Dr. Natalie J. Engelbart
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YourTopLife.com
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Date of Initial Consultation: _______________ **How Did You Hear About Us?:**___________________________

Full Legal Name: ____
Last First Middle Initial

How Would You Like to Be Addressed? ____

Date of Birth: __________________Age: _____ Gender Assigned at Birth: ☐M ☐F Pronouns:______________

Primary Address: ____
Number & Street City State Zip

Mobile Phone: __________________ Home Phone: ________________ Email: _______________________

Occupation: _______________________ Employer: ______________________ Work Phone: ___________

Marital Status: check all that apply ☐ Single ☐ Married ☐ Divorced ☐ Long Term Partnership ☐Widow/Widower

# of Children __________ Age of Each Child: ____

Is Patient a Minor? ☐Y ☐N Responsible Party:____
Name Relationship Phone

Emergency Contact: ____
Name Relationship Phone

Primary Physician: ____Date Last Seen: ______________
Name Phone

Height (feet/inches)_______Current Weight _______Desired Weight Range +/- 5 lbs _____

Body Fat % if known, and method of measurement: _________________________Blood Type: ___________

Do you currently follow a special diet or nutritional program? ☐Yes ☐No

Describe: ____

Do you avoid any particular foods? ☐Yes ☐No

If yes, types and reason: ____

How many meals do you eat out per week? ☐0-1 ☐1-3 ☐3-5 ☐ >5 meals per week

HOW CAN WE HELP YOU? List your top three health problems in order of priority:

Describe Problem	Mild	Moderate	Severe
Eg: headaches		X	

Prior Treatment / Therapeutic Approach	**Excellent**	**Fair**	**Poor**
Eg: Elimination Diet	X		

List any other condition(s) you suffer from and the treatment you are receiving, if any:

____

____

____

____

SEVERE INJURIES, ILLNESSES, SURGERIES & HOSPITALIZATIONS

 None

Date:	Event:

CURRENT MEDICATIONS: Prescription and Over-The-Counter

MEDICATION	DOSE	FREQUENCY	START DATE (mo/yr)	REASON FOR USE

NUTRITIONAL SUPPLEMENTS: Vitamins, Minerals, Herbs, Homeopathy

SUPPLEMENT & BRAND	DOSE	FREQUENCY	START DATE (mo/yr)	REASON FOR USE

ALLERGIES: **List allergies or major sensitivities to any medication, supplement, food, ingredient, or environmental factor:**

____

Reaction:____

____

____

Family Medical History: List any member of your family that has been diagnosed with any of the following conditions (include deceased family members):

Heart Disease: ____________________
High Blood Pressure ____________________
Stroke ____________________
Cancer ____________________
Glaucoma ____________________
Diabetes ____________________
Epilepsy/Convulsions ____________________
Bleeding Disorder ____________________
Kidney Disease ____________________
Thyroid Disease ____________________
Neurological Disease: ____________________
Mental Illness ____________________
Osteoporosis ____________________
Addiction ____________________
Autoimmunity ____________________

Exercise Program: List current type of activity, duration of sessions , and number of sessions per week:

____

List anything that limits your ability to exercise:____________________

Sleep:

What time do typically you go to bed? ________ Wake up?______ Average hours sleep each night: _____

Trouble falling asleep? ☐Yes ☐No Trouble staying asleep? ☐Yes ☐No

Do you feel rested upon awakening? ☐Yes ☐No

Do you snore? ☐Yes ☐No

Do you use sleeping aids? ☐Yes ☐No

Explain: ____

Alcohol Consumption:

How many alcoholic beverages do you currently consume per week?1 drink = 5 oz. wine, 12 oz. beer, or 1.5 oz. spirits

☐None ☐1-3 ☐ 4-6 ☐ 7-10 ☐ >10

Previous alcohol intake: ☐None ☐Yes (☐Mild ☐Moderate ☐High)

Caffeine Intake: ☐Yes ☐No List type and quantity

____

Current or Previous Smoking or Vaping? ☐Yes ☐No

Type, how often, and for how long?____________________

Second-hand smoke exposure? ____________________

Recreational Drug Use (marijuana, psilocybin, etc)? ☐Yes ☐No

Type, how often, and for how long?____________________

Have you ever used IV recreational drugs? ☐Yes ☐No

Daily Stressors: Rate on scale of 1-10 , with 10 being the most

Work ______Family ______Social ______Finances______Health______Other (list & rank)___ __________

SYMPTOM REVIEW

Please check all symptoms experienced within the past 6 months to the present.

GENERAL

☐ Cold Hands or Feet
☐ Cold Intolerance
☐ Heat Intolerance
☐ Low Body Temperature
☐ Low or High Blood Pressure
☐ Sleep Issues
☐ Fatigue
☐ Fever
☐ Bad Breath
☐Dental and/or Gum Problems
☐ Dry Mouth
☐ Canker Sores
☐ Cold Sores
☐ Nose Bleeds
☐ Coated Tongue

HEAD, EYES & EARS

☐ Headache
☐ Migraine
☐ Sensitivity to Loud Noises
☐ Distorted Sense of Smell
☐ Distorted Taste
☐ Hearing Problems
☐ Ear Fullness or Pain
☐ Ear Ringing/Buzzing
☐ Eye Pain
☐ Vision problems (other than glasses)

MUSCULOSKELETAL

☐ Chest Tightness
☐ Joint Deformity
☐ Joint Pain
☐ Joint Swelling
☐ Joint Stiffness
☐ Muscle Weakness
☐ Muscle Cramps
☐ Muscle Pain
☐ Muscle Tightness
☐ Muscle Twitches - eyes
☐ Muscle Twitches - arms, legs
☐ Tendonitis
☐ Tension Headache
☐ TMJ Problems

MOOD / NERVOUS SYSTEM

☐Previous concussion/TBI
☐ Brain Fog
☐ Anxiety
☐ Depression
☐ Panic Attacks
☐ Phobias: ____________
☐ Dizziness / Vertigo
☐ Fainting
☐ Blackouts
☐ Fall
☐ Fearfulness
☐ Irritability
☐ Lightheadedness
☐ Numbness
☐ Seizures
☐ Suicidal Thoughts
☐ Tremor/Trembling

Difficulty:

☐ Concentrating
☐ With Balance
☐ With Thinking
☐ With Speech
☐ With Memory

EATING

☐ Can't Gain Weight
☐ Can't Lose Weight
☐ Frequent Dieting
☐ Poor Appetite
☐ Salt Cravings
☐ Carbohydrate Cravings (breads, pastas)
☐ Sweet Cravings (candy, cookies, cakes)
☐ Chocolate Cravings
☐ Caffeine Dependency
☐ Binge Eating
☐ Anorexia or Bulimia

DIGESTION

☐ Difficulty Swallowing
☐ Bloating
☐ Burping/Reflux
☐ Excess Flatulence/Gas
☐ Constipation
☐Diarrhea
☐ Heartburn
☐Indigestion
☐ Nausea
☐ Vomiting
☐Hemorrhoids
☐Fissures
☐ Liver Disease/Jaundice
☐ Abdominal Pain
☐ Strong Stool Odor
☐ Undigested Food in Stools
☐ Mucus in Stools
☐Blood in Stools

Intolerance to:

☐ Lactose
☐ All Dairy Products
☐ Wheat
☐ All Gluten (Wheat, Rye, Barley)
☐Corn
☐Eggs
☐Fatty Foods
☐Yeast

Other: ___________________________

SKIN & HAIR PROBLEMS

☐ Itchy Skin
☐ Dry Skin
☐ Oily Skin
☐ Pale Skin
☐ Rash
☐ Hives
☐Acne on Face
☐ Acne on Body
☐ Athlete's Foot
☐ Bumps on Back of Upper Arms
☐ Easy Bruising
☐ Eczema
☐ Hair Loss
☐ Dandruff
☐ Jock Itch
☐ Red Face / Ears
☐ Sensitivity to Insect Bites
☐ Shingles
☐ Strong Body Odor
☐ Sweating - Excessive
☐ Sweating - None
☐ Vitiligo
☐ Irregular Mole(s)

URINARY

☐ Frequent need to urinate
☐Hesitancy (trouble getting started)
☐ Urgency
☐Decreased urine stream
☐ Leaking/Incontinence
☐ Infection
☐ Pain/Burning
☐ Prostate Infection
☐ Bed Wetting
☐ Kidney Disease

LYMPH NODES

☐ Neck: Enlarged
☐Neck: Tender
☐ Other Area Enlarged or Tender

____

NAILS

☐ Bitten
☐ Brittle
☐ Fungus-Fingers
☐ Fungus-Toes
☐ Ridges
☐ Soft
☐ White Spots/Lines

Thickening of:

☐ Fingernails
☐ Toenails

RESPIRATORY

☐ Mouth Breather
☐ Cough-Dry
☐ Cough-Productive
☐ Hoarseness
☐ Sore Throat
☐ Allergies, seasonal
☐ Allergies, perennial (all year)
☐ Nasal Stuffiness
☐ Postnasal Drip
☐ Sinus Fullness
☐ Sinus Infection
☐ Snoring
☐ Wheezing

CARDIOVASCULAR

☐ Angina/chest pain
☐ Shortness of Breath
☐ Fainting
☐ Heart Murmur
☐ Irregular Pulse
☐ Heart Pounding
☐ Palpitations
☐ Swollen Ankles/Feet
☐ Varicose Veins
☐Pace Maker

MALE REPRODUCTIVE

☐ Prostate or Urinary Infection
☐ Slow urine stream
☐ Waking at night to urinate
☐ Lumps In Testicles
☐ Low Libido (Sex Drive)
☐ Ejaculation Problem
☐ Genital Pain or Discharge
☐ Erectile Dysfunction
☐ Impotence

FEMALE REPRODUCTIVE

☐ Breast Cysts
☐ Breast Lumps
☐ Breast Tenderness
☐ Ovarian Cyst
☐ Low Libido (Low Sex Drive)
☐ Vaginal Discharge
☐ Vaginal Odor
☐ Vaginal Itch
☐ Vaginal Pain with Sex
☐ Birth Control Pill or Patch
☐ Hormone Replacement Therapy

____

Premenstrual/Menstrual:

☐ Bloating
☐ Breast Tenderness
☐ Carbohydrate Cravings
☐ Sweet Cravings
☐ Salt Cravings
☐ Chocolate Cravings
☐ Constipations
☐ Diarrhea
☐ Acne
☐ Trouble Sleeping
☐ Increased Sleeping
☐ Fatigue
☐ Irritability
☐ Anxiety
☐ Depression
☐ Cramps
☐ Heavy Periods
☐ Irregular Periods
☐ No Periods
☐ Scanty Periods
☐ Spotting Between
☐ First Day of Last Menstrual Cycle:

____

The best health and wellness services are based on a mutual understanding between the healthcare provider and the patient. By initialing after each statement, you attest that you understand and agree to the following:

- Your Top Life is a fee-for-service practice. Our policy requires payment in full for all services rendered at the time of the visit. ______
- Credit cards (MasterCard, Visa, Discover, American Express), Debit Cards, and HSA cards are all accepted methods of payment for services. _____
- If you would like to schedule, reschedule, or cancel an appointment, or have questions about your care or treatment plan, please email DrE @YourTopLife.com. *Please note that it can take up to 72 hours to respond to emails, particularly during weekends or holidays.*
- I understand that text messaging is not an appropriate method for communicating with Dr. Engelbart about my health condition or treatment plan. _____
- There is a 48-hour/2 business day cancellation and rescheduling policy for all appointments. We reserve the right to charge for the full office visit if an appointment is missed, cancelled late (outside the 48 hour/ 2 business day window), or if you are more than 10 minutes late for your scheduled appointment. _____
- When you schedule the initial visit, we request that you provide a method of payment to hold the appointment for you. No charges will be applied unless you miss or cancel an appointment without 48 hours / 2 business days advanced notice. _____
- Your preferred method of payment will be kept on file to use for all appointments unless you specify otherwise. Phone, email or internet video appointments will be billed to your method of payment on file, unless you provide alternative payment information and instructions prior to your appointment. _____
- Medical insurance is not accepted for consultations and appointments, and Dr. Engelbart is not a Medicare provider. If requested, we can provide you with an itemized receipt that you can submit to your insurance carrier. However, our office cannot assist you with claim filing or resolution, and Dr. Engelbart does not submit her medical notes to insurance companies. _____
- Dr. Engelbart does not fill out medical disability forms, nor does she submit medical notes to support disability claims. _____
- It is my responsibility to inform this office of any changes in my medical or health status. ____
- I authorize Dr. Engelbart to perform any necessary services or testing needed for proper diagnosis and treatment. ____
- This form was completed correctly and to the best of my knowledge. _____

Patient Name (Print): ____

Signature of Responsible Party: ___________________________________ **Date:** ______________

- I have received a copy of the "Notice of Privacy Practices" (see following page).
- I consent and authorize the utilization of my Private Health Information (PHI), for health/wellness and treatment purposes, as well as for internal administrative purposes.
- I consent and authorize the releasing of my PHI to another service organization in direct regard to my health/wellness and treatment being performed.
- I consent and authorize Your Top Life to discuss, document, provide and/or request PHI to/from another organization for means of collection of payment or reimbursement.
- I consent and authorize Your Top Life to discuss, document, provide and/or request PHI from another organization for administrative purposes.
- I have the right to deny and/or limit the use of my PHI. Should my requests and or choices affect my care as deemed necessary by the doctor, I understand that I may be released as a patient of Your Top Life.

Patient Name (Print): ____

Signature of Responsible Party: ___________________________________ **Date:** ________________

NOTICE OF PRIVACY PRACTICES
Dr. Natalie J. Engelbart, Your Top Life

This Notice of Privacy describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

1) We have a legal, ethical and moral obligation to protect your confidentially. Any information about you and/or your family will be held strictly confidentially by all employees.

2) In order to provide you with quality care, as well as operate this office in an efficient manner, we will need to access your private health care information for the purposes of treatment, payment and operations (such as quality assurance). In using this information this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy and Security Protections provided to you by the Health Insurance Portability and Accountability Act ("HIPPA").

3) Specifically, we will need to disclose your private information under the following circumstances:

    a) Sharing information for purposes of treatment: we will share information with all members of your treatment team, both within this office and with other providers (personal and institutional), and for education/wellness programs.

    b) Sharing of information for the purposes of collecting payment: if applicable we will share all necessary information with your insurer(s), payor(s), governmental entities (such as Medicare) and their representatives, including, but not limited to benefit determination and utilization review, as well as our representatives involved in the billing process, including, but not limited to claims representatives, data warehouses, and billing companies.

    c) Sharing of information for purposes of operations: We will share all information necessary for ongoing operations of this office, including, but not limited to, credentialing processes, peer review, accreditation, and compliance with all federal and state laws.

4) Your consent for use and disclosure of information as described may be revoked in writing at any time. Please notify the office/Privacy Officer if you ever decide to revoke your consent.

5) Your specific authorization will be required for the release of any information not included above. Your authorization will need to be in writing, and it will be specific to the disclosure requested.

6) This office will not release any information other than those incidents described above unless disclosure is required by law, a court, a legal process or government agencies.

7) You have the right to inspect and copy your protected information, amend your record, have reasonable requests for confidential communications accommodated and may obtain an accounting of disclosures. All other rights afforded to you by state and federal law will be honored as they are created. This office will attempt to comply with any of your requests if feasible. Please contact the Privacy Officer if you have any questions about your rights, or with any other privacy related questions you may have.

8) This office will continue to respect you and your family's privacy and confidentiality. The Privacy Officer is available to discuss any questions or concerns you may have regarding the security and privacy of you and/or your family's private health information.