

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, and treat the cause of the illness by taking into consideration physical, mental, and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

It is very important therefore, that you provide such information as any medications or over the counter drugs you are currently taking, disease processes you are currently suffering from or if you suspect that you are pregnant.

**This is to acknowledge that I have been informed and I understand that:**

1. I have read all the foregoing information and that I understand that the ultimate responsibility for my health is my own.
2. I am a Naturopathic Doctor, not a Medical Doctor.
3. All treatments offered are within the Naturopathic scope of practice.
4. Any treatment or advice given to me as a patient is not mutually exclusive from any treatment or advice that I may receive now, or in the future, from another licensed health care provider.
5. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider.
6. I accept full responsibility for any fees incurred during care and treatment. I agree to fully discharge this responsibility at the time of the visit unless prior arrangements have been made.
7. There are some slight health risks to treatment by Naturopathic medicine. These include but are not limited to:
  - Allergic reactions to supplements or herbs
  - Side effects of medications (eg. Hormone Therapy, Antibiotics)
  - Pain, bruising, infection or injury from injections

**PLEASE NOTE: There is a 24-hour cancellation policy at the clinic. If you are unable to make your appointment, please notify the clinic 24-hours in advance to ensure you are not charged the initial visit fee. \_\_\_\_\_ initial here please**

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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Patient Signature/ Signature of Guardian

**CONFIDENTIAL HEALTH RECORD**

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 Doctor of Naturopathic Medicine

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Last Name		First Name	
Home Address		City	Zip Code
Home Phone ( )		Work Phone ( )	E-mail
Date of Birth ( mm / dd / yy )		Gender <input type="radio"/> Male <input type="radio"/> Female	Marital Status: <input type="radio"/> S <input type="radio"/> M <input type="radio"/> W <input type="radio"/> D <input type="radio"/> Sep
Emergency Contact & Name		Permission to Leave Message: <input type="radio"/> YES <input type="radio"/> NO	
Occupation/Employer			
Medical Doctor's Name & Number			
How did you hear about our clinic?			
Height:		Current Weight:	Ideal Weight:

**Your usual health is:**  Excellent  Good  Fair  Poor

**Major health concerns in order of importance**

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

**Please list ALL of your Prescription medications taken on a regular basis (include birth control)**

Name	Dose	Duration	Side Effects
1.			
2.			
3.			
4.			
5.			
6.			

*Use the back of this sheet if additional paper is necessary*

**Non-Prescription medications you take (include vitamins / minerals / herbs)**

Name and brand	Dose	Duration	Side Effects
1.			
2.			
3.			
4.			
5.			
6.			

*Use the back of this sheet if additional paper is necessary*

**Have you had all standard vaccinations:**  YES  NO **Are you following any special diets?** \_\_\_\_\_

**Other treatments you are currently following (massage, rehab, diets etc.)** \_\_\_\_\_

**Family History (include siblings, parents, grandparents, uncles, aunts):**

Anemia  Arthritis  Eczema  Glaucoma  Seizure or epilepsy  Heart disease  Hypertension  Other \_\_\_\_\_  
 Thyroid  Diabetes  Asthma  Alcoholism  High cholesterol  Mental illness  Cancer \_\_\_\_\_

**Please list any past surgeries:** \_\_\_\_\_

**Please list any hospitalizations or injuries:** \_\_\_\_\_

**Number of times per week you exercise:** \_\_\_\_\_ **Type of exercise:** \_\_\_\_\_ **Do you lift weights?**  YES  NO

**Record the number of servings you consume daily of each of the following:**

Coffee	Decaf Coffee	Regular Tea	Herbal Tea	Soft Drinks	Milk	Juice	Water	Alcohol / Beer
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**Allergies**

Medications	Have you ever had an allergy test? <input type="radio"/> YES <input type="radio"/> NO
Food	
Environment (pollen, dust)	

**Smoking History**

Do you currently smoke tobacco?	<input type="radio"/> YES <input type="radio"/> NO	Start date:	If yes, how many/day
Did you previously smoke:	<input type="radio"/> YES <input type="radio"/> NO	Start date:	Quit date:

**Stresses**

*Do you currently face or have faced any of the following*

	Ü	Year	Ü	Year
Loss of someone close			Divorce	
Illness in someone close			Pregnancy	
Loss of job			Alcohol/Drug addiction (you or loved one)	
Change of workplace			Physical abuse	
A move			Emotional abuse	
Marriage			Other:	