Legal Name (First Last)	Preferred Name (if different)	Date of Birth

What brings you in today?

Concern	Started when?	How often?	How severe?

You may list more on the Health Systems Check-list

What medications are you currently taking? (Both prescriptions and OTC)

Medication and Dose	Reason	Started?	Prescribed By
Prozac 20mg 2x/day	*Feeling Down*	*11/2008*	*Alan James, MD*

If you would like, we can provide you with a longer medication and supplement form

Supplement, Brand and Dose	Reason	Started?	Recommended By
Super Vitamin C (Thorne) 500mg / day	*Immune Support*	*11/2008*	*Self*

Preferred Pharmacy?

Name Address Phone

PAST PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

Heart/Lungs
- ☐ Asthma
- ☐ Heart Disease (valve, *vessel, rheumatic, etc.)*
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pneumonia

Endocrine
- ☐ Adrenal Disorders
- ☐ Diabetes
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Thyroid Disorder

Kidney
- ☐ Chronic Kidney or Bladder Disease
- ☐ Kidney Stones

Ears/Eyes/Nose/Throat
- ☐ Chronic Sinus Infections
- ☐ Eye Disorders (other than glasses or contacts)
- ☐ Hearing Loss
- ☐ Nasal Allergies/Hayfever

Stomach/Bowel
- ☐ Celiac Disease
- ☐ Food Poisoning
- ☐ Irritable Bowel Syndrome
- ☐ Stomach/Duodenal Ulcers
- ☐ Ulcerative Colitis/Crohn's
- ☐ Other Liver, Stomach, or Bowel Disease

Neurological
- ☐ Concussions
- ☐ Convulsions/Seizures
- ☐ Migraines/Severe Headaches
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Stroke/TIA

Mental Health
- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Anorexia *(Eating Disorder)*
- ☐ Anxiety Disorder
- ☐ Bulimia *(Eating Disorder)*
- ☐ Depression
- ☐ Drug Dependency
- ☐ Other Mental Health Problems

Hematology/Oncology
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Blood Clots/Clotting Disorders
- ☐ Cancer
- ☐ Radiation Therapy

Orthopedics
- ☐ Arthritis
- ☐ Fractures/Broken Bones

Infectious Diseases
- ☐ Chickenpox/Varicella
- ☐ Hepatitis Type: _____
- ☐ HIV Infection
- ☐ Infectious Mononucleosis
- ☐ Malaria
- ☐ Mumps
- ☐ Tuberculosis
- ☐ Typhoid Fever

Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives

STDs
- ☐ Chlamydia
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ HPV
- ☐ Other STD

Surgical History
- ☐ Appendectomy
- ☐ Breast Surgery
- ☐ Ear Tubes
- ☐ Gallbladder Removal
- ☐ Hysterectomy
- ☐ Knee ACL Repair
  L ___ R ___
- ☐ Knee Arthroscopy
  L ___ R ___
- ☐ Organ Transplant
- ☐ Ovarian Cyst Removal
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Weight Loss Surgery
- ☐ Other Prior Surgeries

OB/GYN History
- ☐ Abnormal Pap
- ☐ Endometriosis
- ☐ Pregnancies #: _____

Exercise History
- ☐ Lack of exercise
- ☐ Exercising regularly

Moderate Exercising
Walking briskly, water aerobics, etc.
- ☐ Less than 3 times per week
- ☐ 3 or more times per week

Strenuous Exercising
Running, swimming laps, etc.
- ☐ Less than 3 times per week
- ☐ 3 or more times per week

☐ **NO Significant Health Problems**

Allergies
Have you ever had an allergic reaction? ☐ Yes ☐ No

Medication Allergies: _____

Food Allergies: _____

Other Allergies (latex, beestings, etc.): _____

Other History
☐ Previous Hospitalizations _____

_____

☐ OTHER Health Problems _____

_____

Does YOUR IMMEDIATE FAMILY have any of the following? ☐ Adopted (Family history unknown)

	Mother	Father	Siblings	Grandparents
Addiction				
Auto Immune				
Asthma				
Cancer – Breast				
Cancer – Colon				
Cancer – Melanoma				
Cancer – Other Cancers (List Type)				
Diabetes				
Digestive Concerns				
Eating Disorder				
Heart Disease				
Hepatitis				
High Blood Pressure				
Lung Disease				
Mental Health				
Neurological				
Seizures				
Skin Condition				
Stroke				
Thyroid Condition				

As a New Patient, please check any items that are **CURRENTLY** concerning you.

GENERAL:	☐ NO COMPLAINTS	☐ WEIGHT LOSS	☐ FATIGUE	☐ COLD/FLU	☐ HARDER TIME EXERCISING
	☐ STRESS	☐ WEIGHT GAIN	☐ INSOMNIA	☐ CHANGES IN STRENGTH	☐ OTHER _____
HEAD/EAR:	☐ NO COMPLAINTS	☐ DIZZINESS	☐ HEADACHES	☐ HEAD TRAUMA	☐ MENTAL FOG
	☐ EARACHE	☐ CHANGES IN HEARING	☐ RINGING IN EARS	☐ CLOGGED EARS	☐ OTHER _____
EYES:	☐ NO COMPLAINTS	☐ CHANGES IN VISION	☐ BLURRING OF VISION	☐ EXCESSIVE TEARING	☐ OTHER _____
	☐ BLIND SPOTS	☐ EYE PAIN	☐ EYE IRRITATION	☐ DRY EYES	
NOSE/MOUTH:	☐ NO COMPLAINTS	☐ FREQUENT BLEEDING	☐ BLEEDING GUMS	☐ COLD/CANKER SORES	☐ TOOTH PAIN
	☐ BAD BREATH	☐ NASAL DISCHARGE	☐ NASAL CONGESTION	☐ DRY MOUTH/NOSE	☐ OTHER _____
NECK/THROAT:	☐ NO COMPLAINTS	☐ NECK PAIN/STIFFNESS	☐ LUMPS/BUMPS	☐ POSTNASAL DRIP	☐ OTHER _____
	☐ SORE THROAT	☐ DIFFICULTY SWALLOWING			
CHEST/LUNG /BREAST:	☐ NO COMPLAINTS	☐ BREAST TENDERNESS	☐ PAIN W/ BREATHING	☐ CHEST CONSTRICTION	☐ SHORT OF BREATH/WHEEZING
	☐ LUMPS/SWELLING	☐ NIPPLE DISCHARGE	☐ COUGH	☐ CHEST CONGESTION	☐ OTHER _____
CARDIOVASCULAR:	☐ NO COMPLAINTS	☐ PALPITATIONS	☐ CHEST PAIN	☐ HIGH BLOOD PRESSURE	☐ OTHER _____
		☐ IRREGULAR BEAT	☐ LEG SWELLING	☐ LOW BLOOD PRESSURE	☐ LOSS OF CONSCIOUSNESS
ABDOMEN/DIGESTION:	☐ NO COMPLAINTS	☐ ABDOMINAL PAIN	☐ DIARRHEA	☐ HEART BURN	☐ BLOATING/GAS
BOWEL MOVEMENTS PER DAY_____	☐ NAUSEA/VOMITING	☐ CHANGE IN APPETITE	☐ CONSTIPATION	☐ BLOOD IN STOOL	☐ OTHER _____
URINATION:	☐ NO COMPLAINTS	☐ FREQUENCY	☐ URGENCY	☐ FREQUENT INFECTIONS	
	☐ PAINFUL URINATION	☐ INCONTINENCE	☐ DRIBBLING	☐ INCOMPLETE EMPTYING	☐ OTHER _____
WOMENS HEALTH:	☐ NO COMPLAINTS	☐ PAIN WITH MENSES	☐ PELVIC PAIN	☐ DIFFICULTY CONCEIVING	☐ CYCLE LENGTH: _____DAYS
DAY #_____ IN CYCLE	☐ CHANGE IN MENSES	☐ VAGINAL DISCHARGE	☐ DECREASED LIBIDO	☐ MENOPAUSE/NO PERIOD	☐ OTHER _____
MENS HEALTH:	☐ NO COMPLAINTS	☐ ERECTILE DYSFUNC.	☐ NIGHTIME URINATION	☐ OTHER _____	
	☐ DECREASED LIBIDO	☐ PROSTATE	☐ ____TIMES PER NIGHT		
MUSCULOSKELETAL:	☐ NO COMPLAINTS	☐ MUSCLE PAIN	☐ MUSCLE TENSION	☐ NUMBNESS/TINGLING	☐ RECENT INJURY
	☐ MUSCLE CRAMPS	☐ MUSCLE WEAKNESS	☐ JOINT PAIN	☐ RANGE OF MOTION	☐ OTHER _____
MENTAL/EMOTIONAL:	☐ NO COMPLAINTS	☐ SEIZURES	☐ MOOD CHANGES	☐ DEPRESSION	☐ LOSS OF COORDINATION
	☐ MEMORY CHANGES	☐ TREMOR	☐ MENTAL CHANGES	☐ COGNITIVE IMPAIRMENT	☐ OTHER _____
TEMPERATURE:	☐ NO COMPLAINTS	☐ RUNS COLD	☐ NIGHT SWEATING	☐ EXCESS SWEATING	☐ OTHER _____
	☐ COLD HAND/FEET	☐ RUNS HOT	☐ HOT FLASHES	☐ LACK OF SWEATING	☐ SPONTANEOUS SWEATING
SKIN/HAIR:	☐ NO COMPLAINTS	☐ EASY BRUISING	☐ RASH	☐ TEXTURE CHANGES	☐ CHANGES IN NAILS
	☐ DRYNESS	☐ SLOW HEALING	☐ COLOR CHANGES	☐ THINNING HAIR	☐ OTHER _____

Preventative Care	**Date of Last**	**Results?**
Pap		
Mammogram		
Colonoscopy		
Annual Screening		
DEXA Scan (Bone Density)		
PSA (Prostate-specific antigen)		
Vaccines (Flu, Shingles/Travel)		

Tell us about your lifestyle

Alcohol? □ YES □ NO What kind?_____ Drinks per day _____

Per week_____

Tobacco? □ YES □ NO □ FORMER Packs per day?_____ Years smoked?_____

Recreational Drug Use? □ YES □ NO What kind?_____ Times per week_____

Cannabis Use? □ Recreational □ Medical

Sexual Activity with □ Male □ Female □ Both □ _____

Exercise □ None □ Regularly □ Moderate □ Strenuous □<3 times a week □>3 times a week

Tell us about how you eat

Sodas, oz/day

Coffee, oz/day

Water, oz/day

Food Cravings

Snack Foods

Typical Breakfast

Typical Lunch

Typical Dinner

Food Sensitivity

Food Restrictions

Food Ethics ☐ Vegan ☐Vegetarian ☐Kosher ☐Other:

Do you eat?

□ In the car	□ Watching TV	□ Standing
□ With others	□ On the go	□ In a hurry
□ After 11pm	□ In your sleep	□ On waking

How often do you eat out? Where?

Tell us about your home life

With whom do you live? (Including family, pets, and roommates)?

Name	Age	Relationship	Name	Age	Relationship

What is your occupation?

What are the major stressors in your life? (work, financial, emotional health, romance/love, physical health, family, spiritual, other)

How is your sleep? When do you go to sleep and wake up?

What do you do to relax? What are your hobbies?

Do you have religious or spiritual beliefs that may affect your healthcare?

Clinic Policies for Naturopathic Medicine

We take a personal approach to care. It is not the policy of our office to manage medical care via email. While email can be an efficient method of communicating we believe we can best serve you face to face or over the phone if necessary.

On occasion, phone consults are requested of our providers. If such a consult is requested you will be responsible for a telephone visit fee, which may not covered by insurance. From time to time your provider may contact you by phone for a brief exchange to clarify a previous treatment plan. There would no fee for this kind of clarification.

Payment is due at the time of service. After your visit, you will checkout with our staff and be asked for any copays or co-insurance for the services performed. We believe it is the patient's responsibility to understand their insurance benefits. Additional fees for outside labs will may billed to you by the lab performing those services.

Your initial visit will include a complete discussion of your health history and current symptoms. Physical exams relating to your symptoms will likely be performed in this visit. Your provider will make a treatment plan tailored to you. Your provider may order labs in this appointment, which will be released and discussed with you in a follow-up office visit.

If you need a prescription refill please call your pharmacy. They will fax us your request or send it electronically. In order for your provider to make an informed decision with ample time to review your medical record we need 2-3 business days notice for your refill or non-urgent referral request.

For records requests for other providers we will do our best to get these processed within 7 business days. However, please keep in mind that common standards allow for 30 days to fulfill these requests.

Letters of medical necessity for supplements will be completed within 7 business days.

I acknowledge that I have read and understand the clinic policies for naturopathic medicine at Today Integrative Health + Wellness and have discussed any concerns or questions I have with the office staff.

Signature _____ Date _____

CONSENT FOR NATUROPATHIC TREATMENT

General Information: Today Integrative Health + Wellness is an Integrative Medical Clinic which integrates a number of medical modalities. Due to the diversity of modalities offered at Today, your treatment may include any or all of the following general modalities: Naturopathic Medicine, Physical Medicine, Therapeutic Exercise, Homeopathy, Psychological Counseling, Nutritional Counseling, and Intravenous Therapies.

Methods, Procedures, and Therapeutic Approaches: Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

General Diagnostic Procedures: Including but not limited to venipuncture, pap smears, radiography, blood labwork, urine labwork, general physical exams, neurological and musculoskeletal assessments.

Herbs/ Natural Medicines: Prescribing of various therapeutic substances including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol), topical creams, pastes, plasters, washes, suppositories, or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substances, may also be used.

Dietary Advice and Therapeutic Nutrition: The use of foods, diet plans, or nutritional supplements for treatment (may include intramuscular injection or intravenous therapies).

Soft Tissue and Osseous Manipulation: The use of massage, neuro-muscular techniques, muscle energy stretching, visceral manipulation, as well as manipulations of the extremities and spine including traction and cranio-sacral therapy.

Pharmaceutical Medication: Your physician may prescribe medication for your care that is within the scope of practice.

Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Potential Risks: Pain, discomfort, blistering, discoloration, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Notice to Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy or during breast feeding.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been giving to me by Today or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or as otherwise permitted or required by law.

_____	_____
Patient Name (PRINT)	Guardian/Personal Representative (PRINT)
_____	_____
Patient Signature	Guardian/Personal Representative Signature
_____	_____
Date	Relationship/ Representative Authority