Advanced Naturopathic Wellness

PERSONAL INFORMATION

Last Name_____ First Name: _____

Birth date:_____ Age:_____ Gender:_____

Street Address:_____ City:_____ State:____ Zip:_____

Email Address:_____

Home Phone:_____ Cell:_____ Office:_____

Marital Status: (Circle) Minor / Single/ Married/ Widowed/ Long Term Partner

Name and address of person responsible for patient, if different from patient:

_____

Associations

Are you currently: (Circle One) Employed Retired Disabled Other:_____

Occupation:_____ Employer:_____

Primary Care Provider:_____ Contact Number:_____

How did you hear about us?_____

Name of referring patient or practitioner: _____

May we contact them to thank them for referring you? YES NO

Emergency Contacts

Name of family member to contact:_____

Relationship:_____ Phone:_____ Alt Phone:_____

Friend or relative not at the same address:_____

Relationship:_____ Phone:_____ Alt Phone:_____

How To Contact You

Some patients prefer not to have health related messages left where others might hear them. Please let us know where we may leave messages that may be sensitive and initial after you make a choice.

You MAY leave messages for me on: (circle one) Home Cell Office E-mail

Initials:_____

You MAY discuss details of my health with:_____

Initials:_____

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Health Concerns

Please list your main concerns that you would like to address

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

Patient Signature: _____
Date:_____

Guardian Signature:_____
Date:_____

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Informed Consent

I, _____, acknowledge that I am accepting treatment from a Naturopathic Doctor at Auburn Naturopathic Medicine. I understand that there are intrinsic differences between the care of Naturopathic Doctors and Medical Doctors. At this time it is my decision to pursue Naturopathic treatment for any condition I have. I also understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution of any or all conditions that I may have. _____

Acknowledgment of Separate and Distinct Clinic: I acknowledge that the clinic Auburn Naturopathic Medicine including its doctors and staff, are distinctly and completely separate from (1) the doctor and/or clinic and their staff that referred me, and/or (2) the doctor(s) and/or clinic in which other care is being rendered._____

Consent to Routine Clinical Services: I consent to all services rendered by the doctor, or any other licensed doctor(s) or therapist(s) who are now or will in the future treat me while employed by or associated with this practice. As in all medical practices I understand that there are inherent risks. I do not expect the doctor(s) to anticipate and or explain all risks and all possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regard to any procedure. I understand that no guarantees have been made to me as to the result or cure that may be obtained from examination or treatment. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment. I understand that Auburn Naturopathic Medicine is NOT responsible or liable for any lost, stolen or misplaced personal items. _____

Consent to Intravenous Therapy: I consent to all intravenous therapy procedures rendered by the doctor(s) who are now or will in the future treat me while employed by or associated with this practice. I understand that there are risks to intravenous therapy including but not limited to pain, bruising, inflammation, injury, infection, allergic reaction and metabolic disturbances. I do not expect the doctor(s) to anticipate and or explain all risks and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regard to my procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment. _____

Patient/Guardian Signature _____ Date _____

Physician/Witness _____ Date_____

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Privacy Policy and Legal Notice

Auburn Naturopathic Medicine complies with all aspects of the federal HIPAA law, which stipulates your rights as a medical patient. At Auburn Naturopathic Medicine you have the following rights:

- All of your medical records in our possession are controlled so that only your medical provider and essential office staff are allowed to see the contents of your records.
- Your records will not be shared with anyone outside of this office except for the very rare occasions as mandated by law including a court order or in cases where the law mandates that we act to preserve life by breaking confidentiality, as in the case where we firmly believe that you might endanger the life of another or yourself.
- Clinics that contract with insurance companies are required by contract to divulge records to the insurance company as well as your social security number. Because of this we do NOT accept insurance, we will NOT share your records with outside private companies and we will only ask for your social security number if required when ordering lab work. Your social security number will NOT be saved in any form in our office.
- We believe that your medical records are YOUR records. You may request a copy of your records and we will make you a copy within 5 working days of your request. We may charge you reasonable copying fees for this service. Your "records" include anything actually in your chart, but does not include incidental notes that doctors may make for their own use, but which are never entered into the official chart notes. The HIPAA law allows doctors to refuse a request for records in extremely rare and unusual cases.
- We will not confirm or deny that you are a patient of our clinic, even to your family members, unless you give us explicit permission to do so. Your right to seek medical care with complete confidentiality is a right we take seriously.

If you have any questions or concerns about our privacy policy, or your rights as a patient in our clinic, please bring them to us at your earliest convenience.

I understand the above notice: _____

_____

Signature Today's Date

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Your Name: _____

Thank you for taking the time to tell us a little more about you. By filling this out before your appointment, it gives us much more time to discuss your concerns and our plan to address them.

1. Why did you choose to come to our office?

2. What 3 expectations do you have for your initial visit?

3. What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

4. What behaviors or lifestyle habits do you currently engage in regularly that ***do not*** support your health?

5. What potential obstacles do you see in making changes to your lifestyle and following the directions necessary to support your health?

6. What is your present level of commitment to address lifestyle changes that are underlying causes of your signs and symptoms? Please circle a number:

(No commitment) 1 2 3 4 5 6 7 8 9 10 (100% committed)

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Health History

Please List All Major Illnesses, Surgeries and Hospitalizations you have had throughout Your Lifetime:		
Approximate Dates	Illness or Reason	Outcome

Health Habits: Check all that apply				
✓	Habit	What Forms	Amount	For How Long
	Alcohol			
	Caffeine			
	Tobacco			
	Recreational Drugs			
	Exercise			

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Review of Systems: Check all that apply

HEAD

	Headaches		Light-Headed		Dizziness				Earaches/Pain
	Other:								

SKIN, HAIR and NAILS

	Itching		Rashes		Breakouts		Dry Skin		Skin Tags
	Easy Bruising		Hair Loss		Ridges on Nails				
	Other:								

EYES

	Pain		Itchy		Watery		Recent Change in Vision
	Wear Glasses		Wear Contacts				
	Other:						

EARS

	Excessive Wax		Infections		Itching		Ringing		Earaches/Pain
	Other:								

NOSE AND SINUSES

	Runny Nose		Sinus Infections		Nose Bleeds		Seasonal Allergies
	Other:						

MOUTH and THROAT

	Frequent Sore Throats		Frequent Strep Throat		Recent Pain or Problems with Teeth		Trouble Swallowing		Dripping down back of Throat
	Other:								

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RESPIRATORY

	Asthma		Pneumonia		Bronchitis		Cough		Difficulty Breathing
	Shortness of Breath		… with exercise		… with lying down		… at night		
	Other:								

CARDIAC

	Chest Pain		Palpitations		High Blood Pressure		Low Blood Pressure		High Cholesterol
	Other:								

GASTROINTESTINAL

	Stomach Pain		Gas		Bloating		Diarrhea		Constipation
	Heartburn		Indigestion		Nausea		Belching		Ulcers
	Blood in Stool		Mucus in Stool		Undigested Food in Stool		Colitis		Hemorrhoids
	Other:								

How often do you have a bowel movement? _____
Is this a change for you? _____yes _____no

URINARY

	Burning/Pain		Change in Frequency		Blood in Urine		Urgency		Leakage
	Other:								

GENITAL (Male)

	Testicular Mass or Pain		Erectile Dysfunction		Prostatic Hypertrophy		Poor Libido		Genital Herpes
	Heterosexual		Bisexual		Homosexual				
	Other:								

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GENITAL (Female)

	Irregular Cycles		Painful Menses		Birth Control Pills		Pain During Intercourse		Yeast Infections
	Itching		Discharge		Genital Herpes		Infertility		Spotting
	PMS		Endometriosis		Heavy Bleeding		Tender Breasts		Hysterectomy
	Hot Flashes		Night Sweats		Vaginal Dryness		Poor Libido		
	Heterosexual		Bisexual		Homosexual				
	Other:								

Date of Last Period: _____ Number of Days from Period to Period: _____
Number of Days You Bleed: _____ How Many of these Days are Heavy: _____
Number of Pregnancies: _____Age your Periods began: _____
Age Menopause Began: _____

MUSCULOSKELETAL

	Muscle Pain		Joint Pain		Arthritis		Joint Swelling		Spasms
	Other:								

NEUROLOGICAL

	Weakness		Numbness		Tingling		Hyperactivity		Seizures
	Anxiety or Nervousness		Mood Swings		Poor Memory		Depression		Irritable
	Other:								

ENDOCRINE

	Cold Intolerance		Heat Intolerance		Hypoglycemia		Diabetes		Excessive Thirst
	Hyperthyroid		Hypothyroid		Fatigue				
	Other:								

How do you feel if you miss a meal? _____

IMMUNE

	Recurrent Illnesses		History of Cancer		Allergic to Everything		Chemical Intolerance		Autoimmune
	Other:								

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Environmental and Toxic Exposures

What type of heat do you have for your home?

	Gas		Oil		Electric		Wood		Wood Pellets		Coal
	Other:										

Are you currently being exposed to any of the following? (check all that apply)

	Tobacco smoke		Fabric Softener		Hair Dyes/ Permanents		Electric Blankets		Metal Tooth Fillings
	Paints		Solvents		Dry Cleaning		Nail Polish		Mothballs
	Breast Implants		Dental Implants		New Carpet		Chemical Pet Collars		Candles
	Other:								

Do you have symptoms of fatigue if you are exposed to any of the above? ○ Yes ○ No

Check all that apply to you:

_____ Live in an agricultural area now or in the past
_____ Live near industrial areas
_____ Live in an area that is sprayed with herbicides or pesticides
_____ Use of pesticides on your personal grounds

List any known chemical exposures:

_____
_____
_____
_____

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Medications and Supplements

Please list any and all prescription medications, over-the-counter medications, vitamins, herbs, and stimulants you are currently taking.

On your first visit, please bring all of your supplement bottles with you.

Name of Product	Brand	Dose	Frequency/How Long
Ex) Vitamin C	Thorne Research	1.000 mg per day	2 years

Do you have any adverse (or opposite) reactions to medications: Y ___ N __
If so, please explain:

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