Welcome! Below you will find detailed information regarding your New Patient Visit.

PLEASE DOWNLOAD AND COMPLETE THE NEW PATIENT FORMS BEFORE YOUR VISIT

Please click on this link or copy and paste it into your browser

http://www.nalinichilkov.com/our-practice/patient-forms

Driving and parking information is available on our website at
http://www.nalinichilkov.com/contact-us

If you need to reschedule your appointment we appreciate 48 hours advance notice

WHAT TO BRING TO THE FIRST VISIT:

1. **Completed New Patient Forms**
2. **Supplements and Medications**: A list of all of your current supplements and medications AND also bring the actual bottles of your herbs and supplements
3. **Records**: Any pertinent medical records. Medical records can only be released with your authorization. A medical records release form is included for your use. You are responsible for obtaining previous medical records from other physicians or health care providers. Please contact your physician or other health care provider to obtain these records.

Bring your records with you to your first visit OR have them sent

- By Fax: 424-280-3014
- By Email: patients@healthtools.com
- By Mail: 2428 Santa Monica Blvd., Ste. 100, Santa Monica, CA 90404

If you do not have relevant records for review at your first appointment Dr. Chilkov will review them at a later date.

Time: On the first visit Dr. Chilkov will spend approximately 60 minutes with you going over your health and lifestyle history in detail and discussing all of your concerns.

The first visit may or may not include a treatment, depending upon the complexity of your history and the nature of your concern. Of course, if you are in pain or suffering from an acute condition, an exam and treatment will be included. If your history is complex the examination and treatment will be done on your second visit.

We accept cash, checks, Visa, Mastercard and American Express for payment.

If you have any questions or concerns please do not hesitate to contact us at

310-453-5700 or patients@healthtools.com

To learn more about Integrative Cancer Care visit Dr. Nalini's LIVE WELL Blog

http://integrativecanceranswers.com/live-well-blog

To join our private exclusive patient email list PLEASE CLICK HERE

We look forward to being of service to you!

CHILKOV CLINIC
ORIENTAL WELLNESS MEDICINE
INTEGRATIVE CANCER CARE

CONFIDENTIAL

TODAY'S DATE_____

PATIENT BILLING AND CONTACT INFORMATION

Name:_____ Social Security Number:_____

Parent's Name(s) *(if patient is a child)*_____

Address:_____ City:_____State:_____ZipCode:_____

Birthdate:_____Age:_____Sex:_____Marital Status:_____

Home Phone:_____Fax:_____

Cell Phone:_____Email Address:_____

Occupation:_____Employer:_____

Address:_____ City:_____State:_____ZipCode:_____

Work Phone:_____Work Fax:_____Employer's Phone:_____

Spouse's Name:_____Phone Number:_____

Who is responsible for this account?_____

If address is same as patient's, check here: ☐

Name:_____Address:_____

City:_____State:_____ZipCode:_____Phone:_____

Referred By:_____

In case of Emergency contact: Name:_____Phone:_____Relationship:_____

☐ YES!!!

Please add me to Dr. Chilkov's Exclusive email list_____

1158 26th Street, Ste. 496
Santa Monica, CA 90403
Phone (310) 453.5700 Fax(424) 280-3014
patients@healthtools.com
www.nalinichilkov.com

OFFICE POLICIES AND FINANCIAL AGREEMENT

The fees charged in this office are comparable to those charged by other specialists with similar qualifications in this area. The fees for office services, supplements and supports are payable in full at the time of your visit unless other arrangements have been made.

Phone and email consultations (longer than 5-10 minutes) are charged on an hourly rate.

If it is necessary for you to cancel or reschedule an appointment we require a **FULL 24 HOURS NOTICE** to change your appointment without charge. Any *appointments canceled or rescheduled without 24 hours notice* will be charged for a *full office visit*. Please realize we have reserved this time for you and that another person in need of care will be able to have time with the doctor when 24 hours notice is given. If you are more than 20 minutes late for your appointment, we may not be able to accommodate you.

Please understand that we have no payment agreements with your insurance company. Insurance benefits are a matter between you and your insurance company. We will be happy to supply you with any information you may need to assist you in procuring payment of your medical claims. Submission of medical insurance claims is the responsibility of the insured.

If you are a patient who has had a non-work related accident, automobile or other injury, it is your responsibility to provide us with the name and address of both the responsible insurance companies and that of your attorney.

We reserve the right to make a finance charge at an interest rate of 1.5% per month for every month that your account remains overdue after 30 days.

I have read, understand, and agree to the above policies.

Name (Print)_____

(If patient is a minor) Name of child for whom I am parent or legal guardian_____

_____ _____

Signature Date

☐ By typing my name above I indicate my understanding and agreement

INFORMED CONSENT

Nalini Chilkov, L.Ac., O.M.D.. is a Licensed Acupuncturist and Doctor of Oriental Medicine. Dr. Chilkov is not a medical doctor. She does not claim to diagnose, treat, cure or prevent any medical conditions or pathologies, nor prescribe medicine, nor in any way represent herself as so doing. The services of a Doctor of Oriental Medicine cannot replace those of a licensed physician. For any medical condition, you are advised to seek care from an appropriate medical practitioner. Whether you choose to engage a medical practitioner or not to assist you in your care is your right and Dr. Chilkov assumes no responsibility for your decision in this matter.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that (a) no claims are made that acupuncture, herbal, nutritional, or dietary recommendations can treat or cure any medical condition, (b) all recommendations are given for informational purposes only, (c) there is no implied or stated guarantee of success or effectiveness of any specific acupuncture, dietary, nutritional, or herbal recommendations, (d) I am free to act upon or disregard the recommendations of Nalini Chilkov, L.Ac., O.M.D as I so choose. I hereby release Dr. Nalini Chilkov and the Office of Nalini Chilkov, O.M.D from all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage in the services offered by Nalini Chilkov, L.Ac., O.M.D. and participate in a professional relationship with her pursuant to the statements herein.

Name (Print)_____

(If patient is a minor) Name of child for whom I am parent or legal guardian_____

_____ _____

Signature Date

☐ By typing my name above I indicate my understanding and agreement

CONFIDENTIAL MEDICAL HISTORY

Name:_____ Social Security Number:_____ Age_____ Sex_____

Birthdate:_____ Marital Status:_____ Height:_____ Weight:_____

Name of Family Physician:_____ Gynecologist:_____ Chiropractor:_____

Occupation:_____ Referred By:_____

Instructions: In order to carefully evaluate your condition and acquire a thorough overview of you as a unique individual, please take the time to thoughtfully complete this questionnaire. With a detailed picture an individualized treatment plan can be developed.

Primary Reason(s) and Goal(s) for your Consultation and Treatment

_____

_____

Have you previously been treated by: ☐ Acupuncture ☐ Herbal Medicine ☐ Nutritional Therapy ☐ Homeopathy ☐ Chiropractic ☐ Name of Practitioners:_____

FAMILY HISTORY	Self	Mother	Father	Brother	Sister	Grand parents	Comments
Alive? Yes/No?		Y N	Y N	Y N	Y N	Y N	
In Good Health? Yes/No?	Y N	Y N	Y N	Y N	Y N	Y N	
Arthritis/Gout	Y	Y	Y	Y	Y	Y	
Asthma	Y	Y	Y	Y	Y	Y	
Allergies	Y	Y	Y	Y	Y	Y	
Cancer	Y	Y	Y	Y	Y	Y	
Diabetes	Y	Y	Y	Y	Y	Y	
Epilepsy	Y	Y	Y	Y	Y	Y	
Heart Disease	Y	Y	Y	Y	Y	Y	
High Blood Pressure	Y	Y	Y	Y	Y	Y	
Thyroid Disease	Y	Y	Y	Y	Y	Y	
Kidney Disease	Y	Y	Y	Y	Y	Y	
Emotional Disorders	Y	Y	Y	Y	Y	Y	
Stroke	Y	Y	Y	Y	Y	Y	
Ulcers	Y	Y	Y	Y	Y	Y	
Tuberculosis	Y	Y	Y	Y	Y	Y	
Bleeding Disorders	Y	Y	Y	Y	Y	Y	
Weight Problems	Y	Y	Y	Y	Y	Y	

Please check any other illness which you have had:

- ☐ Anemia
- ☐ Eczema
- ☐ Psoriasis
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Diverticulitis
- ☐ Colitis
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ Eye disease
- ☐ Gall stones
- ☐ Malaria
- ☐ Liver disease
- ☐ Typhoid fever
- ☐ Yeast infection
- ☐ Tropical disease
- ☐ Neuralgia
- ☐ Pancreatitis
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Chicken pox
- ☐ Measles
- ☐ Mumps
- ☐ Jaundice
- ☐ Parasites
- ☐ Chronic fatigue syndrome
- ☐ Epstein Barr Virus
- ☐ *Sexually transmitted disease:*
  - ☐ Herpes
  - ☐ Gonorrhea
  - ☐ Syphilis
  - ☐ HIV
  - ☐ Genital warts (HPV)
- ☐ Other:_____

DIAGNOSTIC TESTS AND IMMUNIZATION HISTORY - PLEASE NOTE THE YEAR (*if known*)

X-RAY/ULTRASOUND

☐ Chest ☐ Kidney ☐ Upper GI ☐ Lower GI
☐ Gall Bladder ☐ Sinus ☐ Bone ☐ Spine

CT-SCAN/MRI

☐ Brain ☐ Bone
☐ Spine ☐ Other:_____

OTHER TESTS/EXAMS

☐ Thyroid Test/Exam ☐ Mammogram ☐ Prostate Exam
☐ Hearing Test ☐ PAP Smear ☐ EKG (*Electrocardiogram*)
☐ Eye Exam ☐ Urine Test ☐ EEG (*Electroencephalogram*)
☐ Blood profile ☐ Bone Density (*Osteoporosis screen*)
☐ Other:_____

VACCINES & IMMUNIZATIONS

☐ Smallpox ☐ Flu ☐ DPT (*Diptheria, pertussis-typhoid*)
☐ Hepatitis ☐ Yellow Fever ☐ MMR (*Measles, mumps, rubella*)
☐ Polio ☐ Cholera ☐ HPV
☐ Typhoid ☐ Malaria Pills ☐ Other:_____

Please name physicians and practioners you are currently seeing or have seen in the past two (2) years:

Name	Reason for Visit	Date or Age

Please list past illnesses, accidents, injuries or surgeries:

Current prescriptions or over the counter medications:

Past use of antibiotics or steroids (*prednisone, cortisone, etc.*)

Current vitamins, herbal, homeopathic and natural medicines: (*Attach separate sheet if necessary*)

Are you now or have you ever taken:

- ☐ Birth control pills
- ☐ Anti-anxiety medication
- ☐ Antihistamines
- ☐ Estrogen or Progesterone
- ☐ Thyroid medication
- ☐ Chemotherapy
- ☐ Sedatives or sleeping pills
- ☐ Allergy Shots
- ☐ Radiation Therapy
- ☐ Anti-depressant medication
- ☐ Pain Medication
- ☐ Other:_____

Please list any know allergies (*food, drugs, pollens, animals, etc.*)

LIFESTYLE

Have you ever smoked cigarettes? ☐ Y ☐ N Currently Smoking ☐ Y ☐ N

If yes, how long?_____Packs per day_____ If yes, do you want to quit? ☐ Y ☐ N

Recreational drug use ☐ Past ☐ Present ☐ IV Drug Use

Do you drink alcohol? ☐ Y ☐ N How often?_____ Type_____

Do you drink ☐ Coffee ☐ Black tea ☐ Decaf ☐ Regular _____Total cups per day

	Exercise	TV	Computer	Yoga	Meditation	Outside	Inside
Amount of time spent daily (hours)							

DIET

What do you eat for:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

☐ Cook for yourself ☐ Eat out ☐ Use artificial sweeteners or Splenda ☐ Carbonated beverages ☐ Diet beverages

Are you on a Special Diet ☐ Y ☐ N If yes, why, and please describe:

Cravings (C) and Aversions (A)

____ Salty	____ Sour	____ Sweet	____ Spicy	____ Bitter
____ Bread/Pasta	____ Oily/Fatty	____ Eggs	____ Milk/Dairy	
____ Chocolate	____ Warm Foods	____ Iced/Cold Foods	____ Other: _____	

Eating Issues

☐ Weight Fluctuations	☐ Overeating	☐ Bulimia	☐ Use of diet pills/appetite suppressants
☐ Food Binges	☐ Anorexia	☐ Vomit after eating	
☐ Frequent Dieting	☐ Dissatisfied with current body weight	☐ Satisfied with current body weight	

Other problems with food or eating habits:

SYMPTOMS REVIEW

Instructions: Check any of the following symptoms that have bothered you in the past six (6) months. Please comment about frequency, time of last occurrence, duration, patterns, etc.

HEAD
- ☐ Headaches
- ☐ Sore scalp/dandurff
- ☐ Dizziness
- ☐ Hair Loss

EYES
- ☐ Dry eyes
- ☐ Inflamed eyes
- ☐ Swelling or pain
- ☐ Dark Circles
- ☐ Excessive tearing
- ☐ Double Vision
- ☐ Eyeglasses
- ☐ Puffiness
- ☐ Light sensitivity
- ☐ Blurred Vision
- ☐ Contact Lenses
- ☐ Eye Surgery

EARS
- ☐ Ear Pain
- ☐ Poor hearing
- ☐ Ear Ringing
- ☐ Deafness
- ☐ Ear discharge
- ☐ Loss of Balance
- ☐ Dizziness

NOSE
- ☐ Poor sense of smell
- ☐ Post nasal Drip
- ☐ Frequent colds
- ☐ Frequent bloody nose
- ☐ Hay Fever/Allergies
- ☐ Sinus Pain
- ☐ Sinus Infection
- ☐ Sores in the nose
- ☐ Nasal obstruction
- ☐ Nose runs constantly

SENSITIVITY TO
- ☐ Dust
- ☐ Animal hair
- ☐ Molds
- ☐ Chemical fumes
- ☐ Pollens
- ☐ Pesticides
- ☐ Perfumes

MOUTH
- ☐ Bleeding gums
- ☐ Oral herpes (cold sore)
- ☐ Dental cavities
- ☐ Ulcers in mouth
- ☐ Dry lips
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Change in sense of taste

THIRST
- ☐ Normal
- ☐ Rarely
- ☐ Excessive

Prefererence for:
- ☐ Hot
- ☐ Cold
- ☐ Iced
- ☐ Room temperature drinks

RESPIRATORY
- ☐ Sore throats
- ☐ Spitting up mucus often
- ☐ Bronchitis
- ☐ Blood in sputum
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Thick sputum
- ☐ Pain in breathing
- ☐ Tonsillitis
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Sensation as if something is caught in throat

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Leg cramps at night
- ☐ Cold hands or feet
- ☐ Shortness of breathe
- ☐ Ankle swelling
- ☐ Leg cramps when walking
- ☐ Heart Attack
- ☐ Swollen ankles/feet
- ☐ Heart palpitations
- ☐ Bruise or bleed easily

- ☐ Stroke
- ☐ Palpitations
- ☐ Difficulty lying flat
- ☐ Varicose veins
- ☐ High Cholesterol
- ☐ Heart murmur
- ☐ Tightness in chest
- ☐ Mitral valve prolapse
- ☐ Rheumatic fever
- ☐ Wounds become infected easily or heal slowly
- ☐ Irregular Heart Beat

SKIN

- ☐ Rash
- ☐ Itching
- ☐ Herpes
- ☐ Warts
- ☐ Pigment changes
- ☐ Abnormal sweating
- ☐ Acne with stress
- ☐ Skin or nail fungus
- ☐ Dryness
- ☐ Eczema
- ☐ Acne with menstruation
- ☐ Changing moles or lumps
- ☐ Psoriasis

GASTROINTESTINAL

- ☐ Poor appetite/ Loss of appetite
- ☐ Excessive appetite
- ☐ Pain with eating
- ☐ Intestinal gas/bloating
- ☐ Poor digestion
- ☐ Nausea
- ☐ Heartburn
- ☐ Belching
- ☐ Vomiting
- ☐ Ulcers
- ☐ Food Allergies
- ☐ Spit up blood
- ☐ Hypoglycemia
- ☐ Sleepy after eating
- ☐ Difficulty swallowing
- ☐ Gall bladder problems
- ☐ Chronic Inflammatory Bowel Disease
- ☐ Diarrhea
- ☐ Loose or watery stool
- ☐ Undigested food in stool
- ☐ Black or tarry stools
- ☐ Dry hard stool
- ☐ Hernia
- ☐ Stool painful to pass
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Mucus in stool
- ☐ Use laxatives often

How often do you have a bowel movement?_____

URINARY

- ☐ Frequent urination
- ☐ Loss of force of urine stream
- ☐ Pus in urine
- ☐ Frequent bladder infections
  - ☐ with intercourse
  - ☐ with stress
- ☐ Need to urinate at night
- ☐ Sand/ gravel in urine
- ☐ Dribbling urine after urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Pain or burning with urination
- ☐ Urination with cough or sneeze
- ☐ Retain water or fluids
- ☐ Change in quantity of urine
- ☐ Hesitancy of urination
- ☐ Hands or ankles swell easily

Color of Urine:

- ☐ Clear
- ☐ Straw
- ☐ Yellow

How often do you urinate each day?_____

REPRODUCTIVE

- ☐ Decreased sexual desire
- ☐ Infertility
- ☐ Excessive sexual desire
- ☐ Celibate
- ☐ Multiple sexual partners

Sexual Orientation

- ☐ Heterosexual
- ☐ Gay/Lesbian
- ☐ Bisexual

MEN ONLY

- ☐ Burning or discharge from penis
- ☐ Anal sex
- ☐ Seminal emission
- ☐ Low sperm count
- ☐ Male sexual partners
- ☐ Premature ejaculation
- ☐ Prostate surgery
- ☐ Prostate infections
- ☐ Pain or coldness in genital area
- ☐ Prostate inflammation
- ☐ Prostate enlargement
- ☐ Swelling or lumps in testicles
- ☐ Difficulty in achieving or maintaining erection

Method of birth control_____

Frequency of intercourse_____

Date of last prostate exam_____

Have you had a PSA test (blood test screen for prostate cancer) _____

Date:_____

WOMEN ONLY

- ☐ Vaginal pain
- ☐ Vaginal sores
- ☐ Infertility
- ☐ Discharge from nipples
- ☐ Vaginal dryness
- ☐ Vaginal itching
- ☐ Ovarian cysts
- ☐ Breast lumps or cysts
- ☐ Vaginal discharge
- ☐ Pelvic infection
- ☐ Uterine fibroids
- ☐ Breast tenderness
- ☐ Vaginal infections
- ☐ Painful intercourse
- ☐ Endometriosis

Frequency of intercourse_____

Do you practice regular breast self exam?_____

Date of last mammogram_____

Date of last PAP test and pelvic exam_____

Personal or family history of cancer

- ☐ Breast
- ☐ Ovarian
- ☐ Cervical
- ☐ Other_____

MENSTRUATION & PREGNANCY

Age at First Period _____

How many days apart are your periods_____

How many days do you flow _____

- ☐ No menstrual period
- ☐ Heavy blood flow

- ☐ Light blood flow
- ☐ Menstrual cramps/pain
- ☐ Clots in blood
- ☐ Spotting between periods
- ☐ Irregular periods
- ☐ Premenstrual bloating

Premenstrual syndrome Describe

_____

_____

Are you or might you be pregnant?

☐ Yes ☐ No

Number of pregnancies_____

Number of abortions_____

Number of miscarriages_____

Number of live births_____

Caesarian sections?_____

Complications with pregnancy, labor or delivery?_____

Fertility treatment? Describe

_____

Method of birth control:

Current:_____

Past _____

MENOPAUSE RELATED:

Age when menstrual cycle ceased

_____

Currently menstruating?_____

How often_____

Changes in cycle_____

Hormone replacement therapy?

- ☐ Drugs_____
- ☐ Herbal Medicines _____
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Change in mood
- ☐ Change in sex drive
- ☐ Change in sleep

Other_____

ENDOCRINE/IMMUNOLOGIC

- ☐ Neck enlargement
- ☐ Hair or nail changes
- ☐ Intolerance to
  - ☐ Heat
  - ☐ Cold
  - ☐ Wind
- ☐ Dry skin
- ☐ Fluid retention
- ☐ Perspiration
  - ☐ Excessive
  - ☐ Diminished
- ☐ Depression
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Infertility
- ☐ Abnormal weight gain
- ☐ Unexplained fever or chills
- ☐ Night sweats
- ☐ Fatigue
- ☐ Abnormal weight loss
- ☐ Loss of feeling of well-being
- ☐ Frequent low grade fever

NEUROLOGIC

- ☐ Nervousness
- ☐ Dizziness
- ☐ Numbness
- ☐ Tremors
- ☐ Shaking Seizures
- ☐ Convulsions
- ☐ Loss of coordination
- ☐ Paralysis
- ☐ Drowsiness
- ☐ Memory changes
- ☐ Fainting
- ☐ Muscular weakness
- ☐ Loss of sensation
- ☐ Changes in handwriting
- ☐ Nerve pain

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Muscle Spasm
- ☐ Swelling
- ☐ Stiffness
- ☐ Sciatica
- ☐ Disc Injury
- ☐ Scoliosis
- ☐ Osteoporosis
- ☐ Pain/Describe:_____

_____

_____

SLEEP

- ☐ Insomnia
- ☐ Difficulty staying asleep
- ☐ Wake up often at night
- ☐ Nightmares
- ☐ Wake up tired
- ☐ Position you sleep in_____
- ☐ Difficulty falling asleep
- ☐ Type of pillow_____

WORK

Type of work/profession

_____

Number of hours you work daily? ____

I spend much of the day:

- ☐ Sitting ☐ Lifting
- ☐ Standing ☐ On the phone
- ☐ Heavy physical work

I find my work:

- ☐ Fulfilling ☐ Enjoyable
- ☐ Boring ☐ Frustrating
- ☐ Challenging ☐ Stressful
- ☐ Exhausting ☐ Pressured

STRESS/EMOTIONS

What are your sources of stress in your life now?

_____

_____

My ability to cope with stress is: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

I am under the care of a ☐ Psychotherapist ☐ Psychiatrist

I am taking medication for ☐ Mood ☐ Sleep ☐ Pain

Please check your feelings and state that describe your tones, qualities, tendencies and experiences in the last twelve (12) months.

- ☐ Frequent stress
- ☐ Undue fatigue
- ☐ Lonely/ isolated
- ☐ Mood swings
- ☐ Difficulty with decisions
- ☐ Nervous/ anxious
- ☐ Loss of well-being
- ☐ Overwhelmed
- ☐ Listless/ lethargic
- ☐ Withdrawn
- ☐ Pressured

☐ Conflicted	☐ Shaky	☐ Fragile	☐ Forgetful
☐ Poor concentration	☐ Memory Changes	☐ Loss of mental clarity	☐ Frustrated
☐ Feeling hostile	☐ Unusual tension	☐ Angry outbursts	☐ Despair
☐ Irritable	☐ Frequent crying	☐ Sadness	☐ Depression
☐ Grief/ loss/ sorrow	☐ Disappointment	☐ Hopelessness	☐ Unhappy
☐ Suicidal thoughts	☐ Self-critical	☐ Critical of others	☐ Optimistic
☐ Content	☐ Relaxed	☐ Fulfilled	☐ Daytime sleepiness
☐ Motivated	☐ Inspired	☐ Joyful	☐ Change in marital status
☐ Disturbing dreams	☐ Insomnia	☐ Worried by little things	☐ Easily offended
☐ Perfectionist	☐ High achiever	☐ Very sensitive	☐ Introspective
☐ Change in residence	☐ Change in work/ job	☐ Death of a loved one	☐ Comfortable with myself
☐ Spiritual	☐ Religious	☐ Philosophical	☐ Substance Abuse
☐ Expressive	☐ Tend to be social	☐ Tend to be a loner	☐ Alcoholism
☐ Eating Disorder	☐ Weight problems		

TOXIC EXPOSURES

☐ Lead	☐ Radiation	☐ Tobacco	☐ Asbestos
☐ Chemical Fumes	☐ Chemotherapy	☐ Pesticides	☐ Coal
☐ Uranium	☐ Herbicides	☐ Mercury (silvery mercury dental fillings	
☐ Other: _____			

TIME OF DAY / CLIMATIC FACTORS

What hour(s) of the day do you feel at your best? (*Be specific*) ☐ ☐ AM PM At your worst? ☐ AM PM

Season/ months of the year ___Spring ___Summer ___Indian Summer ___Fall ___Winter

Do you feel better **(B)** or worse **(W)**	____ At home	____ Indoors	____ At works
	____ Outdoors	____ By the sea	____ In wind
Climate better **(B)** or worse **(W)**	____ Dry	____ Hot	____ Warm
	____ Cool	____ Cold	____ Damp
	____ Rain	____ Snow	____ Fog

List the problems below that concern you most in order of importance

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

In your opinion what are the primary factors contributing to the onset and continuation of your illness or loss of well-being?

What do you feel will help you to achieve your goals? How long do you expect the process to take?

Anything else??

CANCER HISTORY *(for cancer patients only)*

Name:_____ Date:_____

Have you ever been diagnosed with pre-cancer, cancer, a mass or a tumor? ☐ Yes ☐ No

If yes, please give details below:

Type of Cancer	Date	Location(s) of cancer cells, mass or tumor	Stage

Oncologist: Surgeon:

Radiation Oncologist: Other Physicians/(Specialty)

TUMOR MARKERS

☐ Estrogen Positive ☐ Progesterone Positive ☐ Her2 neu Positive ☐ Triple Negative

☐ HPV Positive ☐ Gleason Score ☐ Other:_____

CURRENT STATUS

Recently Diagnosed:_____ Date:_____

Surgery Date:_____ Describe:_____

Recurrence/Date/Locations:_____

Metastastis/Date/Locations:_____

Current Stage:_____

CONVENTIONAL ONCOLOGY TREATMENT

Chemotherapy: Current ☐ Past ☐ Date(s):_____

Drugs Used _____

Schedule _____ For how many weeks/months?_____

Radiation Therapy: Current ☐ Past ☐ Location_____

Type of Radiation Therapy_____

Schedule _____ For how many weeks/months?_____

Hormone Therapy: Current ☐ Past ☐ Drugs/Hormones Used_____

Date Started?_____ Date Discontinued_____

Immunotherapy

Other Medications:

Have you had any blood transfusions? Yes ☐ No ☐ If yes, how many?_____

SIDE EFFECTS ☐ Yes ☐ No *If yes, please check past or current:*

	Past	Current		Past	Current		Past	Current
Anemia	☐	☐	Change in Weight	☐	☐	Constipation	☐	☐
Diarrhea	☐	☐	Difficulty eating or swallowing	☐	☐	Difficulty performing tasks of daily living	☐	☐
Dizziness	☐	☐						
Hair Loss	☐	☐	Dry Mouth	☐	☐	Fatigue	☐	☐
Insomnia	☐	☐	Hot Flashes	☐	☐	Infection	☐	☐
Kidney damage	☐	☐	Itching	☐	☐	Joint Pain	☐	☐
Lymphedema	☐	☐	Liver enzymes	☐	☐	Loss of Appetite	☐	☐
Nausea	☐	☐	Mood Change	☐	☐	Mouth Sores	☐	☐
Rash	☐	☐	Nerve pain or damage	☐	☐	Pain/ location_____		
Vomiting	☐	☐	Scar tissue	☐	☐	Numbness/location_____	☐	☐
						Swelling/Location_____	☐	☐

DIAGNOSTIC

	Date of Most Recent		Date of Most Recent		Date of Most Recent
Mammogram		Breast MRI		Breast Ultrasound	
Bone Density		Other MRI		Other Ultrasound	
CT ScanPET Scan		X-ray		Blood Test	
Biopsy		Thermography		Prostate Exam	
Other					

OTHER TREATMENTS, THERAPY AND ACTIVITIES

☐ Acupuncture	☐ GlutaThione	☐ Psychotherapy/Counselling
☐ Herbal Medicines	☐ Insulin	☐ Support Group
☐ Nutritional Supplements	☐ Hyperthermia	☐ Prayer
☐ Homeopathy	☐ Massage	☐ Meditation
☐ Special Diet	☐ Yoga	☐ Visualization
☐ Detox/Cleanse	☐ Exercise	☐ Art Therapy
☐ IV Vitamins	☐ Other_____	

How are you feeling emotionally?

Do you have a good support system?

Anything else you would like to share or include? Any specific concerns or questions you would like to discuss?

THREE DAY FOOD INVENTORY

Name:_____

From:_____ to _____

Beginning Weight_____ Ending Weight:_____

	DAY ONE	DAY TWO	DAY THREE
MORNING MEAL			
AFTERNOON MEAL			
EVENING MEAL			
SNACKS			

Notes/Comments:

1158 26th Street, Ste. 496
Santa Monica, CA 90403
Phone (310) 453.5700 Fax(424) 280-3014
patients@healthtools.com
www.nalinichilkov.com

CONFIDENTIAL

REQUEST FOR RECORDS

Date:_____

Doctor:_____

Address:_____ Suite:_____

City:_____State:_____ZipCode:_____

Voice:_____Fax:_____Email_____

I authorize you to furnish the following information regarding my condition, history, findings and diagnosis. Please send copies today:

By Mail : Chilkov Clinic
1158 26th St. Suite 496
Santa Monica CA 90403
Please send records for the period

By Fax
(424) 280-3014

OR

By Email (PDF)
patients@healthtools.com

_____

☐ Laboratory Reports ☐ Pathology Reports ☐ Radiology Reports
☐ Surgical Reports ☐ Treatment Notes ☐ Other:_____

_____ _____
Patient Name Patient Signature (Parent if Patient is a Minor)

_____ _____
Date of Birth Social Security Number

_____ _____
Address Phone

_____ _____
City State Zip Code Fax

Thank you for your prompt attention to this matter!!!

CHILKOV CLINIC
ORIENTAL WELLNESS MEDICINE
INTEGRATIVE CANCER CARE

CONFIDENTIAL

Credit Card Authorization Form

Patient's Name *(printed)*:_____

Credit Card Type: _ Account Number:_____

Expiration Date:_____ Security Code:_____
(This is a 3 digit code found on the back of Mastercard/Visa and 4 digit on front of American Express Cards)

Relationship to Patient:_____

COMPLETE BILLING ADDRESS

Address:_____ City:_____State:_____ZipCode:_____

Telephone:_____ Email:_____

I authorize Nalini Chilkov, OMD to charge the above listed credit card for professional services which includes face to face, telephone and email consultation fees, as well as charges for review of records, re-evaluation or revision of treatment plans, evaluation of diagnostic studies, report writing and herbal and nutraceutical supplements and supplies as well as missed appointment and late payment and back fees as indicated by my signature below:

_____ _____
Cardholder's Signature Date

☐ By typing my name above I indicate my authorization, understanding and agreement

(for office use only)

☐ Authorized by Telephone
☐ Authorized by Email
☐ Received via FAX

DATE:_____

1158 26th Street, Ste. 496
Santa Monica, CA 90403
Phone (310) 453.5700 Fax(424) 280-3014
patients@healthtools.com
www.nalinichilkov.com

Understanding and Waiver of Physical Exam

Patient's Name *(printed)*:_____

Address:_____ City:_____State:_____ZipCode:_____

Primary Phone Number:_____ Email:_____

By signing below I understand that by the very nature of a phone or Skype consultation, that the clinician providing the consultativeservices is unable to perform a physical exam on a patient.

Physical exams can reveal to the clinician important information about the patient and the patient's condition. I understand that it is it is not possible to perform a physical exam during a phone or Skype consultation. I agree to furnish the name and phone number of my physicians and a copy of my most recent physical exam performed by one of my physicians. I understand that this information must be received by your office before the time and date of the phone or Skype consultation.

_____ _____

Signature Date

☐ **By typing in your name above, you agree that all the information provided is truthful and accurate and legally binding.**

_____ _____

Name

1158 26th Street, Ste. 496
Santa Monica, CA 90403
Phone (310) 453.5700 Fax(424) 280-3014
patients@healthtools.com
www.nalinichilkov.com

CHILKOV CLINIC
ORIENTAL WELLNESS MEDICINE
INTEGRATIVE CANCER CARE

Informed Consent for Telemedicine Services

(please sign on page 2)

Introduction

Telemedicine involves the use of electronic communications to enable health care providers and other practitioners at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, nutrition professionals, health coaches or other practitioners. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices, wearables, apps, and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her home or work setting (or another remote site) while the provider obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist or care team member.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time.
3. I understand that I have the right to inspect all information recorded in my medical record in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other practitioners who may be located in other areas, including out of state.
6. I understand that it is my responsibility to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize ***Dr. Nalini Chilkov and Chilkov Clinic*** to use telemedicine in the course of my diagnosis, treatment, or other care.

Print or Type

First Name _____ Last Name _____ Date of Birth

Authorization

_____ _____

Sign or Type name *Date*

☐ *By Typing in your name above you agree that all information provided is truthful and accurate and legally binding.*

I acknowledge that I have been provided a copy of this document