The Office of Dr. Mischa Grieder, N.D.

at

San Francisco Preventive Medical Group

Dear New Patient,

Welcome to the office of Dr. Mischa Grieder at San Francisco Preventive Medical Group! The enclosed New Patient Package contains our office policies and procedures, as well as a comprehensive intake form. The following checklist will help you navigate the packet.

- ☐ Read the welcome letter that highlights the office policies and procedures for appointments, labs, financial information, and pricing. Please be sure to sign the end of the letter and our cancellation policy.

- ☐ Enclosed are a symptom check sheet, medical history and physician contact form, and a medication list. We ask you return it to our office 7 days prior to your appointment. If you are unable to scan the forms and send them back, please arrive at least 15 minutes early to your appointment.

Lastly, when you arrive at our office, you will be enrolled in Elation's Patient Passport. Elation is the Electronic Medical Record (EMR) software utilized by our office. The Passport is our preferred method of contact for the office. You can use it to request appointments, order supplements, keep us updated of any symptoms, and directly contact Dr. Grieder.

In the case of urgent clinical matters that require his attention during the evening and weekend hours, you may contact Dr. Grieder via email at **grieder@me.com**

Please remember, if you are experiencing a medical emergency, go to the Emergency Room or dial 911.

We look forward to meeting you!

Best,

The SFPMG Team

The Office of Dr. Mischa Grieder, N.D.

at

San Francisco Preventive Medical Group

Dear Patient,

Thank you for choosing our practice for your medical care. Dr. Grieder is a licensed Naturopathic Doctor with a focus on the treatment of chronic illness, specifically tick-borne diseases and immune related disorders, through an integrative approach. We are pleased that you have chosen to entrust Dr. Grieder with your healthcare needs and look forward to assisting you on your journey to health. We would like to take this opportunity to provide you with the necessary information regarding your upcoming appointment at our office. To make your visit as productive as possible, please read the following carefully prior to visiting our office.

- **Complete the enclosed patient information and history sheets prior to your arrival at the clinic.** It is extremely important for you to complete them to the best of your availability. This will help ensure a more complete and accurate evaluation.
- **We ask you return this packet to our office (7) seven days prior to your appointment. Packets brought in the day of the appointment may affect your time with the doctor as he cannot review you history and symptoms in advance.** (Exceptions would include appointments made less than 7 days in advance)
- Patients who are being evaluated for Lyme disease and other tick-borne diseases often have extensive histories with multiple symptoms, physician encounters, and numerous tests and procedures. It will greatly assist Dr. Grieder to document your history in the form of a brief timeline. You may use the chronological medical history form, or a separate sheet of paper. **If you have already obtained positive testing for Lyme disease, please make sure you bring copies of those results to your initial appointment. Also, please include any relevant lab work or test results from the last three years.** Should copies need to be made in our office, you may be charged for extensive copying operations.
- **Please supply a copy of your current driver's license and insurance card (back and front).** While we are a "fee for service" clinic, having your insurance information on file will be necessary to provide you with proper paperwork to process your claim, should you choose to do so. It will also aid in the prior authorization process for prescriptions should your insurance require it for certain medication coverage.
- **Please arrive (15) fifteen minutes prior to your scheduled appointment time.**
- **We require (5) five business days' notice if you need to cancel or reschedule your appointment. Cancellations made within 5 days of the appointment will result in the forfeit of the deposit.**
- Please read the cancellation policy closely and sign at the end of the document.
- **If you know that you may be late for your appointment, please call our office at 415-566-1000.** If your tardiness exceeds twenty minutes, you may need to reschedule your appointment for another day.

If you have any questions regarding your travel, appointments, or the enclosed forms, please do not hesitate to contact the office. Next, in order to provide you with the quality of service that ensures your needs are best met, we ask that you please review our practice policies prior to your visit.

We look forward to meeting you,

Dr. Grieder and staff

The Office of Dr. Mischa Grieder, N.D.

at

San Francisco Preventive Medical Group

Scheduling

We realize that many of our patients are not local to San Francisco and travel from a distance to visit Dr. Grieder. In order to properly care for you, we require that you come to our office for follow-up visits and regular consultation. *Patients should plan to be seen every 4-8 weeks, depending on the complexity of their illness.* Phone consultations are available for in between appointments, but are not meant to replace in office follow up visits. Please take the travel requirement into your decision to visit Dr. Grieder at San Francisco Preventive Medical Group. At the time of your initial visit, a follow-up visit will also be scheduled to discuss our findings. *This must be an on-site visit.*

New Patients

Dr. Grieder accepts new patients from either physician referral or self-referral. As a patient of Dr. Grieder, we strongly recommend that your Primary Care Physician be informed of our evaluation and treatment plans. This is not to say that your doctor must agree with our theories; however, the physicians to whom you entrust your health need full disclosure of any medications and/or supplements that could possibly interact with other prescriptions.

Your initial appointment:

In order for your appointment to be efficient and productive, you must have all forms in this packet completed and sent into our office at least 5 days prior to your arrival at the office. Should you have any questions on the packet, please contact our office at 415-566-1000. On the day of your appointment, please arrive at the clinic 15 minutes prior to your scheduled appointment time.

At your initial appointment, Dr. Grieder will do the following:

- Review your admission packet
- Obtain a thorough history
- Review any previous lab testing
- Perform a physical assessment
- Answer questions about our practice

Dr. Grieder will also recommend any pertinent testing, discuss treatment options, and recommend a treatment schedule if indicated. **Please plan to spend up to two hours at this visit.**

***It is highly recommended that a family member, partner, close friend, or advocate accompany the patient to their initial evaluation. This is to ensure a most successful and productive appointment.**

About Laboratory Testing:

Following this encounter, you may have blood drawn for lab tests. Some labs, such as those performed by Quest or Labcorp may be covered by your insurance. Please make sure that your insurance information is presented to the laboratory technicians when services are rendered.

Additionally, we may use specialty labs (including IGeneX) that do not accept insurance assignments, therefore prepayment is required. In regards to tick-borne illnesses, if your labs do not show a Center for Disease Control (CDC) positive result, it may be necessary to repeat specific labs due to current regulations prior to initiation of treatment.

The Office of Dr. Mischa Grieder, N.D.

at

San Francisco Preventive Medical Group

Labs prior to your visit:

If you have had testing for Lyme disease, or other relevant conditions, please bring the results to you.

Your second visit:

The purpose of the second visit is to review your new lab results with Dr. Grieder and to further develop the plan of care specifically tailored to you. This must be an **on-site** visit. *We do not fax any lab results prior to the second visit. Following this second visit, copies of lab results are available upon request.*

Please plan to spend up to **one (1) hour for this visit.**

Follow up visits:

Follow-up visits are scheduled according to your clinical needs and will vary according to the type of treatment you are prescribed. *In general, follow-up visits are every 4-8 weeks depending on the complexity of your illness and current protocol.* Please plan to spend **thirty (30) minutes at these visits.**

Prescription refill requests:

Should you need to have a prescription refilled, **please call your pharmacy and have them fax a refill authorization request form to 415-665-6732. The office will not refill any request directly from patients unless an original prescription is needed.** Please allow 24-48 hours for our staff to process this request. Neither Dr. Grieder nor the staff have access to patient charts after hours or on weekends; therefore prescriptions can only be handled during regular business hours.

Financial

Dr. Mischa Grieder, N.D. is fee-for-service, self-pay practitioner. Payment is due at the time services are rendered. We will provide you with a super bill, which you may submit to your insurance company or HSA/FSA. Depending on your insurance plan and coverage, it is possible you may be eligible for reimbursement. Additionally, we do our best to use utilize commercial labs where insurance is accepted, and work with companies that can ensure some medication coverage. Unfortunately, we cannot guarantee coverage on behalf of your insurance company. We regret that today's insurance can be so complicated; it is your responsibility to understand your insurance plan. If you have any questions regarding the rules and coverage provided by your health insurance, please contact the insurance company directly.

Dr. Grieder does not participate with any U.S. Federal Gov't Health Insurances, including Medicare/Medicaid or Tricare. However, supervising physician Paul Lynn does participate in Medicare/Medicaid and to maintain an active status as his patient, you must be seen by him every six (6) months. Depending on the type of health insurance the patient has, the patient may be required to sign an Advance Beneficiary Notice (ABN) or Balance Billing Waiver, which states that a patient accepts the clinic fees for services and waives the allowable fee limitations.

I have read the above policies and understand what is required of me as a patient of Dr. Grieder, N.D.

_____ _____

Patient Signature **Date**

The Office of Dr. Mischa Grieder, N.D.

at

San Francisco Preventive Medical Group

_____ _____

Patient Representative/Guardian Signature **Date**

Fee Schedule

Fee Schedule for Dr. Mischa Grieder, N.D.*

Type of Appointment	Appointment Fee	Appointment Description
Initial Visit with Dr. Grieder	$775	This visit includes a complete evaluation by Dr. Grieder. Please allow up to two (2) hours for this visit, which includes a review of your medical history, current health and symptoms, medical records or test results, and a physical examination. To schedule this appointment, we require a deposit. Failure to cancel within the required time period will result in the loss of deposit.
Second Visit	Up to $600	This visit includes a review of your lab and test results and planning session for your treatment protocol for ongoing care. Please allow up to one (1) hour for this visit.
Follow-up visits	30 minutes: $300 45 minutes: $450 60 minutes: $600	This visit will include an evaluation of your treatment response and plans for ongoing care. These visits are traditionally 30 minutes in length, but longer visits may be scheduled.
Between visit phone consultation	15 minutes - $150 30 minutes - $300 5 min add on - $50	We realize the hardship of travelling to the office from far distances, and so established patients are offered phone consultations, but are not meant to replace in-office appointments. This option is also available for in-town patients who need extra care between regular appointments. *Prior to phone consults, we ask patients to submit a current medication/supplement and symptom list. Failure to submit this information 24 hours prior to the scheduled appointment will result in the appointment being rescheduled.*

*Prices are subject to change without notice.

Payment methods accepted include cash, personal check and all major credit cards with the exception of American Express

- **If a patient's tardiness exceeds twenty (20) minutes, they will need to reschedule their appointment.**
- **All cancellations made with more than 48 business hours' notice will not incur a fee.**
- **Cancellations made with less than 48 hours' notice will incur a penalty of ½ the cost of the visit.**
- **No show appointments will be responsible for paying the full cost of the appointment.**

The Office of Dr. Mischa Grieder, N.D.

at

San Francisco Preventive Medical Group

Cancellation and No-Show Policy

Dear Patients,

We understand your life is busy and scheduling can be challenging at times, as it can be with us as well. While we truly sympathize with you, the clinic cannot absorb the financial responsibility of last minute cancellations.

Please read and sign the cancellation policy below. In fairness to all patients, this policy is in effect regardless of the reason for cancellation. This is to benefit all patients in our office and to respect our time and yours. Our office and community is grateful for your understanding.

Best,
San Francisco Preventive Medical Group

Cancellation Policy of San Francisco Preventive Medical Group

I _____, accept the following cancellation policy for
(First and Last Name)

phone and office appointments.

- If an appointment is cancelled 48 business hours or more in advance we are happy to reschedule with no fee.
- If an appointment is scheduled less than 48 business hours before an appointment, you will be charged half of the appointment cost.
- If an appointment is cancelled on the same day, you will be charged the full appointment cost.
- Cancellations are only accepted via the patient portal, email, or directly speaking with a staff member.

_____ _____

Patient signature Date

San Francisco Preventive Medical Group

Mischa Grieder, ND
Paul Lynn, MD
380 West Portal Avenue Suite. C
San Francisco, CA 94127
Telephone: (415)-566-1000
Fax: (415)-665-6732

AUTHORIZATION TO RELEASE MEDICAL RECORDS

☐ *STAT* ☐ *ROUTINE*

DATE: _____/_____/_____

A	**TO:**
	FAX NUMBER:
	TELEPHONE NUMBER:

B		
	PATIENT'S NAME	**PATIENT'S D.O.B**
	PATIENT SIGNATURE	**DATE**

You are hereby authorized and requested to furnish to us any and all medical information, history, records, diagnosis, reports or X-rays in your possession concerning the undersigned. If faxing is an option, please send medical records to (415)-665-6732. If a digital or pdf copy is available please email to mail@sfpmg.com.

C	☐ **Paul Lynn, M.D.**	☐ **Mischa Grieder, N.D.**
	PHYSICIAN SIGNATURE	**DATE**

The Office of Dr. Mischa Grieder, N.D.

at

San Francisco Preventive Medical Group

Informed Consent for Integrative Medical Treatment

As a patient I have the right to be informed about my condition and recommended care. This disclosure is to help me become better informed so I may make the decision to give or withhold my consent to receive treatment.

- I understand I can request further explanation of the treatment, other alternative procedures or methods of treatment, and information about the risks of the treatment at any time.
- I understand that the U.S Food and Drug Administration has not fully evaluated or approved all nutritional, herbal and homeopathic supplements, compounded IV's/injections, ozone therapies, or bioidentical hormone replacement therapies; however, they have been widely used in Europe and the U.S for years.
- I understand that, as with drugs, hormones, nutritional supplements, herbal, and homeopathic remedies, ozone, nutritional IV therapies and injections may exhibit some side effects in certain sensitive individuals, may interact with certain allopathic medications or lab tests, or show symptoms, due to certain pre-existing disease conditions.
- I do not expect the medical provider to be able to anticipate and explain all risks and complications, and I wish to rely on the medical provider to exercise judgment in recommending the dietary supplements, medications, and treatment, that the medical provider feels at the time, based on the facts then known, is in my best interest.
- I understand that if I do not take the supplements or treatments as recommended, I may not get the desired result or may increase chances for an adverse effect.
- It is my responsibility to keep my medical provider up to date with all of the current medications and supplements that I am taking, so that he/she can make the best informed recommendations for my care.

By signing this form, I acknowledge I have carefully read, or have had read to me, and understand the above consent. I give my permission and consent to care and authorize medical treatment by San Francisco Preventive Medical Group and their staff, and I am fully aware of what I am signing. 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 and I may ask my physician for a more detailed explanation.

_____ _____

Printed Name Date

_____

Signature

The Office of Dr. Mischa Grieder, N.D.

At

San Francisco Preventive Medical Group

Today's Date ____/____/____ Primary Care Physician_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Sex

❑ M ❑ F Preferred Pronoun: Him Her They Other: _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No Gender Specified on Insurance:

Please indicate primary insurance

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

PATIENT CELL PHONE NUMBER:_____

The Office of Dr. Mischa Grieder, N.D.

at

San Francisco Preventive Medical Group

Medical History Form

Date:_____

DOB:_____

Patient Name:_____ Occupation:_____

PCP:_____ Referring Physician:_____

Allergies:

- Drugs _____
- Asthma: Hay Fever_____
- Environmental Allergies _____
- Other Allergies _____

Past Medical History:

Have you ever had any of the following diagnoses? If yes, please check the box.

❑ALS	❑Alzheimer's Disease	❑Anemia
❑Asthma	❑Autism	❑Baker's Cysts
❑Bell's Palsy	❑Bursitis (Where?_____)	❑Carpel Tunnel Synd.
❑PANDAS	❑ME/CFS	❑Encephalitis
❑Fibromyalgia	❑Iritis	❑Meningitis
❑Multiple Sclerosis	❑Polymyalgia Rheumatica	❑Prostatitis
❑Psoriasis/Eczema	❑Tendonitis	❑TMJ
❑ Heart Disease	❑ Tuberculosis	❑ Kidney Stones
❑ High Blood Pressure	❑ Positive TB Skin Test	❑ Cancer
❑ Rheumatic Fever	❑ Stomach Ulcer	❑ Stroke
❑ Heart Murmur	❑ Hepatitis	❑ Convulsions
❑ Enlarged Heart	❑ Gallstones	❑ Phlebitis
❑ Pneumonia	❑ Thyroid Trouble	❑ Bleeding Disorder
❑ Pleurisy	❑ Diabetes	❑ STI

❑ Other_____

Patient Name: Todays Date_____

_____ DOB_____

Surgeries (Please give approximate date)

❑ Tonsillectomy_____ ❑ Hysterectomy_____ ❑ Gallbladder_____

❑ Hernia Repair_____ ❑ Biopsy_____ ❑ Splenectomy_____

❑ Appendectomy_____ ❑ Ulcer Surgery_____ ❑ Joint Surgery_____

❑ Other _____

Other Hospitalizations or Accidents:

Date ***Reason***

_____ _____

_____ _____

_____ _____

_____ _____

Immunizations (Give approximate dates)

❑ Tetanus_____ ❑ Diphtheria_____ ❑ Polio_____ ❑ Childhood_____

❑Lyme_____ ❑Hepatitis_____ ❑Travel_____ ❑Military_____

❑ Other_____

Women's Health:

Are you currently, or think you may be pregnant?_____ date of last period_____

Pregnancies ____ Miscarriages ____ Live Births _____

Age Menstruation Began_____ Cycle Length_____ Duration _____

Irregular periods?_____ Spotting between?_____ Painful?_____

PMS?_____ Other_____

Family Medical History:

Father's Age _____ Health Problems or Cause of Death_____

Mother's Age _____ Health Problems or Cause of Death _____

Siblings _____ their health _____

Have any of your relatives had: (list who, ie: parent, grandparent, sibling, etc.)

❑ Diabetes_____ ❑ Tuberculosis_____ ❑ Cancer_____

❑ Allergies_____ ❑ Arthritis_____ ❑ Heart Disease_____

❑ Bleeding Disorder_____ ❑ High Blood Pressure_____

❑ Chronic Back Pain_____ ❑ Psoriasis_____

❑ Other conditions not listed_____

Patient Name: Todays Date_____

_____ DOB_____

Current Health

Do you currently have any of the following?

General

- ❑Fatigue
- ❑Fevers – high low
- ❑Flu-like symptoms
- ❑Loss of voice/hoarseness
- ❑Sore Throats
- ❑Skin Rash
- ❑Swollen Glands
- ❑Recurring Nosebleeds
- ❑Goiter
- ❑Loss of Appetite
- ❑Hair Loss
- ❑Night Sweats
- ❑Unexplained Chills
- ❑Recent Weight Change
- ❑Other:_____

Gastrointestinal & Urinary

- ❑Abdominal Pain
- ❑Frequent Indigestion
- ❑Trouble with Swallowing
- ❑Change in Bowel Habit
- ❑Constipation
- ❑Diarrhea
- ❑Bloody Bowel Movement
- ❑Diverticuloses
- ❑Irritable Bladder
- ❑Urinary Frequency
- ❑Urinary Retention
- ❑Frequent Urination at night
- ❑Blood in Urine
- ❑Slow Urinary Stream
- ❑Painful Urination
- ❑Liver Enlargement
- ❑Spleen Enlargement
- ❑Tenderness in Abdomen
- ❑Vomiting
- ❑Vomiting blood
- ❑Other:_____

Heart and Lung

- ❑Abnormal echocardiogram
- ❑Chest Pain/Tightness
- ❑EKG Abnormalities
- ❑Heart Attack
- ❑Heart Palpitations
- ❑Skipped Heartbeats
- ❑High Blood Pressure
- ❑Mitral Valve Prolapse
- ❑Swelling of Ankles or Feet
- ❑Shortness of Breath
- ❑Wheezing
- ❑Frequent Coughing
  - Dry or Productive
- ❑Coughing up Blood
- ❑Other:_____

Eye and Ear

- ❑Blind Spots
- ❑Blurred Vision
- ❑Conjunctivitis
- ❑Diminished Periph. Vision
- ❑Double Vision
  - Horizontal *or*
  - Vertical
- ❑Drooping eyelids
- ❑Flashing Lights
- ❑Lazy Eye
- ❑Light Sensitivity
- ❑Optic Atrophy
- ❑Pressure behind Eyes
- ❑Uveitis
- ❑Vision loss/blindness
- ❑Eye pain
- ❑Ringing in the Ears
- ❑Hearing loss/deafness
  - One ear *or*
  - Both ears
- ❑Other:_____

Musculoskeletal

- ❑Muscle Pain or Aches
- ❑Muscle Cramps
- ❑Stiff Muscles
- ❑Loss of Muscle Tone
- ❑Jaw Pain or Stiffness
- ❑Back Pain or Stiffness
- ❑Neck Pain
- ❑Joint Pain
- ❑Stiff Joints
- ❑Hand Pain and/or
- ❑Swelling
- ❑Elbow Pain and/or
- ❑Swelling
- ❑Shoulder Pain / Swelling
- ❑Hip(s) Pain / Swelling
- ❑Knee Pain / Swelling
- ❑Feet/Ankle Pain /
- ❑Swelling
- ❑Leg aches
- ❑Other:_____

Reproductive

- ❑Breasts:
  - Infections or discharge?
- ❑Loss of Libido (decreased sex drive/activity)
- ❑Pelvic Pain
- ❑Menstrual Irregularities - _____
- ❑Symptoms Worsen around Menstruation
- ❑Other:_____

Cont'd on following page…

Patient Name: Todays Date_____

_____ DOB_____

Neurological

❑Abnormal EEG
❑Anxiety Attacks
❑Burning Sensation:
External
Internal
❑Change in:
Smell
Taste
❑Confusion
❑Decreased Concentration
❑Dementia
❑Depression
❑Difficulty:
Chewing
Swallowing
❑Dizziness
❑Fainting
❑Fatigue
❑Hallucinations
❑Headache:
Mild
Severe
❑Migraine:
With Aura
❑Involuntary Jerking
❑Irritability
❑Memory Problems
❑Meningitis
❑Mood Swings
❑Motion Sickness
❑Muscle Twitching
Where?_____
❑Nightmares
❑Numbness
Where?_____
❑Obsessive/Compulsive Behavior
❑Panic Attacks
❑Paranoia
❑Partial Paralysis
Where?_____

Neurological, cont'd…

❑Personality Change
❑Poor balance/difficulty walking
❑Restless Legs
❑Seizures
Epileptic or
Non-Epileptic
❑Sleep Disturbances:
Falling Asleep
Waking Frequently
❑Suicidal
❑Tearfulness
❑Tingling
Where?_____
❑Tremors or Shaking
❑Weakness of Limbs
❑Unusual Clumsiness
❑Other:_____

Special Children's Questions

❑Decreased Interest in Playing?

❑Poor School Performance?

❑When did he/she start whimpering/whining?

Abnormal Lab Results

Date / Lab

❑Pos. Lyme Elisa
❑Pos. Lyme WB
IgG
IgM
❑Pos. Lyme PCR
❑Pos. Lyme Culture
❑Other positive Lyme Tests:
_____

_____

❑Pos. Babesia
❑Pos. Erlichia
❑Pos. Bartonella
❑Pos. Mycoplasma
❑Elevated Liver Enzymes
❑Eosinophilia
❑Elevated ANA
❑Elev. SED rate
❑Elev. Cholesterol
❑Elev. Anticardiolipin
❑Rheumatoid Factor
❑VDRL (Syphillis)
❑Low IgG Serum
❑Low IgG Subclasses (1, 2, 3, 4)
❑CD57
❑C4A
❑Methylation Panel

Patient Name: Todays Date_____

_____ DOB_____

Toxicity Questionnaire

Travel History:

If you have traveled outside of the U.S., please list destinations, and if applicable, any related illness here:

_____	_____	_____
Place	Date	Travel related Illness?
_____	_____	_____
Place	Date	Travel related Illness?
_____	_____	_____
Place	Date	Travel related Illness?
_____	_____	_____
Place	Date	Travel related Illness?

(Please use an additional sheet of paper if needed)

Mold Exposure:

❑In home? *If yes,* age of home_____ ❑Previous home? *If yes,* age of home_____

❑Workplace ❑School

Infection History:

Please indicate if you've had these infections, and if so, how many times.

❑ear infections_____ ❑strep_____ ❑pneumonia_____ ❑sinus_____

❑Frequent Antibiotic use? ❑Frequent use of Tylenol?

Dental:

❑Amalgams how many_____ ❑Root Canals_____ ❑implants_____

Any removed?_____ ❑infections_____

Medical:

❑Breast Implants ❑Other Implants

Silicone or Saline?

❑Blood Transfusion ❑Plasma ❑Brain Injury (acquired or traumatic)

❑CNS Injury ❑Seizure ❑Stroke

❑Chemotherapy ❑Radiation

Diet:

Aspartame Intake: ❑Artificial Sweeteners ❑Diet Tea ❑Diet Soda

High Fish Intake: ❑Tuna ❑Swordfish ❑Shark

Other Foods: ❑Wild Game ❑Mushrooms

Other:

Pesticide exposure: ❑in home ❑outside home ❑golf ❑farm

Hobbies: ❑Painting ❑Photo Development ❑Home Renovation

❑Firearms - Sanding off Paint?

Radiation: ❑Workplace ❑Cancer Treatment ❑Radon in Home

Electrical: ❑EMF ❑High Tension Wire ❑Workplace Computers

❑Transit Station

❑Well Water Consumption ❑Frequent Hot Springs

Patient Name: Todays Date_____

_____ DOB_____

Health Summary

Present Well Being:

Poor Below Average Average Fairly Good Good

Overall, how do you feel today?_____

Most Prominent Symptoms:

_____

_____

_____

Date of First Symptoms:_____

History of Tick Attachment? ❑Yes ❑No Date(s):_____

If yes, location on body:_____

Do you engage in any high-risk activities or hobbies? (ie: hiking, gardening, working with dogs)

❑Yes ❑No *if yes,* what?_____

Do you have indoor/outdoor pets?

❑Yes ❑No *If yes:* What type of animal?_____

How long have you had?_____

Do you let them sleep in your bed with you?_____

Are they sick?_____

Lifestyle:

❑Tobacco use_____per day ❑Vaping ❑Alcohol use_____drinks per week

Recreational Drugs: ❑Mushrooms ❑Cocaine ❑Ecstacy/MDMA ❑Marijuana ❑LSD

❑Caffeine (coffee, soda, tea) _____ per day ❑Exercise _____per week

❑Milk_____glasses per week ❑Healthy diet?_____

Your Birthplace:

_____

Other Cities/Towns where you have lived:

_____

_____

_____

Mischa Grieder, N.D.

Patient Name: Todays Date_____

_____ DOB_____

Past Physicians

Please list the Doctors you have seen and reason seen – Please include Naturopaths. **Begin your list with most recent Doctor**

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Patient Name: Todays Date_____

_____ DOB_____

Past Medications:

Please list past antibiotics/medications used to treat your current condition

Medication	Dosage/frequency	How long	Rx by
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Medical Tests

Tests/Imaging	Date	Results
1) CT Scan of:		
2) CT Scan of:		
3) MRI:		
4) MRI:		
5) EEG:		
6) Nerve Conduction:		
7) Cardiac:		
8) Tilt Table:		
9) Lumbar Puncture:		
10) Endoscopy:		
11) Biopsy (of):		
12) Neuropsych Eval:		
13) Other:		
14) Other:		
15) Other:		
16) Other:		

Mischa Grieder, N.D.

Patient Name: Todays Date_____

_____ DOB_____

Current Medications/Supplements

Medication/Supplement	Dosage/Frequency	How Long	Who

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

9)_____

10)_____

11)_____

12)_____

13)_____

14)_____

15)_____

16)_____

17)_____

18)_____

19)_____

20)_____

21)_____

22)_____

23)_____

24)_____

25)_____

26)_____

27)_____

28)_____

29)_____

Mischa Grieder, N.D.

Patient Name: Todays Date_____

_____ DOB_____

Chronological Case History

*Please list event dates in bullet form **chronologically**, starting from earliest date and ending with most recent. Give short (2-3 sentences) summaries of each event. If important medical event details are incomplete, please bring copies of Doctor's office or hospital encounter information.*

Date/Event/Doctor/Description:

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Date/Event/Doctor/Description:

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Date/Event/Doctor/Description:

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Date/Event/Doctor/Description:

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Date/Event/Doctor/Description:

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Date/Event/Doctor/Description:

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Patient Name: Todays Date_____

_____ DOB_____

Chronological Case History, cont'd…

Date/Event/Doctor/Description:

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Date/Event/Doctor/Description:

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Date/Event/Doctor/Description:

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Date/Event/Doctor/Description:

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