Consultation Form

Please return (via email) this packet of completed forms, which includes the following three documents, 8 pages total:

- ❑ Consultation Form (6 pages)
- ❑ HIPPA Acknowledgment and Consent Form (1 page)
- ❑ Financial Policy Form (1 page)

Additionally, submit your most recent lab results to Sudha L. Kumar, MD, **within two weeks of scheduling your appointment.** We maintain confidentiality.

Sudha L. Kumar, MD | Functional & Integrative Medicine
Sudha@SudhaKumarMD.com | 703-851-9210

Patient Name: _____ Date of Birth: _____

Phone (Mobile): _____ Email Address: _____

Home Address: _____

How did you hear about us? _____

Occupation: _____

1. **For women, are you pregnant?** ❑ Yes ❑ No

2. **Please check the following where you experience pain (or conditions you suffer from):**

❒ Headache
❒ Knee pain/degenerative disease
❒ Lower back or neck pain
❒ Arthritis
❒ Digestion symptoms
❒ Cardiovascular Problems
❒ Hypertension
❒ Anxiety and/or depression
❒ Diabetes
❒ Forgetfulness or memory decline
❒ Fatigue
❒ Breathing problems
❒ Sleep problems
❒ Nerve pain or neuropathy
❒ Skin-related issue

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3. Other Joint Pain (which joints)?

4. Please add any other health conditions not listed above.

5. Which of the above is the worst?

6. How long have you been suffering or struggling with this condition?

7. How often does it occur (daily, weekly, monthly)?

8. What is your pain on a scale of 1 = mild, 10 = severe? _____

9. Please check the items below for any you suffer from.

- ❒ Irritability or anger.
- ❒ Interrupted sleep.
- ❒ Restricted daily activity.
- ❒ Feeling frustrated or experiencing mood disorder.
- ❒ Fatigue.
- ❒ Decline in physical activity.

10. Does this affect your life?

- ❒ Holds me back from enjoying my family or friends.
- ❒ Affects my ability to work (or provide income).
- ❒ Restricts my productivity or household duties.
- ❒ Prevents me from exercising or practicing sports.
- ❒ Interferes with my ability to enjoy my hobbies.

11. What have you tried that did not help?

12. How do you see your life in 3 years if the problem/s will get worse?

13. How would your life be if this/these problem/s will improve or resolve?

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14. Conditions:

Conditions	Have you ever experienced this? (yes/no)	Has a close family member? (yes/no)	Please explain.
Cancer (Type:_____)	_____	_____	_____
Depression	_____	_____	_____
Diabetes	_____	_____	_____
Digestive Disorders	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
High Cholesterol	_____	_____	_____
Lung Disease (asthma, etc.)	_____	_____	_____
Liver Disease	_____	_____	_____
Seizures	_____	_____	_____
Stroke	_____	_____	_____
Thyroid Disease	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

15. Have you ever been exposed to harmful environmental substances? ❑ Yes ❑ No
If yes, please describe what you have been exposed to and how it has affected you.

16. Please list any medications to which you are allergic:

17. Please list the prescription medications you are taking now.

Medication	Dosage	Start Date (month/year)	Reason for Use

18. Please list any supplements, vitamins, or herbs you are taking now.

Supplement/Vitamins/Herbs	Dosage	Start Date (month/year)	Reason for Use

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19. Have you had any injuries or surgical procedures? If yes, please describe the injury/surgical procedure and when it occurred.

20. What substances do you take?

Substance	None	Once or Twice per Week	Everyday
Alcohol or Wine	_____	_____	_____
Artificial Sweeteners	_____	_____	_____
Candy, Desserts, Refined Sugar	_____	_____	_____
Soda Drinks	_____	_____	_____
Cigarettes	_____	_____	_____
Chewing Tobacco	_____	_____	_____
Pipes/Electronic Cigarettes	_____	_____	_____
Recreational Drugs	_____	_____	_____
Fast Food	_____	_____	_____
Fried Food	_____	_____	_____
Milk Products	_____	_____	_____

21. How do you spend your days and what do you do to relax?

22. With whom do you live (include roommates, spouse, children, relatives, pets, etc.)?

Name	Age	Relationship

23. In what physical activities do you participate?

Activity	Duration	Frequency

24. What are three major stressors in your life?

Major Stressors

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25. Do you have a meditation, relaxation, spiritual, reflective, or centering practice that you do? If yes, what are they?

26. What gives you a sense of meaning and purpose? If it feels appropriate, describe how spirituality or religion fits into your life, or how it has been in the past.

27. What prior experience have you had with complementary and alternative medicine?

28. Nutrition:

Please list all foods and drinks you have consumed in the previous 24 hours. Include meals, snacks, beverages, and condiments.

List any food allergies or intolerances.

List any types or groups of food you crave or eat a lot.

List types or groups of food that you dislike or rarely eat.

Describe what do you drink on a typical day and how much.

What type of oil do you cook with?

What spreads do you add to your food?

How many servings of fruit do you eat/drink/day (serving = 1 small piece of fruit, ½ cup of juice, ½ cup canned or chopped fruit, or ¼ cup dried fruit)?

How many servings of vegetables do you eat/drink/each day (serving = ½ cup raw or cooked, 1 cup fresh, green leafy vegetables, ¼ cup dried or 1 small piece)?

Please check all that apply:

❑ Vegetarian ❑ Vegan ❑ Paleo ❑ Gluten Free/No Wheat ❑ Low Sodium ❑ No Dairy

❑ Other _____

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29. Describe your relationship with food.

30. How well do you sleep? How many hours?

31. Please describe your bowel movements (i.e., frequency).

32. Is there anything else you would like to share with me as well as discuss?

I understand the purpose of the consultation is to better understand my health concerns.
I understand that this consultation is not a medical evaluation or treatment and does not establish a provider-patient relationship.

Patient Name (please print): _____

Patient Signature/Responsible Party: _____

Date: _____

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HIPAA Acknowledgment and Consent Form

Consent to email or text usage for appointment reminders and other healthcare communications.

Sudha L. Kumar, MD, clients may be contacted via email and/or text messaging to remind you of an appointment and/or to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receive appointment reminders and other healthcare communications/information from Sudha L. Kumar, MD, at that email or text address.
_____ (Client initials)

I consent to receive text messages from Sudha L. Kumar, MD, on my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/ feedback/ health information unless I request a change in writing. The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is (include area code) _____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is _____.

Sudha L. Kumar, MD, does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Name (print clearly): _____

Date of Birth: _____

Patient Signature/Responsible Party: _____

Date: _____

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Financial Policy Form

FINANCIAL POLICY

Thank you for choosing Sudha L. Kumar, MD, to assist you in achieving and maintaining your health and well-being. We are committed to your successful treatment. We feel that everyone benefits when there is a definite and clear financial agreement prior to treatment. To maintain the highest level of professional care possible, we have established the following as our financial policy, which we require you to read and sign before receiving treatment: *Full payment is due at the time of service. We accept cash, checks, and all major credit cards.*

INSURANCE

We do not accept insurance assignments. We request that our fees be paid in full on your first visit and each visit thereafter. We do not participate in managed care or preferred provider organizations. We do not promise that any insurance company will pay our fees as charged to you. You must clearly understand and agree that you are charged directly and are personally responsible for all services rendered to you in our office. As a service to you, our office will complete any necessary reports and forms to help you collect from your insurance company.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's determination of usual and customary rates.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardian) are responsible for full payment.

CANCELLATION POLICY

Sudha L. Kumar, MD, requires a 48-hour notification of appointment cancellation. If this notification is not received, by signing below you understand and agree that you will be charged for the entire scheduled appointment fee and billed immediately. Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. My signature below indicates that I both understand and agree to this Financial Policy. The amount will not be billed to any insurance company.

Patient Name (please print): _____

Patient Signature/Responsible Party: _____

Date: _____

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