	0	1	2	3	
Category IV					
Greasy or high-fat foods cause distress	0	1	2	3	
Lower bowel gas and or bloating several hours after eating	0	1	2	3	
Bitter metallic taste in mouth, especially in the morning	0	1	2	3	
Unexplained itchy skin	0	1	2	3	
Stool color alternates from clay colored to normal brown	0	1	2	3	
History of gallbladder attacks or stones	0	1	2	3	
Have you had your gallbladder removed?	Yes		No		
Category V					
Crave sweets during the day &/or night	0	1	2	3	
Irritable if meals are missed	0	1	2	3	
Depend on coffee/caffeine to keep yourself started & going.	0	1	2	3	
Get lightheaded, shaky/tremors if meals are missed . . .	0	1	2	3	
Category VI					
Fatigue after meals	0	1	2	3	
Eating sweets doesn't relieve cravings for sugar	0	1	2	3	

Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

<u>Category VII</u>

Cannot fall or stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3

<u>Category VIII</u>

Under high amounts of stress	0	1	2	3
Tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

<u>Category X</u>

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Increase in weight gain & on low-calorie diet	0	1	2	3
Depression, lack of motivation, mental fog	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals or	0	1	2	3
excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3

<u>Category XI</u>

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Difficulty gaining weight	0	1	2	3

<u>Category XII (Males only)</u>

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels, or feel like sitting on a ball .	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3
How often do you urinate at night?	______________ times			
Decrease in libido	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Involuntary discharge from penis?.	Yes		No	
History of abnormal PSA?.	Yes		No	

Category XIV (Menstruating Females Only)

Age at first menses?.	______________________			
Do you think you may be pregnant?.	Yes		No	
Alternating menstrual cycle lengths?	Yes		No	
Extended menstrual cycle, > than 32 days?.	Yes		No	
Shortened menses, < every 24 days?.	Yes		No	
Quantity of pads/tampons used on heaviest day	______________________			
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Menstrual clots	0	1	2	3
Breast pain and swelling during menses.	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Vaginal discharge.	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3
Use birth control, if yes, what?.	______________________			
Last Pap Smear?. . . . . ___________	Results__________________			

Category XV (Menopausal Females Only)

How many years have you been menopausal?.	______________________			
Since menopause, any uterine bleeding?.	Yes		No	
Last Mammogram?.	______________________			
Hot flashes	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Painful intercourse	0	1	2	3
Increased vaginal pain, dryness or itch	0	1	2	3

GENERAL LIFESTYLE

How many alcoholic beverages do you consume per week? ____
How many caffeinated beverages (coffee, tea, soda) do you consume per day? ________________________

When during the day is your energy the best? _________________ Worse? __________________________
What is your current approximate weight? ________________ Height? _____________________________

Weight a year ago?_________________ Any unplanned weight loss?______________________________

Do you work in an office building? _______________ Do the windows open? ________________________
Do you or other house hold member work in the presence of toxic fumes or chemicals?
____
Are you exposed to second hand smoke?____
Are you bothered by certain odors that others don't seem to mind? _______________________________

Like what?____

How many amalgams (fillings in your teeth) do you have? _________ When was the last one put in?_________

How often do you eat canned fish? ___ ____/month. Other fish? ___________________/month
Have you ever used illegal drugs? ______If yes, which ones and do you currently still use?
____

Have you ever used tobacco in any form? ____ How long? _____Pack/day______ Current smoker? ______

How do you rate your sleep? (on a scale of 1-10)_____________ Is this normal for you? ______________
How many hours do you sleep a night? __________________ Is insomnia a problem for you? __________
Do you wake refreshed? ____

How often do you get colds, flu's, sore throat, during the year? _________________________________

PERSONAL LIFESTYLE

Who lives in your home with you? __________________________ Any pets? _______________________
Are you currently in a satisfied relationship? (*Yes?, No?, Somewhat?*)________________________________

Do you enjoy your work? *(very, mostly, somewhat, not*) ____

What are a few of your hobbies? ____

Do you have a religious or spiritual practice? ________ If yes, what? ______________________________

How would you describe your temper? ____

Rate your stress levels on a scale of 1-10 during the average week: _________________________________
Please describe your typical reaction to stress? ____

How do you relieve stress? ____

DIET AND EXERCISE

What is a typical breakfast for you? Please describe some of your most common choices.
____

What is a typical lunch for you? Please describe some of your most common choices.

____

What is a typical dinner for you? Please describe some of your most common choices.

____

Do you snack? ________ When? ____

What are your typical choices? ____

What kinds of foods or beverages do you crave?____

How many times do you eat out per week? ____
How much water do you drink in a typical day? _______(ounces/liters) and what kind of water ___________

Do you exercise? ________What kind/type? ___________________________Frequency_______________

Do you feel this amount is: _______adequate, _______less than _______more than adequate?_________

How committed are you to your health care goals? ____

Yippee, you have finally completed this form aside from two signatures. Thank-you for your time in being detailed with these questions and I assure you that all your hard work will be worth the effort. Welcome to the healing power of nature!

INFORMED CONSENT

****Please sign in both gray boxes.***

I hereby request and consent to the performance of naturopathic modalities and procedures by Dr. Veronica Hayduk, naturopathic doctor, even though the State of Maryland currently does not recognize Naturopathic doctors as primary care providers but as Allied Health Professionals. I understand that Dr. Hayduk is licensed and registered in the state of Maryland to practice naturopathic medicine and have had the opportunity to discuss with her the nature and purpose of my visit. I understand and am informed that, as in the tradition of medicine, in the practice of naturopathy there may be some risks to treatment, most common are allergic reactions to certain supplements, botanical/herbs and homeopathic preparations. I understand that this risk is minor and do not expect the doctor to be able to anticipate or explain all risks and complications, and I wish to rely on the doctor to exercise her best judgment during the course of the procedure and treatment which the doctor feels at the time, based upon the facts then known, is in my best interest. The focus of naturopathic care is to alleviate the underlying condition that brings on illness rather than the treatment of symptoms. While I may experience some immediate improvement from the use of herbs, homeopathic remedies and other naturopathic methods, I understand that the most effective results occur when I make a long term commitment to rebuild my health with the assistance of Dr. Hayduk. I also understand that Dr. Hayduk does not offer after-hours services or provide any hospital-based/emergency services. I also understand that Dr. Hayduk will not be able to prescribe pharmaceutical medications but can send me a referral for such treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent and by signing below agree to the above and below named naturopathic procedures and treatments as deemed appropriate by Dr. Veronica Hayduk and Second Nature Health, LLC. I also agree to the following policies of Second Nature Health, LLC. A copy of this agreement will be in the new patient folder that I receive at my first appointment with Dr. Hayduk.

Privacy will always remain confidential, unless I authorize the release of information in writing or by court order. I also understand that ***Dr. Hayduk may send communication to me through E-mail, I will notify the office immediately if this is not my preference***. I will not email the doctor regarding emergencies and am aware that time-sensitive matters are not appropriate for email communication.

Unless otherwise required by law, my record is the physical property of Dr. Hayduk but the information belongs to me. I have the right to request a restriction on certain uses and disclosures of my information and request amendments to my health record. I may also request a copy of my medical records at any time and a small fee may apply. This organization is required to maintain privacy of my health care information. Second Nature Health is required by law to maintain the privacy & security of my protected health information. They will let me know promptly if a breach occurs, yet Dr. Hayduk *does NOT maintain electronic medical charting*. They will not use or share my information without my consent first.

Email to communicate with the office is preferred even though Dr. Hayduk is aware that email communication is not 100% reliable or secure, but I acknowledge that the doctor and her staff assure me that they make every effort to protect my privacy. Dr. Hayduk and her staff will try to respond to email messages within 72 hours but there is no way to guarantee that will occur due to many legitimate reasons like misaddressed email, server down and/or power outages. I also agree to limit my email to clarify a current treatment plan or symptoms relating to current treatment plan. *I am aware of the email policy* (see separate form) and understand charges based on time to answer, which will be discussed before Dr. Hayduk answers the email. I also understand that phone calls from Dr. Hayduk are billable and rates will be discussed before she answers. New health complaints will require an office visit, phone visit or email consult, which is billable, at same hourly rate as an office visit. **All scheduled phone or office appointments, unless directly notified otherwise, are billable and payment is due at time of service** (the 'free consultation' is done by phone or email only.) I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment with Dr. Hayduk.

I will continue to be monitored by a primary care physician.
Any naturopathic treatment suggestions made should not replace the care and/or advice of my primary care health team.

This notice is provided to you pursuant to Maryland law. Dr. Hayduk is a registered and licensed doctor of naturopathic medicine (ND) but not a licensed medical doctor (MD/DO). Therefore, she does not practice, "the application of scientific principles to prevent, diagnosis and treat physical and mental diseases, disorders, its conditions or to safeguard the life and health of any pregnant woman & infant through pregnancy and parturition." *I will let Dr. Hayduk know immediately if I become pregnant or planning on conceiving; or if I become pregnant during the course of treatment.*

Also, I will notify the office either in person, via phone or e-mail when I wish to terminate my care with Dr. Hayduk and Second Nature Health, LLC. Dr. Hayduk also reserves the right to discontinue this agreement at any time and will do her best to find appropriate care for my continued treatment.
I understand that fees are due and payable on the same date that services are rendered , including all tests, and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement, unless other arrangements have been made in advance. I also understand that in Maryland, ***most insurance companies do not cover naturopathic services***, but that Dr. Hayduk's office will provide me with a 'Superbill' for my submittal for reimbursement, if I chose to do so. Second Nature Health *will not provide an insurance claim form (HFCA 1500) nor will it respond to requests for additional information from insurance companies*. Flexible spending and health savings accounts are accepted but I understand it's my responsibility to fill out any 'Letter of Medical Necessity' and have Dr. Hayduk sign and code it only. I understand there will be a nominal filling fee if I elect Dr. Hayduk to fill it out on my behalf.

Do NOT submit to Medicare/Medicade. *They will not reimburse you and as a result this office could be penalized.*

I agree to a service charge of $100 for any amount that is unpaid past 30 days and/or for returned checks, unapproved credit cards. I understand this agreement is legally binding. I also agree to $100 for less than 24 hours' notice of changed or missed appointments.

Date: ___________________________ Signature: ____

CANCELLATION POLICY

The following are our policies regarding cancellations and no-shows. You may have been asked to leave a $100 non-refundable deposit. We will deduct this amount from your appointment. If appointments are rescheduled or canceled before 24 hours of your appointment time, the deposit will be applied to your visit.

If less than 24 hours notice of your appointment and it is canceled without emergency, it will be kept.

We take this subject very seriously because it can make a difference whether you succeed in your treatment or not. Dr. Hayduk sets appointments for one patient at a time and this time is set aside just for you and you alone. If you don't show up when scheduled, this affects everyone.

To not show up to your scheduled appointment on time or not at all is a concern we take very seriously!

If you are habitually late or don't make it to your other scheduled appointments on time, then we suggest you chose another naturopathic practitioner. Dr. Hayduk is ready to get you better and it requires your commitment to adhere to your scheduled time. We promise to see you on time and never have you wait longer than 10 minutes for your appointment.

We require at least 24 hours' notice (the more time the better) in the event of a cancellation. Patients who cancel under 24 hours' notice or don't show up to their appointments are subject to a $100 charge and/or forfeit any deposit. Yes, this is enforced! ***You MUST call if you are running late or your appointment will be canceled. We cannot hold your appointment time for longer than 15 minutes. We cannot extend your appointment length if you are late.***

Date: ____________________ Signature____

Patients that experience the best results, do this:

- Show up on time with this form completed and signed, supplements and medication in a bag, along with copies of lab work, if available, from the last year. Or, have the supplements near by for tele-medicine appointment. Bring copies of lab work with them or have it sent over, the fax number is (240) 404-0389.
- Are ready to listen and participate in their own health care. It is encouraged to bring loved ones with you to the appointment. All caregivers to the patient should attend and be optimistic about the new treatment plan.

We love children! But unless the child is a patient, *arrange for child care*. Or if the child is a patient or must be brought, *do bring things and snacks for the child to do and snack.* Our visits are an hour or longer and kids get bored easily. We have very few toys and no electronic media to entertain children. We also do not offer or have childcare services. Extreme disruptions in our time together may result in a higher fee for service. We have a lot of work to do to get you feeling better and need to limit interruptions. We thank you in advance for being prepared and for your understanding.

Our appointments are long and are often over meal times. Its fine and you are urged to bring snacks and beverages in with you but we do not have a microwave. We do offer bottled water and hot tea service for your convenience.

Thank you in advance for doing 'your homework'. Do call if you have any questions or concerns.
We are looking forward to meeting you and getting you back towards optimal health, naturally!