Desert Oasis CLINIC
"Where The Healing Begins."
John A. Thompson, D.O. · *Medical Director*

Patient Information

Name:_____ Social Security No.:_____
(Last First MI)

Address:_____ City:_____ State:_____ Zip:_____

Sex: ☐ M ☐ F Age:_____ Date of Birth:_____ Marital Status:_____

Employer:_____Occupation:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Best daytime phone *(between 8:00 a.m. and 5:00 p.m.)* ☐ Home ☐ Work ☐ Cell
Best evening phone *(after 5:00 p.m.)* ☐ Home ☐ Work ☐ Cell

E-mail:_____

Emergency Contact: _____Relationship:_____ Phone:_____

Primary Care Physician:_____

If patient is a minor: Parent/Guardian:_____
(Last First)

How were you referred to us? _____

Are you being seen as the result of an accident? (i.e., motor vehicle, slip and fall, etc.) _____

Please inform the receiptionst if you are being seen for a personal injury from a motor vehicle accident, slip-and-fall or other event. You must complete additional personal injury forms

Patient or Guardian Signature: _____ **Date:**_____

DESERT OASIS CLINIC
PATIENT HEALTH HISTORY

Name:_____ **D.O.B:**_____

HEALTH PRIORITIES:

What symptoms, problems or health-related goals would you like to have addressed? Please list them in order of importance to you.

1._____

2._____

3._____

4._____

ALLERGIES:

To medications, foods, or other substances:

_____

_____

_____

_____

_____

Choose three words to describe how you usually feel physically:

1._____ 2._____ 3. _____

Choose three words to describe how you usually feel emotionally:

1._____ 2._____ 3._____

Do you currently smoke cigarettes?

☐ YES, I do now. How much? _____
☐ NO, I did but quit. How long ago?_____
☐ NO, I have never smoked cigarettes.

Do you currently smoke cigars or a pipe?

☐ YES, I do now. How much? _____
☐ NO, I did but quit. How long ago?_____
☐ NO, I have never smoked cigars or a pipe.

Current Medications		
Name of Medication	**For What Reason?**	**For How Long Have You Taken This Medication?**

Name:_____

Please CIRCLE any of the following that you now have or have had in the past:

High Cholesterol	Hepatitis	Asthma	Carpal Tunnel Syndrome
High Blood Pressure	Fatty Liver or Cirrhosis	Pneumonia	Osteopenia or Osteoporosis
Coronary Artery Disease	Gallbladder Problems	Tuberculosis	Osteoarthritis
Atherosclerosis	Lupus	Chronic Fatigue Syndrome	Rheumatoid Arthritis
Peripheral Artery Disease	Multiple Sclerosis	Fibromyalgia	Bulging/Herniated Disc
Congestive Heart Failure	Parkinson's Disease	Epstein Barr Virus	Degenerative Disc Disease
Stroke or TIA	Kidney Disease	Cancer	Spinal Stenosis
Aneurysm	Kidney Stones	Herpes Virus	Sciatica
Bleeding/Clotting Disorder	Hypothyroidism	Shingles	Scoliosis
Stomach/Duodenal Ulcer	Hyperthyroidism	Lyme Disease	Torn Ligament or Tendon
Colitis or Spastic Colon	Sleep Disorder	HIV Positive	Joint Replacement
Gluten Sensitivity or Celiac	Migraine Headaches	Enlarged Prostate	Whiplash
Crohn's Disease	Neuropathy or Neuralgia	Other Prostrate Trouble	Clinical Depression
Diverticulitis	Epilepsy or Seizures	High PSA	Manic Depressive Disorder
Irritable Bowel Syndrome	Cataracts	Uterine Fibroids	Schizophrenia
Colon Polyps	Glaucoma	Ovarian Cyst	Obsessive/Compulsive Disorder
Pancreatitis	Macular Degeneration	Abnormal Pap Smear	Attention Deficit Disorder
Hypoglycemia	Hearing Impairment	Endometriosis	Alcoholism
Type I Diabetes	Emphysema	Fibrocystic Breasts	Drug Addiction
Type II Diabetes	Bronchitis	Breast Tumor or Cyst	Nicotine Addiction

Other conditions/diagnoses you have that are not listed above:_____

_____

_____

List any surgeries you have had and the year performed:

_____

_____

_____

If you have ever had cancer, which organ(s) were involved, how long ago were you diagnosed, and what type of treatment did you receive.

_____

_____

Name:_____

How frequently do you experience each of the following?

	Never or Rarely	Occasionally	Often
Upset stomach / indigestion			
Belching or intestinal gas			
Bloating or distention			
Acid stomach or gastric reflux			
Constipation or hard stool			
Loose stool or diarrhea			
Mucus in stool			
Blood in stool or rectal bleeding			
Anal itching			
Loss of appetite			
Cough			
Wheezing			
Shortness of breath			
Snoring or sleep apnea			
Difficult to get to sleep or stay asleep			
Pain interferes with sleep			
Tinnitis / ringing in ear			
Sinus problems			
Nasal congestion / stuffy nose			
Back or neck pain			
Pain that radiates down the leg			
Painful, swollen or tender joint			
Muscle pain, aches, stiffness			
Joint or muscle weakness			
Irregular heart beat or palpitations			
Chest pressure, pain or angina			
Rapid or racing heart beat			
Shortness of breath on exertion			
Pain in back of calf on exertion			
Easy bruising or bleeding			
Water retention in legs, ankles, feet			
Frequent urination			
Excessive thirst			
Blurred vision			

	Never or Rarely	Occasionally	Often
Headaches			
Low energy; fatigue; feel tired			
Infections, colds, or flu			
General weakness			
Low blood pressure			
Low body temperature or feel cold			
Get lightheaded upon standing up			
Hypoglycemia (low blood sugar)			
Alcohol intolerance			
Craving for sweets or starches			
Craving for salty foods			
Excessive hunger			
Have a difficult time handling stress			
Feel anxious, nervous, frustrated, irritable			
“Brain fog” or moments of confusion			
Poor memory			
Feel depressed, moody, or sad			
Feel apprehensive, fearful, worried			
Have difficulty building muscle			
Low libido; little interest in sex			
Difficulty recovering from exercise			
Feel unrested after sleep			
Palpitations (heart fluttering)			
Tendency towards inflammation			
Scanty perspiration			
Dizziness or vertigo			
Allergies or hayfever			
Need caffeine or other stimulants			
Unexplained hair loss			
Dry or thin skin			
Difficulty losing weight			
Dry, brittle hair and or nails			
Unexplained hair loss			
Numbness or tingling in hands, legs, feet			

Name:_____

DIET & NUTRITION

How often do you eat any food from fast food restaurants?

- ○ More than once daily
- ○ About once per day
- ○ 3 – 5 days per week
- ○ About once per week
- ○ Rarely to never

How much plain water do you typically drink in terms of 8 oz. glasses?

- ○ More than 8 glasses per day
- ○ 6 – 8 glasses per day
- ○ 3 – 5 glasses per day
- ○ 1 – 2 glasses per day
- ○ I drink water only a few times per week or less

How often do you eat fruit? (not including fruit juice)

- ○ Twice or more per day
- ○ About once per day
- ○ A few times per week
- ○ Less than once per week
- ○ I rarely eat fruit

How often do you eat red meat? (beef, pork, lamb, bacon, sausage)

- ○ More than once per day
- ○ About once per day
- ○ 3 – 5 times per week
- ○ About once per week
- ○ 1 – 3 times per month
- ○ A few times per year or never

How often do you eat colorful vegetables (dark green, yellow, red, orange, etc.)?

- ○ At every meal, one or more full servings
- ○ 1 – 2 servings per day
- ○ Several times per week
- ○ Once per week or less

How often do you eat a sweet snack or desert?

- ○ More than once per day
- ○ At least once per day
- ○ 3 – 5 times per week
- ○ About once per week
- ○ Less than once per week

How often do you drink any of the following:

Fruit juice, juice, drinks, smoothies?

- ○ Once or more daily
- ○ Several times per week
- ○ Once per week or less
- ○ Rarely to never

Coffee or coffee-based drinks (e.g. lattes, etc.)?

- ○ Once or more daily
- ○ Several times per week
- ○ Once per week or less
- ○ Rarely to never

Do you typically drink:
____ Caffeinated or ____Decaf

Soda or pop?

- ○ Once or more daily
- ○ Several times per week
- ○ Once per week or less
- ○ Rarely to never

Wine, beer, coolers, or other alcohol?

- ○ Once or more daily
- ○ Several times per week
- ○ Once per week or less
- ○ Rarely to never

Are you currently following a specific diet such as vegan, vegetarian, low fat, low carbohydrate, etc.?
Yes ____ **No** ____ **If yes, please describe:** _____

Do you drink diet beverages? If so, what type and how often? _____

What type of sweetener do you use in your drinks, if any? Include sugar, honey, flavored syrup or powder, etc.:

_____

Do you eat or drink dairy products, including milk and/or cheeses? If so, list what types and how often:

_____

List any vitamins, herbs and supplements you currently take:_____

_____

_____

PHYSICAL ACTIVITY: How often do you engage in the following? (check the appropriate column)

	3 or more days per week	1 – 2 days per week	1-3 days per month	Rarely to never
Aerobic exercise: Running/jogging, fast walking, cycling, stair machine, etc.				
Strength or Resistance training: Weights, bands, body weight, etc.				
Stretching/flexibility work				
Yoga, Pilates, Gymnastics / other combined stretching/strength training				
Leisurely walking				
Other activity (please describe)				

Desert Oasis Clinic Policies

APPOINTMENTS & CANCELLATIONS

All visits to the clinic to see the doctor or receive any treatment require an appointment scheduled in advance. This includes simple IM shots and IV's as well.

Our schedule often books up for 2-3 weeks or more in advance. Please schedule your appointments with this in mind. If you are experiencing an urgent problem that needs immediate attention we will do our best to accommodate you. Call us to see if there are any openings or cancellations available. If you are experiencing an emergency, go to a hospital emergency room or call 911.

When you schedule an appointment you are "purchasing" that time and it is yours unless you cancel it **24 hours in advance.** There is a $35 charge for each appointment not cancelled in advance unless it is an emergency. If we are able to fill the appointment we will not charge a cancellation fee.

We confirm appointments with the doctor 1-2 days in advance by phone, and we request that you return the call to confirm your appointment. If you prefer us to use e-mail or text, please let us know. If we are unable to reach you or do not hear back from you promptly we may cancel your appointment. If for some reason you do not get a confirmation call you are still expected to keep the appointment.

If you are more than 15 minutes late for an appointment with the doctor, he may determine that it is necessary to reschedule the appointment to avoid disruption to the schedule for other clients, and to ensure that there is sufficient time for him to address all necessary concerns.

PATIENT RESPONSIBILITY:

At Desert Oasis Clinic you are expected to play an active role in your healthcare. Come to your visits prepared to take notes and ask questions. Dr. Thompson often provides a great deal of information during office visits to help educate you about your body and your health. Your notes will help refresh your memory on his observations and recommendations.

You are encouraged to read any material he recommends, and to do your own research and reading relevant to your condition. This will not only help you to become a more empowered patient, it will make your visits with the doctor more productive.

Also, please keep a record of the names of all supplements and medications you are given and be ready to provide the names and dosages when you need refills.

INSURANCE:

Dr. Thompson has chosen not to participate on any insurance plan. Your relationship with your insurance company is a contract between you and them, and we do not get involved. If you are part of a PPO, you may be able to obtain reimbursement for if you submit a claim directly to them. Check with your plan to determine their procedure for reimbursing clients who visit ***"out of plan"*** physicians. HMO's generally do not allow their clients to see out of plan physicians, and thus will not reimburse when the client does so.

Many of our services are considered to be non-conventional and your insurance carrier may not deem them reimbursable at all. We will do what we can to help you get reimbursed. However, it is not administratively feasible for our staff to engage in repeated contacts with your insurance company to try to convince them to reimburse. We do not submit insurance claims. However, we will provide you with the necessary codes for reimbursement.

YOU MAY *NOT* SUBMIT ANY CLAIMS FOR REIMBURSEMENT TO MEDICARE OR MEDICAID.
Dr. Thompson is not a Medicare or Medicaid provider. As required by federal law, Medicare patients must sign a contract for services acknowledging that our services are not covered and may not be billed to Medicare

PAYMENT:

Payment is due at time of service. We accept cash, checks, debit cards, and all major credit cards. There is a $35 charge for any returned check. It is our policy to prosecute unresolved returned checks.

We offer discounts on some services that are purchased as a package and paid for in advance. There is a 10% administrative fee when a client later seeks a refund on such prepaid services

PRESCRIPTIONS:

If you need a refill on a pharmaceutical that Dr. Thompson has prescribed, make that request **no less than one week before you run out.**

PLEASE DO NOT WAIT UNTIL YOU ARE COMPLETELY OUT OF YOUR MEDICINE OR HAVE ONLY ONE OR TWO DAYS LEFT TO REQUEST A REFILL.

We prefer that you contact your pharmacy first. Check to confirm whether there are any refills left on the last prescription. If a refill prescription is needed, the pharmacy will then fax us a request. If you need to call the office regarding your prescription, please be ready to provide the phone number to your pharmacy.

If you need a refill on a medication **not** prescribed by Dr. Thompson for a condition being managed or treated by another physician, please request that refill directly from that physician.

CELL PHONE USE:

You may use your cell phone in the waiting room, however keep such use to a minimum and be discrete and as quiet as possible. Please go outside if you need to have an extended conversation on your phone. You may not use your cell phone in the IV room unless you are the only client in the room, while receiving treatment from the doctor or staff, and while at the window checking out.

MEDICAL RECORDS REQUESTS:

We require five business days to fulfill requests for medical records. In some instances such as a request for a copy of a lab report, we may be able to respond more quickly. However when the office is busy we do not guarantee same-day response. If you wish to have your records sent directly to another party, you must sign a Medical Records Release form.