North Valley Wellness Center, LLC
Monica Rempen, D.O.M. Rx1
National Board Certified Oriental Medicine

Welcome! Our goal is to offer you the highest quality health and medical services available. Dr. Rempen has a holistic approach to health care using Functional Medicine concepts and Traditional Chinese Medicine (TCM) as the core.

Please take a moment to read the general policies of our office. Please initial, indicating you have read and understood the policies below:

Initial: _____ All services rendered are to be paid at the time of service. We will discuss our fees with you at any time. A $35 fee will be charged for any returned checks for non-sufficient funds. A second returned check will result in cash or credit card only for all future payments.

Initial: _____ Your medical insurance is a contract between you and your insurance company. We will provide you with information to submit for reimbursement of your office visit.

Initial: _____ Please be aware if you miss your appointment or cancel without a 24 hour notice, you will be charged for the missed appointment. If you are more than 20 minutes late for an appointment, we may reschedule.

Initial: _____ Dr. Rempen is able to answer only brief questions over the telephone (2-3 minutes) relating to a recent office visit or to another simple matter. Telephone consultations pertaining to new medical problems or issues not recently discussed in the office will be billed at rates equivalent to those charged for office visits.

Initial: _____ If an emergency arises after our business hours or on weekends, and you feel you need medical attention, please go to an Urgent Care or Emergency facility.

Thank you for reading and respecting our office policies. Please let us know if you have any questions. Our intent is to provide the safest and most effective treatments available.

Your personal referrals are greatly appreciated.

Date:_____

Patient Name: (print) _____

Signature: _____

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our policy on how our office handles medical information: how information may be used and disclosed, how you can access this information, and how your privacy is protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Workman's Compensation (and your employer in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- ✓ Limited access to facilities where information is stored.
- ✓ Policies and procedures for handling information.
- ✓ Requirements for third parties to contractually comply with privacy laws.
- ✓ All medical files and records (including mailed correspondence, emails, telephone conversation notes, and faxes sent and received) are kept on permanent file.

Types of information that we gather and use:
In administering your health care, we gather and maintain information that may include non-public personal information:

- ➢ About your financial transactions with us (billing transactions).
- ➢ From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- ➢ From health care providers, insurance companies, workman's compensation and your employer and possibly other third party administrators, (e.g. requests for medical records, payment claim information).

We value our relationship and respect your right to privacy. If you have any questions about our privacy guidelines, please call us during our regular business hours.

Yours truly,

Dr. Monica Rempen, DOM Rx1 Initials:_____

Please provide complete contact information:

Patient Name: _____
Age:_____ Date of Birth: _____Sex: M F
Spouse/Partner:_____
Parent/Guardian:_____

Address: _____
_____
_____

(Please put a checkmark (√) for your preferred contact number)
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Do you prefer text messages? If so, please write "text" next to that number.
Email address: _____

Emergency Contact Information:
Name: _____
Relationship to patient: _____
Address: _____
_____
Phone Number: _____
Alternate Phone Number:_____

Legal Guardian/Healthcare Proxy/Power of Attorney Information:
Circle your title: Guardian HealthCare Proxy Power of Attorney
Name: _____
Address: _____
_____
Phone: _____
Alt. Phone: _____

Health Insurance:

Dr. Rempen is contracted with Presbyterian and New Mexico Health Connections and will bill for covered services only. And, only if you have your healthcare with one of the listed insurance companies.
If you are contracted with another company we can review the possibility of billing for you. This will be on a case by case basis.

Please note: In all circumstances, there are only a limited number of services covered by your policy.

To bill insurance on your behalf we need some additional information.

We will need a copy of your insurance card and a copy of your driver's license.

Primary Insurance:
Insurance Company: (ie: NNHC, Presbyterian): _____
Who is the Primary Policy Holder on your health insurance account?
_____
What is his/her date of birth?_____
Insurance Member Number:
_____
Group Number:
_____

Secondary Insurance:
Insurance Company: (ie: NNHC, Presbyterian): _____
Who is the Primary Policy Holder on your health insurance account?
_____
What is his/her date of birth?_____
Insurance Member Number:
_____
Group Number:
_____

I hereby authorize Dr. Monica Rempen to furnish any information, including medical information, to insurance companies for the purpose of processing insurance claims related to services I have received at the clinic. Further, I authorize insurance benefits to be made on my behalf to the clinic for services completed to help expedite insurance carrier payments.

However, I recognized that I, the patient, am responsible for all fees regardless of insurance coverage or lack thereof.

I further understand that insurance coverage does **not** guarantee payment of services and that the patient/guardian/caregiver is responsible for payment of all fees owed to the clinic. Non-payment for services rendered will result in discontinuation of services and, possibly, legal action that may affect the personal credit worthiness of the party(ies) responsible for payment.

Signature:_____Date:_____

North Valley Wellness

Patient Name: _____ Sex: _____ Age: _____ Date: _____

For Women:

Pregnant? ☐Yes ☐No Trying to get pregnant? ☐Yes ☐No Breastfeeding? ☐Yes ☐No
☐Amenorrhea (no period) ☐Dysmenorrhea (painful period) ☐Excessive Flow ☐Scanty Flow
☐Vaginal Itching/Burning ☐Mid-cycle Spotting ☐Clots, if yes, color: _____
☐Oral Contraceptive Use ☐Vaginal Discharge, if yes, color _____ ☐Cramping
Age at 1st Period: _____ # of Days in Cycle: _____ (first day to first day) ☐PMS
# of Days of Flow: _____ Color of Flow: _____
# of Pregnancies: _____ # of Live Births: _____
# of Miscarriages: _____ # of Abortions: _____

Average # of pads you use on: 1st Day: ___ 2nd Day: ___ 3rd Day: ___ 4th Day: ___ 5th Day: _____
Have you been diagnosed with: ☐Fibroids ☐Fibrocystic Breasts ☐Endometriosis
☐Ovarian Cysts ☐PID ☐Other: _____
Location of pain: ☐Lower abdomen ☐Lower back ☐Thighs ☐Other: _____
Nature of pain: (Please indicate before, during, or after menses)
Cramping: _____ Stabbing: _____ Burning: _____ Aching: _____
Dull: _____ Bloating: _____ Constant: _____ Intermittent: _____

Symptoms experienced around menses:
☐Constipation ☐Decreased Libido ☐Diarrhea ☐Headache ☐Hot Flashes
☐Increased Libido ☐Insomnia ☐Mood Swings ☐Nausea ☐Night Sweats
☐Poor Appetite ☐Ravenous Appetite ☐Swollen Breasts ☐Vaginal Dryness
Other: _____

For Men:

Date of last prostate exam: _____ PSA Results: _____
Manual/Lab Results: _____
Frequent Urination? ☐Yes ☐No If frequent, when? ☐Daytime ☐Nighttime
Characteristics of urine: ☐Clear ☐Cloudy Color: _____ Odors: _____

Other Symptoms:
☐Back Pain ☐Decreased Libido ☐Delayed Stream ☐Dribbling
☐Erectile Dysfunction ☐Groin Pain ☐Hemorrhoids ☐Impotence
☐Incontinence ☐Increased Libido ☐Low Testosterone ☐Premature Ejaculation
☐Prostate Problems ☐Testicular Pain ☐Urine Retention Other: _____

Chief Complaint:

What condition are you seeking treatment for today? _____
How long have you had this condition? _____
What diagnosis have you received from a *medical doctor*? _____
Is there pain? ☐Yes ☐No _____
Quality of pain? ☐Sharp ☐Shooting ☐Radiating ☐Dull ☐Achy ☐Intermittent ☐Constant
Please rate the severity of the symptoms. Circle one. 1(mild) 2 3 4 5 6 7 8 9 10(severe)
Symptoms are relieved and worsened by? _____
Please list medications and the dosages that you are taking for this condition. _____

Monica T Rempen, DOM, Rx1
North Valley Wellness Center, LLC
Telephone (505) 615-7972 ♦ Fax (505) 890-1471
NPI #1033239231

Patient Name: _____ Sex: _____ Age: _____ Date: _____

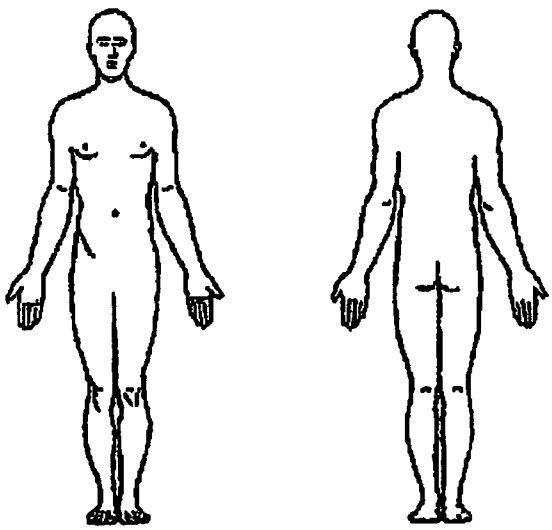
Medical History: (Please list or check all that apply.)

General:	☐Blood Thinner Use ☐Hemophiliac ☐Pacemaker ☐Limb Precautions ☐Seizures ☐Pregnancy
Past Illnesses:	
Sexually Transmitted Infections:	
Circulatory Conditions:	
Immune Conditions:	
Skin Conditions:	
Emotional Conditions:	
Neurological Conditions:	
Respiratory Conditions:	

Have you had any accidents, illnesses, injuries, surgeries, or traumas that have affected your health in a manner that you've never been totally well as a result? ☐Yes ☐No
If yes, please explain: _____

_____

Please place a "**S**" on areas you had **surgery** and place a "**P**" on areas you have **pain.**



Please give more details regarding those marked areas: _____

_____

_____

_____

_____

_____

_____

Taking any medications for the marked areas?

_____

_____

_____

_____

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Patient Name: _____ Sex: ____ Age: ____ Date: _____

Family History:

Any family members who may have the following health issues?

Asthma:	☐Yes	☐No	Who? _____
Cancers:	☐Yes	☐No	Who? _____
Diabetes:	☐Yes	☐No	Who? _____
Genetic Diseases:	☐Yes	☐No	Who? _____
Heart Disease:	☐Yes	☐No	Who? _____
Hypertension:	☐Yes	☐No	Who? _____
Mental Illnesses:	☐Yes	☐No	Who? _____
Stroke:	☐Yes	☐No	Who? _____
Suicide:	☐Yes	☐No	Who? _____
Other: _____			Who? _____

Current Medications or Supplements:

Name	Dosage	For	How Long	Prescribed by

How do you *FEEL* about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Comments
Diet	☐	☐	☐	☐	☐	_____
Exercise	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	_____
Self	☐	☐	☐	☐	☐	_____
Sex	☐	☐	☐	☐	☐	_____
Significant Other	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	_____

Anything else that you would like to share with us? _____

_____

_____

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Metabolic Assessment Form

Name: _____ Age: _____ Sex: ____ Date: _____

PART I

Please list the 5 major health concern in your order of importance:

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

PART II **Please circle the appropriate number "0 - 3" on all questions below.**
0 as the least/never to 3 as the most/always.

Category I: Colon				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal 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
Coated tongue of "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Do you use laxatives frequently	0	1	2	3
Category II: Hypochlorydia				
Excessive belching burping or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3
Category III: Hyperacidity (Ulcer)				
Stomach pain, burning or aching 1- 4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0	1	2	3
Category IV: Small Intestine (Pancreas)				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage bloated	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Excessive passage of gas	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category V: Biliary Insufficiency/Statis				
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
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes		No	
Category VI: Hypoglycemia				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category VII: Insulin Resistance				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category VIII: Adrenal Hypofunction				
Cannot 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
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category IX: Adrenal Hyperfunction				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up 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

Category X: Hypothyroid				
Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over .	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI: Thyroid Hyperfunction				
Heart palpations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII: Pituitary Hypofunction				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII: Pituitary Hyperfunction				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (Male Only): Prostate				
Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males Only): Andropause				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional then in the past	0	1	2	3

Category XVI (Menstruating Females Only)				
Are you perimenopausal	Yes		No	
Alternating menstrual cycle lengths	Yes		No	
Extended menstrual cycle, greater than 32 days	Yes		No	
Shortened menses, less than every 24 days	Yes		No	
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)				
How many years have you been menopausal?	_____			
Do you ever have uterine bleeding since menopause?	Yes		No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

PART III: Foods

How many alcohol beverages they consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____

How many times a week do you workout? _____

List the three worst foods you eat during the average week? _____, _____, _____

List the three healthiest foods you eat during the average week? _____, _____, _____

Do you smoke?_____ If yes, how many times a day _____ , a week _____.

Rate your stress levels on a scale of 1-10 during the average week. _____

Health Questionnaire

MUSCULO- SKELETAL SYSTEM
CODE
____ Neck Problems
____ Arm Problems
____ Pain between shoulders
____ Low back problems
____ Leg Problems
____ Swollen joints
____ Painful joints
____ Stiff joints
____ Sore muscles
____ Weak muscles
____ Walking problems
____ Ruptures of tendons
____ Broken bones

GENITO- URINARY SYSTEM
CODE
____ Bladder trouble
____ Excessive urine
____ Scanty urine
____ Painful urination
____ Discolored urine

FEMALE
CODE
____ Vaginal Discharge
____ Vaginal bleeding
____ Vaginal pain
____ Breast pain
____ Lumps on breast

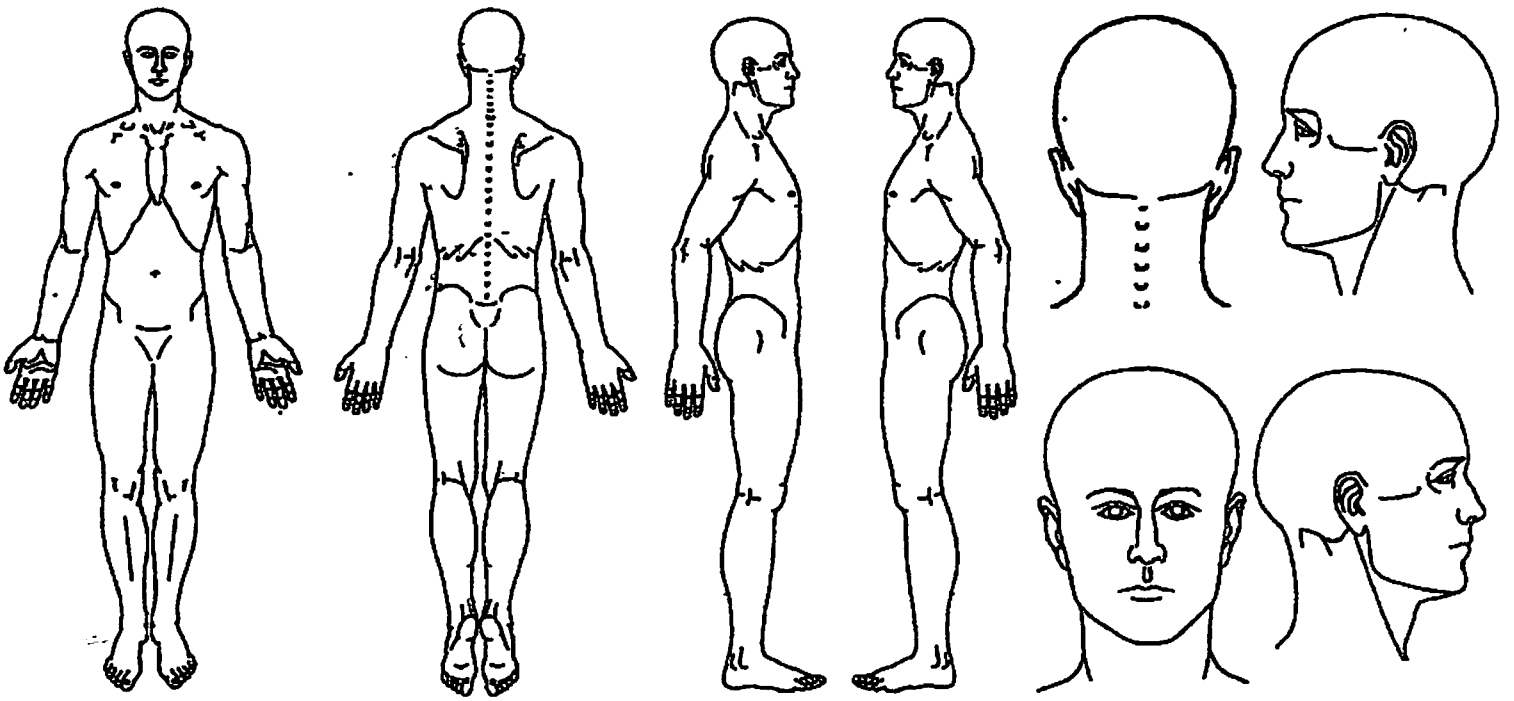
GASTRO-INTESTINAL SYSTEM
CODE
____ Poor appetite
____ Excessive hunger
____ Excessive thirst
____ Difficulty chewing
____ Difficulty swallowing
____ Nausea
____ Vomiting food
____ Vomiting blood
____ Abdominal pain
____ Diarrhea
____ Constipation
____ Black stool
____ Bloody stool
____ Hemorrhoids
____ Liver trouble
____ Gall bladder problems
____ Weight gain/loss

NERVOUS SYSTEM
CODE
____ Numbness
____ Paralysis
____ Dizziness
____ Fainting
____ Headaches
____ Muscle jerking
____ Convulsions
____ Forgetfulness
____ Confusion
____ Depression

CARDIO-VASCULAR- RESPIRATORY
CODE
____ Chest pain
____ Heart pain
____ Rapid heart beat
____ Blood pressure high/low
____ Heart problems
____ Difficult breathing
____ Persistent cough
____ Coughing up phlegm
____ Coughing up blood
____ Lung problems
____ Varicose veins

EYE, EAR, NOSE AND THROAT
CODE
____ Eye strain
____ Eye inflammation
____ Vision problems
____ Ear pain
____ Ear noises
____ Hearing loss
____ Ear discharge
____ Nose pain
____ Nose Bleeding
____ Nose Discharge
____ Difficult breathing through nose
____ Sore gums
____ Dental problems
____ Sore mouth
____ Sore throat
____ Hoarseness
____ Difficult speech

Is there pain? ☐Yes ☐No Where is the pain? _____
Quality of pain? ☐Sharp ☐Shooting ☐Radiating ☐Dull ☐Achy ☐Intermittent ☐Constant



I understand that the doctor and the clinic staff have access to my health records for providing care. I am also assured that any information I provide is kept confidential. Therefore, I authorize the use of the above information as described.

Signature: _____ Date: _____

Your referrals are most welcomed.