MOHRDAR
Institute of Homeopathy and Integrated Medicine

Patient Information

Welcome to Mohrdar Institute of Homeopathic & Integrated Medicine. We are very Pleased That you have selected us as your Healthcare provider. We are looking forward to a very healthy relationship and would like to encourage you to visit our website (www.mohrdar.com) for additional information.

Patient Name:_____ Male ☐ Female ☐

Address: _____

City:_____ State: _____ Zip: _____

Birthdate:_____/_____/_____ Age: _____ Social Security Number:_____

Home #: (____)_____ Cell #:(____)_____ Fax #(____)_____

E-Mail Address: _____ Single Married

Emergency Contact: :_____ Phone Number: :_____

Reason for consulting our office:_____

Referred by:_____

Your current Medical Doctor's First & Last Name:_____

MD's Address:_____ Phone Number:_____

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Office Policies

Appointment Policy:
In order to avoid being charged for a missed appointment, please notify the front desk at least 24hours in advance.

Remedy/ Supplement Refill Policy:
Please allow 48-72 hours for all remedy and supplement orders to be filled. Please allow 1 week for all special orders and mail orders to be processed. We advice that all supplement orders be placed directly thru the supplement ordering line. (951) 781-4529 Ext: 3

Return Policy:
Mohrdar Institute does **NOT** give refunds for ***ANY*** supplements, remedies, blood work, and/or test kits.

Office Fees

New Patient Deposit (Required at Scheduling)	$ 100
New Patient Initial Consult (w/Comprehensive Physical)	$300
Report of Findings (Revision of labs)	$100
General Health Follow up	$85
Chiropractic Visits	$65
Yearly Comprehensive Physical Exam	$170-$375
Thermography Full Body Scan	$285
Cold Laser Therapy (KLaser)	$85 (One location; $15 Additional Areas)
Ambulatory Traction	$80

Consultation Goals

Our goal is to provide you with all essential information regarding your condition and outline treatment program for the restoration of your health and preventive measures for the future. Please take a moment to read the information listed. All comments and questions are appreciated and welcomed.

Initial Visit (Examination-Consultation)

You will have a consultation with Dr. Mohrdar to discuss your health-related problems, concerns, and potential treatment options. This initial visit is designed for the doctor at Mohrdar Institute to learn more about you, your condition, and expectations to determine how chiropractic care can meet your goals.After your consultation, The Doctor will perform a complete chiropractic examination testing your reflexes and flexibility. Other standard neurological, orthopedic, postural, and physical tests will be performed as well. However, nothing will be done in our office without your consent.

Report of Findings (Second Visit)

Once the information is collected and examinations are performed, the Mohrdar team will give you a detailed report of all findings and answer any questions.
After reviewing your health history, goals, examining your spine and Lab Results, the Doctor discuss recommendations. The team at Mohrdar Institute will provide the best treatment and wellness program for your needs.

Informed Consent to Chiropractic Adjustments, and Visceral Manipulation

I hereby request and consent to the performance of chiropractic adjustments, visceral adjustments, and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by
Dr. Arash Mohrdar and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr Arash Mohrdar, including those working at Mohrdar Institute of Homeopathic and Integrated Medicine.

Wellness Program

Prior to leaving, the doctor will suggest a wellness program to incorporate outside of treatment. If you are in pain when you first come into our office this may include: ice or heat application instructions, certain activities or positions to avoid, at home exercises and/or stretches, Nutritional advice or/and special dieting. If you desire, our wellness team will work with you also to create healthy habits and routines for your lifestyle. Every person is unique, therefore everyone requires a customized wellness plan. The purpose of our wellness program is for you to achieve good spinal alignment, have a healthy diet, exercise, and maintain a positive mental state.

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I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks, complications and wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts known, is in the best interests.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above names procedure. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which i seek treatment.

Note: You do not have to submit to any examination procedure. I ask you to comply to the best of your ability and report changes in your condition. All procedures are accomplished to your tolerance.

_____	_____	___/____/_____
Print Patient's Name	Signature of Patient	Date Signed

To be completed by patient's representative if necessary:

_____	_____
Print Patient's Name	Print Name of Representative

_____
Signature of Patient's Representative as :
_____ Relationship to patient.

Mohrdar Institute of Homeopathy & Integrated Medicine
6068 Brockton Ave, Riverside CA 92506
P: (951) 781-4529 F: (951) 781-8198

MOHRDAR
Institute of Homeopathy and Integrated Medicine

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

To: (Provider) _____
Address:_____
Phone Number:_____ Fax:_____

Patient's Name: _____ Date of Birth: _____
Social Security # or
Medical ID #:__ _____

I, _____request the following information

☐X Rays ☐History ☐Records ☐Diagnosis ☐Lab Results
☐Treatment ☐Reports

Concerning my: ☐Accident ☐Injury ☐Illness

For the of purpose:_____

According to Section 123110 of The California Health and Safety Code, these records/films must be provided within 15 days of receipt of this notice.

To be released to:

Mohrdar Institute of Homeopathy & Alternative Medicine
6086 Brockton Ave Ste 4
Riverside, CA 92506
Phone (951)781-4529
Fax (951)781-8198
Via Fax or Mail

Patient Signature: _____ Date Signed: dsdsdd

☐Patient ☐ Spouse ☐ Parent ☐ Guardian

MOHRDAR
Institute of Homeopathy and Integrated Medicine™

(P) 951-781-4529
(F) 951-718-8198
clinic@mohrdar.com

Consent to Authorize Credit Card payment(s)

*Your completion of this authorization form helps us to protect you, our valued patient, from credit card fraud.
All information entered on this form, will be kept strictly confidential.

Patient Information:

Name: _____

Address: _____

City/State/Zip code: _____

Best Contact Number: _____

Email Address: _____

Credit Card Information:

Name as appears on card: _____
Card type: _____
Card Number: _____
Expiration Date: _____
CVV Security Code: _____

Patient Signature: _____ Date: _____

Witness- Verified By: _____ Date: _____

*** I hereby authorize Mohrdar institute to process payment(s) on this credit card on given by my consent.**
***This may be used for: Office Visits OR Supplements (Please circle one or both if desired)**

PATIENT SYMPTOM SURVEY

***DATE*_____**

***PATIENT'S NAME:*_____ *DOB:*_____*AGE:*_____**

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time…

Primary Complaints

090 ☐ General Good Health
091 ☐ Desires Nutritional & Metabolic Analysis
001 ☐ Skin Disorder L25.9
002 ☐ Acne L70.8
003 ☐ Psoriasis L40.8
004 ☐ Urticaria (Hives) L50.9
005 ☐ ADD/ADHD F90.1/F90.9
006 ☐ Allergies, Unspecified J30.9
007 ☐ Allergic Rhinitis from food J30.5
008 ☐ Sinusitis J01.90
009 ☐ Alzheimer's G30.9
010 ☐ Poor Concentration/Memory F07.8
011 ☐ Parkinson's Disease G20
012 ☐ Anemia D64.9
013 ☐ Arthritic Disorder M12.9
014 ☐ Osteoporosis M81.0
015 ☐ Asthma J45.909
016 ☐ Emphysema J43.9
017 ☐ Cancer
- 018 ☐ Breast C50.919female C50.929male
- 019 ☐ Prostate C61
- 020 ☐ Lung C34.90
- 021 ☐ Colon and Rectal C18.9
- 022 ☐ Skin C44.90
- 023 ☐ Leukemia w/o remission C95.90 Leukemia w/ remission C95.91
- 024 ☐ Lymphoma, malignant C85.89
- 025 ☐ Brain Tumor, malignant C71.9

027 ☐ Anxiety Disorder F41.9
028 ☐ Autism F84.0
033 ☐ Edema R60.9
034 ☐ Eczema L25.9
035 ☐ Chronic Fatigue R53.82
036 ☐ Circulatory Disorder I99.9
037 ☐ Heart Disease I51.9
038 ☐ High Cholesterol E78.0
039 ☐ High Blood Pressure I10
040 ☐ Low Blood Pressure I95.9
041 ☐ Tachycardia (High Heart Rate) R00.0
042 ☐ Numbness R20.9
043 ☐ Constipation K59.00
044 ☐ Indigestion K30
045 ☐ Ulcerative Colitis K51.90
046 ☐ Depression F32.9
047 ☐ Diabetes Mellitus E11.9
030 ☐ Diabetes Type I E10.9
031 ☐ Diabetes Type II E11.65
029 ☐ Hyperglycemia [high blood sugar] R73.09
048 ☐ Hypoglycemia [low blood sugar] E16.2
049 ☐ Dizziness/Balance Problem R42
050 ☐ Ear Infection H65.90
051 ☐ Epstein Barr B27.90
052 ☐ Eye Problems H57.13
053 ☐ Cataracts H26.9
054 ☐ Glaucoma H40.9
055 ☐ Macular Degeneration H35.30
056 ☐ Fever R50.9
057 ☐ Fibromyalgia M79.7
058 ☐ Gallbladder Disorder K82.9
059 ☐ Gout M10.9
060 ☐ Headaches R51
061 ☐ Hearing Loss H91.90
062 ☐ Infertility, male N46.9
064 ☐ Liver Disease K76.9
- 065 ☐ Hepatitis K71.6
- 066 ☐ Hepatitis B B16.9
- 067 ☐ Hepatitis C B17.10

068 ☐ Kidney Disorder N28.9 or Bladder Disorder N32.9
063 ☐ Prostate Disorder N42.9
069 ☐ Hyperthyroidism E05.90
070 ☐ Hypothyroidism E03.9
071 ☐ Systemic Lupus M32.10
072 ☐ Infertility, female M97.9
073 ☐ Interstitial Cystitis N30.11
074 ☐ Irregular Menstrual Cycle N92.6
075 ☐ Menopausal Symptoms N95.1
076 ☐ Hot Flashes N95.1
077 ☐ Mental Disorder F99
078 ☐ Insomnia G47.00
079 ☐ Mouth/Throat/Tongue
080 ☐ Canker Sores K12.0
081 ☐ Overweight E66.3
082 ☐ Underweight R63.6
083 ☐ Sexual Disorder F66
084 ☐ Spinal Problems M53.9
085 ☐ Obesity E66.9
086 ☐ GERD K21.9
087 ☐ HIV B20
088 ☐ Crohn's Disease K50.90
089 ☐ Irritable Bowel Syndrome K58.9
092 ☐ Normal Pregnancy Z33.1
**only applicable if *currently* pregnant
093 ☐ Shingles B02.9
140 ☐ Migraines G43.909
141 ☐ Rheumatoid Arthritis M06.9
142 ☐ Non-Systemic Lupus L93.0
143 ☐ Multiple Sclerosis G35
144 ☐ ALS (Lou Gehrig's) G12.21
145 ☐ Polymyalgia Rheumatica M35.3
146 ☐ Scleroderma M34.9
171 ☐ Goiter E04.9
178 ☐ Raynaud's Syndrome I73.00
179 ☐ Hemochromatosis E83.119
180 ☐ Thalassemia D56.8
181 ☐ Brain aneurysm I61.9

If necessary, please state your most significant concern…

General Health

100 ☐ Fingernail base is pink
101 ☐ Fingernail base is purple
102 ☐ Fingernails have ridges or white spots
103 ☐ Fingernails are soft
104 ☐ Fingernails are splitting
105 ☐ Fingernails peel
106 ☐ Pale fingernail beds
107 ☐ Blacks out easily
108 ☐ Balance problems
109 ☐ Difficulty walking
110 ☐ Has tattoos
111 ☐ Brittle hair
112 ☐ Dry hair
113 ☐ Thin hair
114 ☐ Hair loss
115 ☐ Drinks alcoholic beverages daily
116 ☐ Drinks less than 8 glasses of water per day
117 ☐ Currently on Chemotherapy
118 ☐ Currently on radiation treatment
119 ☐ Had chemotherapy in the past
120 ☐ Has had radiation treatments in the past
121 ☐ Gained over 20 lbs in the last 12 months
122 ☐ Somewhat Overweight
123 ☐ Somewhat Underweight

124 ☐ Unexplained loss of >20lbs in last 4 months
125 ☐ Energy level is worse than it was 5 years ago
127 ☐ Sleeps less than 6 hours per night
128 ☐ Unable to recall dreams the next day
129 ☐ Sensitive to chemicals, paint, fumes, cologne
130 ☐ Had blood transfusion in the past
131 ☐ Had transplant in the past
138 ☐ Takes anti-rejection drugs
132 ☐ Had a major accident or injury
137 ☐ Sleep Apnea
139 ☐ Toxic chemical exposure
175 ☐ Has been out of the country recently
176 ☐ Had childhood vaccines
177 ☐ Had a vaccine in the last 12 months
147 ☐ Had a flu shot last year
182 ☐ Had a pneumonia vaccine last year
183 ☐ Had a Hepatitis B vaccine in the last 2 years.

Has a family history of:
184 ☐ Cancer
185 ☐ Heart Disease
186 ☐ Diabetes
187 ☐ Alcoholism
188 ☐ Depression
189 ☐ Obesity

Lifestyle & Environment

Do you use? ☐ Well Water ☐ City Water Filtered? ☐ Yes ☐ No Filter Type? _____
What kind of pipes are in your home? ☐ Steel ☐ CPVC ☐ Copper ☐ Pex ☐ Other _____
What year was your home built? _____ Any renovations in the past year? _____
Do you use chlorine bleach or other heavy duty cleaners in your home/work? ☐ Yes ☐ No
Have you ever worked around heavy machinery, plumbing, automotive or the metallurgic industry? ☐ Yes ☐ No
Explain: _____
Have you ever worked around industrial solvents, chemicals or pesticides? ☐ Yes ☐ No
Explain: _____

380 ☐ Drinks beverages from a can
370 ☐ Drinks alcohol
371 ☐ Drinks caffeinated coffee
372 ☐ Drinks caffeinated pop/soda
373 ☐ Drinks caffeinated tea
374 ☐ Drinks decaffeinated coffee
375 ☐ Drinks decaffeinated pop/soda
376 ☐ Drinks decaffeinated tea
377 ☐ Drinks >3 cups of coffee daily
378 ☐ Drinks >3 cups of tea per day
388 ☐ Drinks diet pop/soda

379 ☐ Drinks >1 pop/sodas per day

I had 4 alcoholic drinks in one day:
172 ☐ never
173 ☐ more than 3 months ago
174 ☐ less than 3 months ago

381 ☐ Has >5 alcoholic drinks/week
391 ☐ Craves sugar / starches
382 ☐ Currently smokes
383 ☐ Quit smoking in last 5 years
384 ☐ Smoked for >5 years
385 ☐ Smokes >1 pack per day

126 ☐ Rarely exercises
133 ☐ Regularly exercises
386 ☐ Takes Vitamins
134 ☐ Vegetarian
135 ☐ Eats no red meat
136 ☐ Eats no meat, no dairy
387 ☐ Frequent use of artificial sweeteners
389 ☐ Anorexia
390 ☐ Bulimic

Surgeries

700 ☐ Tonsillectomy and/or Adenoids
701 ☐ Appendix
702 ☐ Gallbladder
703 ☐ Thyroid
704 ☐ Hysterectomy, complete
705 ☐ Hysterectomy, partial
706 ☐ Tubal ligation
707 ☐ Breast implants
708 ☐ Cancer
709 ☐ Coronary by-pass
710 ☐ Spinal surgery
711 ☐ Extremity surgery
712 ☐ Hip replacement
713 ☐ Knee replacement
714 ☐ Splenectomy
715 ☐ Radiated thyroid
716 ☐ Cataract surgery
717 ☐ Hemorroidectomy
718 ☐ Bariatric/Weight loss Type: _____

Gastrointestinal

265 ☐ 4-5 bowel movements per week
266 ☐ 3 or less bowel movements per week
267 ☐ 6 or more bowel movements per week
268 ☐ Black tarry stools
269 ☐ Pale or yellow colored stool
270 ☐ Blood stools
271 ☐ Constipation
272 ☐ Hemorrhoids
273 ☐ Loose bowel movements
274 ☐ Frequent diarrhea
275 ☐ Frequent nausea
276 ☐ Frequent vomiting
277 ☐ Abdominal gas
278 ☐ Belching and burping after eating
279 ☐ Bloated after eating
280 ☐ Severe abdominal pains
281 ☐ Stomach ulcers
282 ☐ Uses digestive aids
283 ☐ Uses laxatives
284 ☐ Immediate indigestion upon eating
285 ☐ Indigestion in 2 hours or more after meals
286 ☐ Indigestion within 1 hour after meals
287 ☐ Difficulty swallowing
288 ☐ Eating relieves fatigue
289 ☐ Eats when nervous
290 ☐ Excessive hunger
291 ☐ Poor appetite
292 ☐ Experiences fainting spells when hungry
293 ☐ Feels shaky when hungry
294 ☐ Frequently drowsy after eating a meal
295 ☐ Gall bladder disease
296 ☐ Has had intestinal worms
297 ☐ Reflux/Hiatal hernia
298 ☐ Liver disease
299 ☐ Irritable Bowel Syndrome
300 ☐ Diverticulitis
301 ☐ Diverticulosis

Respiratory

485 ☐ Catches severe colds
486 ☐ Chronic chest condition
487 ☐ Chronic cough
488 ☐ Constant runny nose
489 ☐ COPD
490 ☐ Difficulty breathing
491 ☐ Frequent colds
492 ☐ Frequent nose bleeds
493 ☐ Frequent sinus infections
494 ☐ Frequent stuffy nose
495 ☐ Hay fever
496 ☐ Nasal polyps
497 ☐ Night sweats
498 ☐ Post nasal drip
499 ☐ Sneezing spells
500 ☐ Spits up blood
501 ☐ Spits up phlegm
502 ☐ Wheezes

Mouth and Throat

400 ☐ Bad breath
401 ☐ Bitter taste in the mouth in the morning
402 ☐ Dry mouth
403 ☐ Excessive saliva
404 ☐ Sores or cracks in the corners of the mouth
405 ☐ Glands often swell
406 ☐ Frequent canker sores
407 ☐ Frequent fever blisters
408 ☐ Frequent sore throats
409 ☐ Frequently has a sore tongue
410 ☐ Sore gums
411 ☐ Swollen gums
412 ☐ Swollen tongue
413 ☐ Tongue burns
414 ☐ Tongue has grooves or fissures
415 ☐ Tongue is coated
416 ☐ Gums bleed when brushing teeth
417 ☐ Toothaches
418 ☐ Amalgam dental fillings
420 ☐ Other dental fillings (gold, composite, etc)
419 ☐ Has had root canal

Endocrine

245 ☐ Coarse hair
246 ☐ Coarse skin
247 ☐ Diabetic
248 ☐ Excessive thirst
249 ☐ Frequently feels cold
250 ☐ Frequently feels hot
251 ☐ Gets lightheaded when standing quickly
252 ☐ Heals slowly
253 ☐ Unusually jumpy or nervous
254 ☐ Unusually tired most of the time

Cardiovascular

190 ☐ Cold feet
191 ☐ Cold hands
192 ☐ Experiences shortness of breath while sitting still
193 ☐ Heart skips beats
194 ☐ Tendency of High blood pressure
195 ☐ Leg cramps during bedtime
196 ☐ Leg cramps during daytime
197 ☐ Low blood pressure at times
198 ☐ Pain in leg/hips when walking
199 ☐ Frequent swollen ankles
200 ☐ Pains in the heart or chest
201 ☐ Spells of rapid heart rate
202 ☐ Troubled with blood clots
203 ☐ Unusually slow pulse rate
204 ☐ Varicose veins
205 ☐ Heart palpitations

Skin

520 ☐ Bruises easily
521 ☐ Excessive perspiration
522 ☐ Frequent goose bumps
523 ☐ Has acne
524 ☐ Has Psoriasis
525 ☐ Hives
526 ☐ Itchy skin
527 ☐ Problems with Eczema
528 ☐ Has moles which are changing in size and/or color
530 ☐ Skin is rough, especially on the back of the arms
529 ☐ Skin eruptions
531 ☐ Skin is tender
532 ☐ Sores that heal slowly
533 ☐ Troubled with boils
534 ☐ Dry skin

Ears

220 ☐ Discharge from ears
221 ☐ Hard of hearing
222 ☐ Punctured ear drum
223 ☐ Recurrent ear infection
224 ☐ Ringing or noises in the ears
225 ☐ Tinnitus

Eyes

320 ☐ Bloodshot eyes
321 ☐ Blurred vision
322 ☐ Cross eyes
323 ☐ Eye pain
324 ☐ Eyes feel gritty
325 ☐ Eyes watery
326 ☐ Mild Glaucoma
327 ☐ Far sighted
328 ☐ Developing cataracts
329 ☐ Mild Macular degeneration
330 ☐ Itchy eyes
331 ☐ Near sighted
332 ☐ Dry Eyes

Feet

350 ☐ Corns
351 ☐ Frequent foot cramps
352 ☐ Heel spurs
353 ☐ Painful feet
354 ☐ Plantar warts
355 ☐ Swelling in the feet and/or ankles
356 ☐ Plantar fasciitis
357 ☐ Fungal Infection

Neuromuscular

440 ☐ Bites nails
441 ☐ Frequent muscle soreness
442 ☐ Muscle spasms
443 ☐ Muscle weakness
444 ☐ Tremors
445 ☐ Frequent headaches
446 ☐ Often dizzy
447 ☐ Frequently feels faint
448 ☐ Has Epilepsy
449 ☐ Has motion sickness
450 ☐ Has Osteoarthritis
451 ☐ Has Rheumatism
452 ☐ Rheumatoid Arthritis
453 ☐ Joint stiffness in the morning
454 ☐ Swollen joints
455 ☐ Leg pain at rest
456 ☐ Spinal curvature
457 ☐ Low back pain
458 ☐ Neck pain
459 ☐ Pain between the shoulders
460 ☐ Shoulder/arm pain
461 ☐ Numbness/tingling in the body
462 ☐ Sleep walks
463 ☐ Stutters or stammers
464 ☐ Nerve pain

Behavior Patterns

150 ☐ Afraid to eat anywhere except home
151 ☐ Always needs someone to advise
152 ☐ Cries often
153 ☐ Difficulty concentrating
154 ☐ Difficulty falling asleep
155 ☐ Difficulty staying asleep
156 ☐ Easily angered
157 ☐ Feelings are easily hurt
158 ☐ Frequently becomes scared for no reason
159 ☐ Frequently miserable or blue
160 ☐ Has to be on guard even with friends
161 ☐ Often annoyed by people
162 ☐ Recurrent bad dreams
163 ☐ Sometimes wishes to be dead or away from it all
164 ☐ Upset by criticism
165 ☐ Poor memory
166 ☐ Scared to be alone
167 ☐ Strange people or places cause fear
168 ☐ Under considerable emotional stress
169 ☐ Unhappy when others are happy
170 ☐ Brain fog

Urinary

555 ☐ Urinates more than 2 times per night
556 ☐ Bed wetting
557 ☐ Blood in the urine
558 ☐ Difficulty starting urination
559 ☐ Painful urination
560 ☐ Frequent urination
561 ☐ Troubled by urgent urination
562 ☐ Incontinence when sneezing or laughing
563 ☐ Loses bladder control
564 ☐ Frequent bladder infections
565 ☐ Frequent kidney infections
566 ☐ Kidney stones

Men Only

585 ☐ Difficulty completing intercourse
586 ☐ Difficulty getting or keeping an erection
587 ☐ Discharge from the urethra
588 ☐ Had a vasectomy
589 ☐ Had difficulty fathering children
590 ☐ Lumps in the testicles
591 ☐ Painful genitals
592 ☐ Prostate troubles
593 ☐ Sores on external genitalia
594 ☐ Herpes
595 ☐ Sexual diseases

Women Only

610 ☐ Heavy hair growth on face or body
611 ☐ Cycles are every 27-29 days
612 ☐ Abnormal cycle >29 days and/or <26 days
613 ☐ PMS
614 ☐ Menstrual cramps
615 ☐ Painful periods
616 ☐ Acne worse at menstruation
617 ☐ Excessive menstrual flow
618 ☐ Retains fluid during periods
619 ☐ Pre-menstrual depression
620 ☐ Currently taking birth control medication
621 ☐ Has taken birth control medication more than 1 year
622 ☐ Has taken birth control medication within the last year
623 ☐ Has had miscarriage
624 ☐ Hot flashes
625 ☐ Takes hormone replacement medication
627 ☐ Diminished sexual desire
628 ☐ Painful intercourse
629 ☐ Poor or infrequent orgasm
630 ☐ Lumps in the breasts
631 ☐ Tender breasts
633 ☐ Vaginal discharge
634 ☐ Bloody spotting discharge
635 ☐ Yeast infections
636 ☐ Sores on external genitalia
637 ☐ Herpes
638 ☐ Sexual diseases
639 ☐ Endometriosis
640 ☐ Breast reduction
641 ☐ Breast augmentation
642 ☐ Abortion
643 ☐ D&C
644 ☐ Tubal pregnancy
645 ☐ Uterine fibroids
646 ☐ Ovarian fibroids
647 ☐ Breast fibroids
648 ☐ Currently Breastfeeding

Medications

Please list all drugs you are currently taking on a daily basis.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc.)

☐ Dairy	☐ Gluten	☐ Ragweed	☐ Sulfa drugs
☐ Eggs	☐ Mold	☐ Shellfish	☐ Tree nuts
☐ Garlic	☐ Peanut	☐ Soy	☐ Wheat

☐ Other _____

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

VITAMIN	***BRAND***	***DOSAGE***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law. Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitration a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

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Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Mohrdar Institute Stamp

_____
(If Representative, Print Name and Relationship to patient)