
Date: _____ SSN: _____

Patient Name: _____ _____

Phone: Home: _____ Cell: _____

Work: _____ E-mail: _____

Address: _____

City: _____ State: _____ Zip code: _____

Date of Birth: _____ Age: _____ Sex: M F

Employment status: ☐ Full time ☐ Part time ☐ Retired _____(date)

Student _____(school)

Are you: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Spouse's name: _____

If patient is a minor, name of parents or guardians:

_____

**PAYMENT IS REQUIRED AT THE TIME OF SERVICE. Horizon Natural Medicine does not bill insurance, however we will provide you with the necessary materials so that you may do so. We are currently not covered by Medicare and therefore are unable to submit claims.**

Signature: _____

HORIZON
Natural Medicine

Date: _____

Name: _____

Age: _____ Sex: M F

How did you hear about us? _____

When did you have your last health care visit? _____

What was the reason? _____

Primary care physician name: _____

Primary care physician phone number: _____

Pharmacy name and phone number: _____

When was the date of your last blood work? _____

Please list in order of importance your health problems:

1. _____
2 _____
3. _____
4. _____
5. _____

## Family History

Y = yes N = no P = past

Has any family member had the following? If yes, identify family member:

| | | | | |
|---|---|---|---|---|
| Anemia | | Y | N | P _____ |
| Asthma | | Y | N | P _____ |
| Cancer | Y | N | P _____ | |
| Diabetes | | Y | N | P _____ |
| Epilepsy | | Y | N | P _____ |
| Glaucoma | | Y | N | P _____ |
| Heart Disease | Y | N | P _____ | |
| High Blood Pressure | Y | N | P _____ | |

HORIZON
Natural Medicine

| | | | |
|---|---|---|---|
| Kidney Disease | Y | N | P _____ |
| Mental Illness | Y | N | P _____ |
| Pneumonia | Y | N | P _____ |
| Stroke | Y | N | P _____ |
| Tuberculosis | Y | N | P _____ |
| STD | Y | N | P _____ |

Were any of these a cause of death? If so, which family member and at what age?

_____

## Patient History

Did you have the following diseases: Yes (Y), Received Immunization (I), or No (N):

Measles: Y I N Chicken Pox: Y I N Mumps: Y I N Rubella: Y I N Tetanus: Y I N

Whooping Cough: Y I N Hemophilus (Hib): Y I N Hepatits B: Y I N German Measles: Y I N

Rheumatic Fever: Y N Polio: Y I N Tetanus Y N

Date of last tetanus shot: _____

Any vaccination reactions: _____

List all surgeries & hospitalizations, including date occurred:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

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

X-Rays: _____ MRI/Cat Scans: _____

Ultrasounds: _____ Accidents: _____

Last Dental Visit: _____ Last Eye Exam: _____

Allergies:

Foods: _____ Reaction: _____

Medications: _____ Reaction: _____

Environmental: _____ Reaction: _____


Medications:

Please list the medication and dosages that you are currently taking. Please include both prescription and over the counter.

| | Medication | Condition Treated | Dosage |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

Supplements:

Please list all of the supplements that you are currently taking including dosages and brand names.

| | Supplement | Dosage | Brand |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

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

Antacids: Y N P  Steroids: Y N P

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

Pain killers: Y N P  Laxatives: Y N P

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

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

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

HORIZON
*Natural Medicine*

Any Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P

Recreational Drugs: Y N P Any Drug Addictions: Y N P Any Drug Treatment: Y N P

Avg. hours of sleep per night: _____

Trouble falling asleep: Y N P Trouble staying asleep: Y N P Wake rested? Y N P

What sort of exercise do you get and how often? _____

How many hours a day do you work at a computer? _____

Do you enjoy your work: Y N P Do you take vacations? Y N P

What are your main hobbies/interests? _____

**Review of Systems:**

Present Weight: _____ Maximum weight and when: _____

Minimum weight as adult & when: _____ Height: _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| <u>Skin:</u> | | | | | | | | |
| Acne | Y | N | P | Color Changes | Y | N | P |
| Eczema | Y | N | P | Hives | Y | N | P |
| Itching | Y | N | P | Lumps | Y | N | P |
| Moles | Y | N | P | Rashes | Y | N | P |
| Scaling | Y | N | P | Warts | Y | N | P |
| <u>Head:</u> | | | | | | | | |
| Hair loss | Y | N | P | Headaches | Y | N | P |
| Head injury | Y | N | P | Skull fracture | Y | N | P |
| <u>Eyes:</u> | | | | | | | | |
| Eye pain | Y | N | P | Cataracts | Y | N | P |
| Dryness | Y | N | P | Double vision | Y | N | P |
| Glaucoma | Y | N | P | Impaired vision | Y | N | P |
| Tearing | Y | N | P | Night blindness | Y | N | P |
| <u>Ears:</u> | | | | | | | | |
| Ear Pain | Y | N | P | Discharge | Y | N | P |
| Dizziness | Y | N | P | Hearing loss | Y | N | P |
| Ringing | Y | N | P | Trauma to ear | Y | N | P |
| <u>Nose:</u> | | | | | | | | |
| Stuffiness | Y | N | P | Sinusitis | Y | N | P |
| Allergies | Y | N | P | Frequent Colds | Y | N | P |
| Trauma to | Y | N | P | Polyps | Y | N | P |
| Nose bleeds | Y | N | P | Frequent Running | Y | N | P |
| <u>Mouth and Throat:</u> | | | | | | | | |
| Cavities | Y | N | P | Frequent sore throat | Y | N | P |
| Hoarseness | Y | N | P | Sore tongue | Y | N | P |


| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Ulcerations | Y | N | P | Difficult speaking | Y | N | P |
| Bleeding gums | Y | N | P | Difficult swallowing | Y | N | P |
| <u>Neck:</u> | | | | | | | |
| Pain/stiffness | Y | N | P | Swollen glands | Y | N | P |
| Injury | Y | N | P | Lumps | Y | N | P |
| Goiter | Y | N | P | Thyroid medication | Y | N | P |
| <u>Respiratory:</u> | | | | | | | |
| Cough | Y | N | P | Emphysema | Y | N | P |
| Pleurisy | Y | N | P | Difficulty breathing | Y | N | P |
| Asthma | Y | N | P | Bronchitis | Y | N | P |
| Pneumonia | Y | N | P | Pain with breathing | Y | N | P |
| Sputum | Y | N | P | Bloody sputum | Y | N | P |
| Tuberculosis | Y | N | P | Shortness of breath | Y | N | P |
| | | | | with lying down | Y | N | P |
| | | | | with exertion | Y | N | P |
| <u>Cardiovascular:</u> | | | | | | | |
| Chest pain | Y | N | P | Angina | Y | N | P |
| Dizziness | Y | N | P | High blood pressure | Y | N | P |
| Heart disease | Y | N | P | Heart murmur | Y | N | P |
| Palpitations | Y | N | P | Leg pain w/walking | Y | N | P |
| Ankle swelling | Y | N | P | Rheumatic fever | Y | N | P |
| <u>Gastrointestinal:</u> | | | | | | | |
| Change in appetite | Y | N | P | Change in thirst` | Y | N | P |
| Belching | Y | N | P | Gas/bloating | Y | N | P |
| Heartburn | Y | N | P | Gallbladder disease | Y | N | P |
| Liver disease | Y | N | P | Jaundice/yellow skin | Y | N | P |
| Ulcers | Y | N | P | Hemorrhoids | Y | N | P |
| Vomiting | Y | N | P | Vomiting of blood | Y | N | P |

Bowel movements:

How often: _____

Is this a change: Y N

Consistency: hard soft/normal loose

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| <u>Urinary:</u> | | | | | | | |
| Increased frequency | Y | N | P | Frequency at night | Y | N | P |
| Pain with urination | Y | N | P | Inability to hold urine | Y | N | P |
| Kidney stones | Y | N | P | Kidney pain | Y | N | P |
| Urethral discharge | Y | N | P | Frequent infections | Y | N | P |
| <u>Endocrine/Blood:</u> | | | | | | | |
| Anemia | Y | N | P | Easy to bleed/bruise | Y | N | P |
| Heat/cold intolerance | Y | N | P | Excessive thirst | Y | N | P |
| Excessive hunger | Y | N | P | Low energy/fatigue | Y | N | P |
| <u>Musculoskeletal:</u> | | | | | | | |
| Broken bones | Y | N | P | Joint pain/stiffness | Y | N | P |
| Joint swelling | Y | N | P | Muscle cramps | Y | N | P |
| Arthritis | Y | N | P | Weakness | Y | N | P |
| <u>Peripheral Vascular:</u> | | | | | | | |
| Varicose Veins | Y | N | P | Coldness of hands/feet | Y | N | P |

HORIZON
Natural Medicine

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Deep leg pain | Y | N | P | Numbness of hands/feet | Y | N | P |
| Spider veins | Y | N | P | Thrombophlebits | Y | N | P |

Neurological:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Dizziness | Y | N | P | Numbness or tingling | Y | N | P |
| Fainting | Y | N | P | Memory loss | Y | N | P |
| Seizures | Y | N | P | Paralysis | Y | N | P |

Mental/Emotional:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Depression | Y | N | P | Mood swings | Y | N | P |
| Anxiety | Y | N | P | Excessive fears | Y | N | P |
| Excessive anger | Y | N | P | Tension/stress | Y | N | P |

Male Reproductive System:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Hernias | Y | N | P | Prostate disease/pain | Y | N | P |
| Testicular cancer | Y | N | P | Testicular masses | Y | N | P |
| Sexually active? | Y | N | P | Sexual difficulties | Y | N | P |
| Discharges or sores | Y | N | P | STDs | Y | N | P |

Female Reproductive System:

Age menses began: _____ Average number of days: _____ Length of cycle: _____

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Are cycles regular | Y | N | P | Pain with mensis | Y | N | P |
| Heavy flow | Y | N | P | Pain with intercourse | Y | N | P |
| PMS | Y | N | P | | | | |
| Birth Control | Y | N | P | What type: _____ | | | |

Number of pregnancies: _____

Number of live births: _____

Number of abortions: _____

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Difficulty conceiving | Y | N | P | Menopause symptoms | Y | N | P |
| STDs | Y | N | P | Sexually active? | Y | N | P |
| Sexual difficulties | Y | N | P | Self breast exams? | Y | N | P |
| Breast lumps | Y | N | P | Breast pain | Y | N | P |
| Nipple discharge | Y | N | P | Skin discoloration | Y | N | P |

Infants and Children:

Does your child:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Eat well | Y | N | P | Sleep through the night | Y | N | P |
| Frequent earaches | Y | N | P | Frequent sore throats | Y | N | P |
| Diarrhea | Y | N | P | Constipation | Y | N | P |
| Colic | Y | N | P | Hyperactivity | Y | N | P |
| Lethargic | Y | N | P | Constant runny nose | Y | N | P |
| Irritable | Y | N | P | Skin rashes | Y | N | P |
| Behavioral problems | Y | N | P | Abnormal weight loss/gain | Y | N | P |
| Reaction to vaccinations | Y | N | P | | | | |


## Payment Agreement and Cancellation Policies

Please read the following agreement. It explains your financial obligations while under our care and our policies regarding cancellations.

Payment is always due at the time of service. We accept the following forms of payment: cash, debit card, and credit card. We do not accept insurance, however, if you have a PPO-style plan (these are plans that allow you to see doctors who are not part of your insurance company's provider network), we can prepare a health insurance claim form that you may submit to your insurance company to request reimbursement of your visit charges.

We can never guarantee that your insurance company will reimburse you for your visits or cover the cost of your labs and imaging studies. You are ultimately responsible for the cost of your care at our office.

Payment: In order for us to keep our services available to our patients, **it is necessary to require payment at the time of your visit.**

New patient appointments: You are required to provide a credit card number and information when scheduling your first appointment. If you cancel the appointment with less than 24 hours' notice or fail to show up for the appointment, your card will be charged $50.00. This $50.00 will remain a credit for you to use towards re-scheduling an appointment in the future. Follow-up visits: If you cancel a follow-up visit within 24 hours of your schedule appointment or fail to show up for your appointment without notification, your credit card will be charged $25.00. Phone Consultations: We bill for phone consultations. They require the same time and expertise as office visits. Billing for phone consultations is, however, at the doctor's discretion. Your doctor may choose not to bill you if the nature of the phone consultation is uncomplicated, such as taking a minute to answer a question about your treatment protocol. If any type of extended discussion ensues or if a number of questions need to be addressed, it is likely your doctor will bill for the phone consultation. There are no refunds on any labs or services.

By signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you have given your permission to us to charge your credit card for missed appointments, phone consultations, or any of the above stipulations that may apply to you. **We will only automatically charge this card as described by the terms above.** If you request, phone consults or other services may be paid with another card or account at the time of service.

Name of patient or legal guardian: _____

Signature: _____ Date: _____

Type of card: Visa MC American Express Discover

Card Number: _____

Expiration: _____Security Code: _____Billing Zip Code: _____

HORIZON
Natural Medicine

## Notice of Privacy Practices

**To our patients:** This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Our commitment to your privacy:** Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

**Use and disclosure of your health information in certain special circumstances.**

**The following circumstances may require us to use or disclose your health information:**

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

**Your rights regarding your health information:**

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Horizon Natural Medicine, PLLC 610 E Bell Rd. STE 2-128 Phoenix AZ 85022. *Note: We must respond to this request within 30 days.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Horizon Natural Medicine, PLLC 610 E Bell Rd. STE 2-128 Phoenix AZ 85022. You must provide us with a reason that supports your request for amendment. Note: We must respond within 60 days. The Privacy Officer or the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.

HORIZON
Natural Medicine

5. Your health information will not be used for marketing or fundraising purposes unless authorized by you to do so. Additionally, we will not sell patient health care information to 3rd parties unless instructed to do so by you.
6. You have the right to receive them in either written or electronic form.
7. We will obtain written authorization from you should we wish to utilize information in your health records for research purposes.
8. We must obtain your permission to disclose immunization records to schools or other requesting parties.
9. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.
10. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Katie Nuckolls at Horizon Natural Medicine, PLLC. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
11. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or our health information privacy policies, please contact Katie Nuckolls at Horizon Natural Medicine, PLLC.

**Privacy Precautions at Horizon Natural Medicine:**

1. Medical information is entered and stored on an encrypted computer, and all lab results are sent by in encrypted PDF format. Computer is protected with intrusion prevention software to prevent online security breach.
2. Passwords are never shared or saved on said computer.
3. Mobile version of the schedule does not contain any identifying information.
4. In the event of a security breach, we will notify all patients, and we must provide the Secretary with notice of breaches within 60 days of the end of the calendar year in which the breaches were discovered.

## Acknowledgement of Notice of Privacy Practices

I, _____, hereby acknowledge that Horizon Natural Medicine has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact: **Katie Nuckolls, ND 602-359-2893.**

I also understand that I am entitled to receive updates upon request if Horizon Natural Medicine amends or changes it Notice of Privacy Practices in a material way.

Name of Patient or Legal Guardian:_____

Signature:_____Date:_____

You are authorized to discuss my personal medical information with the following people:

1) _____

2) _____

3) _____

HORIZON
Natural Medicine

## Labs and Other Diagnostic Testing:

The purpose of this document is to help you make an informed choice when your doctor recommends lab tests, imaging studies (x-rays, MRI, etc.) or other diagnostic procedures.

You should be aware that **Medicare and private insurance companies may not pay for all diagnostic tests ordered by your doctor**, even those your doctor considers absolutely necessary. If you agree to any testing recommended by your doctor and your insurance company refuses to pay for the testing, you are responsible for the cost of the ordered tests. **Medicare does NOT cover any testing ordered by non-Medicare providers.** Currently, **naturopathic physicians are NOT Medicare providers.**

As a general rule, specialty lab tests are not covered by private insurance companies or Medicare, though there are exceptions. Your doctor will be happy to tell you whether the tests being recommended are specialty labs. Once ordered, there will be NO REFUNDS on labs or any other diagnostic testing. Several things to keep in mind when your doctor orders diagnostic testing:

- Your doctor will be happy to explain any testing to you and why they believe it is necessary. We will be happy to inform you of the cost of the recommended tests.
- You always have the right to refuse any testing recommended, though your doctor also has the right to discharge you from their care if they believe the testing is mandatory.
- Even if you have insurance, you may opt to pay for tests out-of-pocket at the discounted cash price in order to avoid any possibility that your insurance company will refuse to pay.If your insurance company does refuse to pay, the lab or imaging center will usually charge you the full retail price of the tests.
- You may be able to pay for diagnostic testing not covered by your insurance company using a Health Savings Account or Flex Spending Account.

Please choose one option below:

☐ **Yes.** I am open to receiving laboratory testing as recommended at this office.
All of the testing options and prices can be discussed before making any decisions to run labs. I understand that Medicare or my private insurance company may not pay for these tests, and I will be responsible for any lab charges not covered by insurance.

☐ **No.** I have decided not to receive any laboratory tests at this office.I understand that by not having tests done, my doctor may not be able to properly diagnose and treat me, and has the right to discharge me from care. I also understand that if my insurance company covers testing when ordered by my primary care physician or another doctor, I can request tests through my other doctor's office and authorize for a copy of the results to be sent here.

Ordering Physician:_____

Patient Name: _____

Signature of Patient/Gaurdian: _____Date:_____

Witness Signature: _____Date:_____

HORIZON
Natural Medicine

# Instructions for Homeopathic Intake Form

Please answer the questions on the following pages as carefully, thoughtfully, and accurately as possible. Many of the questions may not seem directly related to your problem or main complaint, however, each one may help determine which homeopathic remedy is best suited for you. Feel free to write in extra clarifying information if you feel the need to better explain any answer.

## Weather

**Cold weather affects me negatively**

Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**Rainy or humid weather affects me negatively**

Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**Hot weather affects me negatively**

Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**Change of weather affects me negatively**

Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**Wind or thunderstorms affect me negatively**

Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**I can tolerate exposure to warm sun (around 85 degrees) for a duration of**

10 min. or less  10-30 min.  30-60 min.  1-2 hours  2-4 hours  4 hours or more

**I generally feel better in the following atmosphere/weather**

Mountains  Seashore  Dry weather  Rainy/Stormy weather  Sunny weather  Cloudy weather

**My symptoms get worse during the following seasons:**

No season affects my symptoms  Spring  Summer  Fall  Winter

If so, which symptoms worsen? _____

## Environment

**Bright light affects me negatively**

Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**Warm rooms affect me negatively**

Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**Cold open air affects me negatively**

Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**Loud noise affects me negatively**

Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

HORIZON
Natural Medicine

**Cold drafts affect me negatively (fans, A/C, wind)**

Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

**Strong odors affect me negatively**

Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

## Time of Day:

The time of day that I generally feel the **best** or the most energetic is _____ AM/PM until _____ AM/PM

The time that I generally feel the **worst** or have the lowest energy is _____ AM/PM until _____ AM/PM

## General Physical Characteristics

**I tend to become uncomfortable faster in a room that is**

Warmer than usual (80 degrees) Cooler than usual (60 degrees)

(Circle the one that tends to bother you more)

**Tight clothing affects me negatively (If so, around what part of the body_____)**

Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

**During sleep, I experience the following**

Restlessness Sleep walking Teeth grinding Uncovering Perspiration
Heat Coldness Snoring Strange dreams Talking in sleep
Frequent urination Frequent waking (at a specific hour?_____)

**My usual sleep position is**

On back On abdomen On side (right or left?) Feet/arms uncovered Fully covered

**In general, I tend to perspire**

Never Only with exertion When heated When cold When nervous Easily, all the time

**The part of my body where I tend to perspire the most is _____**

## Food and Drinks

**I crave the following flavors strongly on a daily basis (you may circle more than one)**

Sweet Salty Sour Spicy Bitter Smoked Pungent

**I crave the following types of food or drinks strongly on regular basis (you may circle more than one)**

Apples Bacon Beer Bread Butter Cake/Cookies Cheese Chocolate Coffee Eggs
Fish Fresh fruit Fried food Frozen food Garlic Ham Ice Ice cream Indigestible things (clay, chalk, etc.) Lemons/Lemonade Liquor Meat Milk Nuts/Nut butters Onions
Olives Oranges Pastries Pickles Potatoes Salsa Sausage
Shellfish Tea Vegetables Wine Other: _____

**If all food were healthy, I would enjoy the following foods/drinks multiple times per day:**

_____

HORIZON
Natural Medicine

**I tend to dislike the following foods, drinks, or flavors:**

_____

**With regard to thirst, on an average temperature day without physical exertion, I feel the need to drink water or another beverage to quench my thirst**

Almost never | Several times per day | Several times per hour | Every few minutes

**I prefer my water**

Hot | Room temperature | Cold | Ice cold

**I prefer my food**

Hot | Cold | No strong preference

## Fears

**I have a strong fear of (can circle more than one):**

| | | |
|---|---|---|
| Darkness | Becoming seriously ill | Knives or needles |
| Thunderstorms | Loved one becoming ill or injured | Blood |
| Heights or falling | Ghosts | Spiders or insects |
| Small or narrow places | Evil | Snakes |
| Strangers | Failure | Poverty |
| Being alone | Animals (what kind? _____) | Robbers/intruders |
| Water, lakes, or the ocean | That something terrible will happen | Contagious disease/germs |
| Death | Being in public or in a crowd | Insanity |

Other fears or phobias:_____

## Mental and Emotional Characteristics

**In general, I tend to feel restless**

Almost never | Less than once a week | Once a week | Once a day | More than once a day

**If so, is there a part of your body that tends to be the most restless_____?**

**In general, I feel the need to keep things clean or organized**

Almost never | Less than once a week | Once a week | Once a day | More than once a day

**In general, I tend to feel impatient or hurried**

Almost never | Less than once a week | Once a week | Once a day | More than once a day

**In general, I tend to feel suspicious**

Almost never | Less than once a week | Once a week | Once a day | More than once a day

**In general, I tend to feel jealous or envious**

Almost never | Less than once a week | Once a week | Once a day | More than once a day

**In general, I tend to feel irritable or angry (whether you express it or not)**

Almost never | Less than once a week | Once a week | Once a day | More than once a day

HORIZON
Natural Medicine

**In general, I tend to criticize myself**
Almost never  Less than once a week  Once a week  Once a day  More than once a day

**In general, I tend to criticize others (either verbally or in my thoughts)**
Almost never  Less than once a week  Once a week  Once a day  More than once a day

**I think about disagreeable or troubling events from the past**
Almost never  Less than once a week  Once a week  Once a day  More than once a day

**I have urges to throw things, hit people/things, or break things (whether you act on this desire or not)**
Never/Almost never  Less than once a week  Once a week  Once a day  More than once a day

**I have urges to hurt myself (whether you act on this urge or not)**
Never/Almost never  Less than once a week  Once a week  Once a day  More than once a day

**I cry easily or often**
Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**If someone upsets or offends me, I feel nervous confronting that person about it**
Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree  Only with authority figures

**I am offended easily by rudeness or injustice**
Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**I am overly sensitive to hearing sad or cruel stories about children, adults, or animals**
Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**Being scolded, reprimanded, or criticized affects me negatively**
Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**I am frightened or startled easily**
Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**I often worry about social status and success**
Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**I often feel impulsive, or have sudden changes in mood or behavior**
Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**I have difficulty making decisions**
Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**I have a strong desire to travel or to be outdoors in nature**
Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**I have a strong affinity for and love of animals**
Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

**I have a strong religious or spiritual faith**
Strongly disagree  Slightly disagree  Neutral  Slightly agree  Strongly agree

HORIZON
Natural Medicine

**I am often forgetful of the following**

Dates Names Numbers Words Places Faces Recent events
Distant past events What I was about to say What someone just told me What I was about to do
What I just did What I just said

**I have had dreams or daydreams that have come true (clairvoyant or prophetic dreams)**

Less than twice Less than 4 times Less than 10 times More than 10 times

**Regarding any past emotionally traumatic events, I feel**

Grief Guilt Anger Fear Sadness Shame Indifference Peace Empowerment
Other:_____

**Regarding my health condition, and the possibility of recovery, I feel**

Very optimistic Hopeful Somewhat doubtful Discouraged Fearful Severe despair

**In general, my overall outlook on life at this time is**

Very optimistic Generally positive Indifferent Pessimistic Loathing life
Desire death Suicidal thoughts Suicidal plans

**When I am feeling sad or upset, at the very worst point, I need**

To be completely alone To have someone nearby To be distracted from my feelings
To vent about what I am feeling To have someone talk to me about what I'm feeling, and console me

**If I am feeling at my worst, the following makes me feel much better (circle any that apply)**

Rest/Sleep Massage/Pressure Crying Yelling Music Dancing
Company Being alone Talking Quiet Darkness Sunshine Eating
Gentle exercise Vigorous exercise Exposure to heat Exposure to cold

Anything else that consistently makes you feel better: _____

Anything that consistently makes you feel worse: _____

**(If you have a partner/spouse) My general feeling toward my partner/spouse is**

Loving Affectionate Indifferent Dissatisfied Disappointed Irritated
Resentment Disgust Hatred

**The frequency of my sexual desire or interest is (whether you act on this desire or not)**

Never/Less than 1x/year 1-6 x/year Every 1-2 months Every 1-2 weeks 2-4x/week
Once/day More than once/day

**(If sexually active) Approximate frequency of intercourse**

Never/Less than 1x/year 1-6 x/year Every 1-2 months Every 1-2 weeks
2-4x/week Once/day More than once/day

**Approximate frequency of masturbation**

Never/Less than 1x/year 1-6 x/year Every 1-2 months Every 1-2 weeks 2-4x/week
Once/day More than once/day

**I experience the following (circle any that apply):**

Lack of sexual enjoyment Difficulty reaching orgasm Troubling sexual thoughts Impotence