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WELLNESS HEALTH INFORMATION QUESTIONNAIRE

Name: _____ Date: ___ / ___ / ___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ DOB: ___ / ___ / ___

Occupation: _____ Age: _____ Ht. _____ Wt. _____ #Children _____

Marital status single partner married separated divorced widow(er)

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Reason for office visit? _____

Current problems which you are being treated: _____

List all current medications/supplements:

Medications: _____ Supplements: _____

Allergies: _____

Major Hospitalizations, surgeries, Injuries: List all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Have you ever had any of the following conditions? (check all that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> obesity |
| <input type="checkbox"/> allergy/hay fever | <input type="checkbox"/> depression | <input type="checkbox"/> infection, chronic | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes | <input type="checkbox"/> inflammatory bowel | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> asthma | <input type="checkbox"/> diverticular disease | <input type="checkbox"/> irritable bowel | <input type="checkbox"/> STD |
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> drug addiction | <input type="checkbox"/> kidney/bladder s | <input type="checkbox"/> seasonal affective dis |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> epilepsy | <input type="checkbox"/> liver/gallbladder | <input type="checkbox"/> skin problems |
| <input type="checkbox"/> blood pressure | <input type="checkbox"/> emphysema | <input type="checkbox"/> mental illness | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> gout | <input type="checkbox"/> migraines | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> cancer | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> urinary tract infection |
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> food intolerance | <input type="checkbox"/> neurological problem | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> carpal tunnel | <input type="checkbox"/> GERD reflux | <input type="checkbox"/> sinus problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> cholesterol, elevated | <input type="checkbox"/> genetic disorder | <input type="checkbox"/> stroke | _____ |
| <input type="checkbox"/> circulatory problem | <input type="checkbox"/> glaucoma | <input type="checkbox"/> thyroid trouble | _____ |

Medical conditions women:

- | | | |
|--|--|--|
| <input type="checkbox"/> irregular menses | <input type="checkbox"/> pelvic inflammation | <input type="checkbox"/> # pregnancies _____ |
| <input type="checkbox"/> endometriosis | <input type="checkbox"/> vaginal Infections | <input type="checkbox"/> C-section |
| <input type="checkbox"/> infertility | <input type="checkbox"/> STD | <input type="checkbox"/> last menstrual cycle: _____ / _____ / _____ |
| <input type="checkbox"/> fibrocystic breasts | <input type="checkbox"/> last GYN exam _____ | <input type="checkbox"/> menstrual changes |
| <input type="checkbox"/> fibroid/ovarian cysts | <input type="checkbox"/> Mammogram + - | <input type="checkbox"/> surgical menopause |
| <input type="checkbox"/> premenstrual syndrome | <input type="checkbox"/> PAP + - | <input type="checkbox"/> menopause |
| <input type="checkbox"/> breast cancer | <input type="checkbox"/> birth control _____ | <input type="checkbox"/> other _____ |
| | <input type="checkbox"/> # children _____ | |

Medical conditions men:

- | |
|--|
| <input type="checkbox"/> benign hyperplasia |
| <input type="checkbox"/> prostate cancer |
| <input type="checkbox"/> decreased sex drive |
| <input type="checkbox"/> infertility |
| <input type="checkbox"/> STD |
| <input type="checkbox"/> decreased muscle mass |
| <input type="checkbox"/> fatigue |
| <input type="checkbox"/> other _____ |

Family History:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes | <input type="checkbox"/> heart attack | <input type="checkbox"/> stroke |
| <input type="checkbox"/> asthma | <input type="checkbox"/> drug addiction | <input type="checkbox"/> mental illness | <input type="checkbox"/> suicide |
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> eating disorder | <input type="checkbox"/> migraines | <input type="checkbox"/> thyroid disease |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> glaucoma | <input type="checkbox"/> neurological disorder | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> cancer | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> obesity | |
| <input type="checkbox"/> depression | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> osteoporosis | |

Do you experience any of these general symptoms EVERY DAY?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> debilitating fatigue | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> diarrhea | <input type="checkbox"/> pain/inflammation |
| <input type="checkbox"/> depression | <input type="checkbox"/> headaches | <input type="checkbox"/> constipation | <input type="checkbox"/> itching/ rash |
| <input type="checkbox"/> disinterest in sex | <input type="checkbox"/> dizziness | <input type="checkbox"/> fecal incontinence | <input type="checkbox"/> bleeding |
| <input type="checkbox"/> disinterest in eating | <input type="checkbox"/> nausea | <input type="checkbox"/> urinary incontinence | <input type="checkbox"/> low grade fever |
| <input type="checkbox"/> panic attacks | <input type="checkbox"/> vomiting | <input type="checkbox"/> discharge | <input type="checkbox"/> insomnia |

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What is your current stress level? 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems):

Do you consider yourself: underweight overweight just right. Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pound or more in the last three months? **Y N**

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., fireman, etc.):

Health Habits:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Tobacco:
#cigarettes day _____
chew _____ | <input type="checkbox"/> Alcohol:
wine / beer / liquor
#ounces day/wk _____ | <input type="checkbox"/> Caffeine:
coffee/ tea / soda / other
#6 oz. cups day _____ | <input type="checkbox"/> Narcotics
Methamphetamines
<input type="checkbox"/> other _____ |
|---|--|--|---|

Exercise:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> 5-7 days per week | <input type="checkbox"/> > 45 min. duration | <input type="checkbox"/> walk # days/wk _____ | <input type="checkbox"/> weights # days/wk _____ |
| <input type="checkbox"/> 3-4 days per week | <input type="checkbox"/> 30-45 min. duration | <input type="checkbox"/> jog # days/wk _____ | <input type="checkbox"/> cycle # days/wk _____ |
| <input type="checkbox"/> 1-2 days per week | <input type="checkbox"/> < 30 min. duration | <input type="checkbox"/> run # days/wk _____ | <input type="checkbox"/> other: _____ |

Nutrition & Diet:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Mixed food diet | <input type="checkbox"/> vegan | <input type="checkbox"/> fat restriction | <input type="checkbox"/> calorie restriction |
| <input type="checkbox"/> vegetarian | <input type="checkbox"/> salt restriction | <input type="checkbox"/> carb restriction | <input type="checkbox"/> other _____ |

Food Restrictions:

- | | | | |
|--------------------------------|-------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> dairy | <input type="checkbox"/> eggs | <input type="checkbox"/> corn | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> wheat | <input type="checkbox"/> soy | <input type="checkbox"/> all gluten | <input type="checkbox"/> other _____ |

Food Frequency (number of servings per day):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> fruits _____ | <input type="checkbox"/> grains _____ | <input type="checkbox"/> dairy/eggs _____ | <input type="checkbox"/> poultry _____ |
| <input type="checkbox"/> vegetables _____ | <input type="checkbox"/> legumes _____ | <input type="checkbox"/> meat _____ | <input type="checkbox"/> fish _____ |
| <input type="checkbox"/> water _____ | | | |

Eating Habits:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> skip meals _____ | <input type="checkbox"/> two meals/day | <input type="checkbox"/> small frequent meals | <input type="checkbox"/> eat constantly whether |
| <input type="checkbox"/> one meal/day | <input type="checkbox"/> three meals/day | <input type="checkbox"/> eat on the run | hungry or not |

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Current Supplements:

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> multivitamin/mineral | <input type="checkbox"/> Magnesium | <input type="checkbox"/> Herbs | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Vitamin C | <input type="checkbox"/> Zinc | <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Vitamin E | <input type="checkbox"/> Acidophilus or flora | <input type="checkbox"/> Protein shakes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Vitamin D | <input type="checkbox"/> Amino acids | <input type="checkbox"/> Superfoods | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> EPA/DHA | <input type="checkbox"/> Antioxidants | <input type="checkbox"/> Liquid meals(ensure) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Evening Primrose | <input type="checkbox"/> Digestive enzymes | <input type="checkbox"/> Minerals _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Calcium | <input type="checkbox"/> CoQ10 | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

What are your health goals?

At Paradise Medspa & Wellness, I would like to accomplish? (check all the apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> feel more vital | <input type="checkbox"/> get rid of allergies | <input type="checkbox"/> better muscle tone | <input type="checkbox"/> be less indecisive |
| <input type="checkbox"/> have more energy | <input type="checkbox"/> use less OTC meds | <input type="checkbox"/> be more flexible | <input type="checkbox"/> increase motivation |
| <input type="checkbox"/> more endurance | <input type="checkbox"/> stop using laxatives | <input type="checkbox"/> reduce stress | <input type="checkbox"/> reduce risk of disease |
| <input type="checkbox"/> less tired after lunch | <input type="checkbox"/> improve sex drive | <input type="checkbox"/> focus & think clear | <input type="checkbox"/> slow down aging |
| <input type="checkbox"/> sleep better | <input type="checkbox"/> lose weight | <input type="checkbox"/> improve memory | <input type="checkbox"/> longer, healthier life |
| <input type="checkbox"/> be free of pain | <input type="checkbox"/> burn more body fat | <input type="checkbox"/> decrease depression | <input type="checkbox"/> stop "treating" &
start living |
| <input type="checkbox"/> get less colds & flu | <input type="checkbox"/> build strength | <input type="checkbox"/> decrease moodiness | |

Patients Signature: _____ Date: _____

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PARADISE MEDSPA & WELLNESS
CHECK, CANCELLATION & CREDIT CARD FILE POLICY

Paradise Medspa & Wellness accepts the following forms of payment for services and products at our office: Cash, Credit Card (Visa/Mastercard/Discover/American Express), Cashier's Checks, Money Orders, Care Credit, or Debit Cards that have Credit option. Checks are **not accepted** as a form of payment at our office unless the check is being used as a prepayment for future services scheduled more than 2 weeks from the date of receipt.

It is our policy to require a **24 hour notice of cancellation** for a scheduled appointment. In the event that you must cancel your appointment with less than a 24 hour notice, we will assess a cancellation fee of **\$125** or the cost of the service, whichever is less.

By signing this form, you are agreeing to our cancellation policy and to the cancellation fee for less than 24 hours notice or "no show."

Signature of Patient

Date

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information.

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinated, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that our relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglects: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Sections 164.500.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing) for the clinic. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you. **Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization Or Opportunity To Object Unless Required By Law**

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You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “**designated record set**” contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction or your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request and explanation for you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in the Notice of Privacy Practices.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at this time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Complaints

You may complain to us or to the Office of Civil Rights if you believe your privacy right have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may obtain the address of the OCR Regional Manager, from our privacy officer.

This notice was published and becomes effective on/or before **12/20/2007**.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient's Name: _____ Date: ___ / ___ / ___