THE Lakeside Clinic CENTER FOR INTEGRATED MEDICINE

# Naturopathic Intake & Informed Consent

**PERSONAL INFORMATION**

Patient Name: _____ Date: _____

Birth Date (M/D/Y) _____ Age:_____ Sex/Gender: M F

Address:_____

City:_____ Postal Code_____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Preferred form of contact for reminder/follow-up calls: ○Home ○Work ○Cell ○Email

E-Mail Address:_____

Emergency Contact: _____Phone: _____Relationship:_____

How did you hear about us? _____

Name of the friend or professional who referred you_____

Business Employer _____Occupation: _____

Extended Health Insurance Company Name: _____

Insured Member: _____ Birth Date (M/D/Y): _____

Policy # _____Member ID#_____

Coverage per year: _____

**HEALTH CARE PROVIDERS**

Medical Doctor _____ Location_____

Date of last physical exam: _____ Blood tests included? YES NO

Specialist(s) _____Location_____
Other _____Location_____
Other _____ Location_____

**MAIN HEALTH CONCERNS**

What are your health concerns, in order of importance to you**?**

**1.** _____ **4.** _____
**2.** _____ **5.** _____
**3.** _____ **6.** _____

How would you describe your general state of health? Excellent Good Fair Poor

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**MEDICAL INFORMATION**

Please list any known allergies (prescription or over-the-counter medicines, environmental, natural medicines, food) and any previous drug reactions:

_____
_____
_____
_____

Please indicate any *serious conditions* (**broken bones, surgeries, imaging, accidents…**), *traumatic events* (**divorce, loss of employment, death of loved one, abuse, addiction…)** and any *hospitalizations:*

_____
_____
_____
_____
_____
_____

Please list prescribed and over the counter medications you are currently using or have used in the last 5 years. Include dose, frequency and duration of use.

Medication _____ Dose _____ Frequency _____ Duration____
Medication _____ Dose _____ Frequency _____ Duration____
Medication _____ Dose _____ Frequency _____ Duration____
Medication _____ Dose _____ Frequency _____ Duration____
Medication _____ Dose _____ Frequency _____ Duration____

Please list names and brands of all current vitamins, minerals, botanicals and other natural health products you are currently using. Include dose, frequency and duration of use.

Name _____ Dose _____ Frequency _____ Duration____
Name _____ Dose _____ Frequency _____ Duration____
Name _____ Dose _____ Frequency _____ Duration____
Name _____ Dose _____ Frequency _____ Duration____
Name _____ Dose _____ Frequency _____ Duration____

How many times have you been treated with antibiotics in the last 5 years? _____

Where you ever on antibiotics for an extended period of time? Y N Reason:_____

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## FAMILY MEDICAL HISTORY

Please indicate if any of your family members have experienced the following:

| Condition | Relative | Condition | Relative |
|---|---|---|---|
| Alcoholism/Addiction | | High Blood Pressure | |
| Alzheimer's Disease/Dementia | | Insomnia | |
| Allergies (Food/Hayfever) | | Kidney Problems | |
| Arthritis (osteo/rheumatoid) | | Liver Disease | |
| Asthma/Emphysema | | Mental Health Problems | |
| Autoimmune disease (MS, RA…) | | Migraines/Headaches | |
| Cancer (type) | | Osteoporosis | |
| Diabetes | | Skin conditions | |
| Digestive Problems | | Thyroid problems | |
| Heart Disease | | Other: | |

## REVIEW OF SYSTEMS

### Diet

Scoring Key: 0=do not consume; 1=consume 1-2x/month; 2=consume weekly; 3=consume daily

**1.** 0 1 2 3 Alcohol
**2.** 0 1 2 3 Artificial sweeteners
**3.** 0 1 2 3 Candy, desserts, refined sugar
**4.** 0 1 2 3 Carbonated beverages
**5.** 0 1 2 3 Chewing tobacco
**6.** 0 1 2 3 Cigarettes
**7.** 0 1 2 3 Cigars/pipes
**8.** 0 1 2 3 Caffeinated beverages
**9.** 0 1 2 3 Fast foods
**10.** 0 1 2 3 Fried foods
**11.** 0 1 2 3 Luncheon meats
**12.** 0 1 2 3 Margarine
**13.** 0 1 2 3 Milk products
**14.** 0 1 Radiation exposure(0=no,1=yes)
**15.** 0 1 2 3 Refined flour/baked goods
**16.** 0 1 2 3 Vitamins and minerals
**17.** 0 1 2 3 Water, distilled
**18.** 0 1 2 3 Water ,tap
**19.** 0 1 2 3 Water, well
**20.** 0 1 2 3 Diet often for weight control

### Lifestyle

**21.** 0 1 2 3 Exercise per week(0 = 2 or more times a week, 1 =1 time a week, 2 =1 or2 times a month, 3 = less than once a month)
**22.** 0 1 2 3 Changed jobs(0 = over 12months ago, 1 =within last 12months, 2=within last 6 months, 3 =within last 2 months)
**23.** 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 =within last 2 years, 2 =within last year, 3=within last 6 months)
**24.** 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2= usually, 3 = always)

### Sections 1-16 Scoring Key: 0=symptom does not occur; 1=mild; 2=moderate; 3=severe

### Section 1

**52.** 0 1 2 3 Belching or gas within one hour after eating
**53.** 0 1 2 3 Heartburn or acid reflux
**54.** 0 1 2 3 Bloating within one hour after eating
**55.** 0 1 Vegan diet (no dairy, meat, fish or eggs) 1=yes)
**56.** 0 1 2 3 Bad breath (halitosis)
**57.** 0 1 2 3 Loss of taste for meat
**58.** 0 1 2 3 Sweat has a strong odor
**59.** 0 1 2 3 Stomach upset by taking vitamins
**60.** 0 1 2 3 Sense of excess fullness after meals
**61.** 0 1 2 3 Feel like skipping breakfast
**62.** 0 1 2 3 Feel better if you don't eat
**63.** 0 1 2 3 Sleepy after meals
**64.** 0 1 2 3 Fingernails chip, peel or break easily
**65.** 0 1 2 3 Anemia unresponsive to iron
**66.** 0 1 2 3 Stomach pains or cramps
**67.** 0 1 2 3 Diarrhea, chronic
**68.** 0 1 2 3 Diarrhea shortly after meals
**69.** 0 1 2 3 Black or tarry colored stools
**70.** 0 1 2 3 Undigested food in stool

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## Section2

| | | |
|---|---|---|
| **71.** | 0 1 2 3 | Pain between shoulder blades |
| **72.** | 0 1 2 3 | Stomach upset by greasy foods |
| **73.** | 0 1 2 3 | Greasy or shiny stools |
| **74.** | 0 1 2 3 | Nausea |
| **75.** | 0 1 2 3 | Sea, car, airplane or motion sickness |
| **76.** | 0 1 | History of morning sickness(0 = no, 1 = yes) |
| **77.** | 0 1 2 3 | Light or clay colored stools |
| **78.** | 0 1 2 3 | Dry skin, itchy feet or skin peels on feet |
| **79.** | 0 1 2 3 | Headache over eyes |
| **80.** | 0 1 2 3 | Gallbladder attacks (0=never,1=years ago,2=within last year, 3=within past 3 |
| **81.** | 0 1 | Gallbladder removed (0=no,1=yes) |
| **82.** | 0 1 2 3 | Bitter taste in mouth, especially after meals |
| **83.** | 0 1 | Become sick if you were to drink wine(0=no, 1=yes) |
| **84.** | 0 1 | Easily intoxicated if you were to drink wine (0=no, 1=yes) |
| **85.** | 0 1 | Easily hung over from wine (0=no, 1=yes) |
| **86.** | 0 1 2 3 | Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14) |
| **87.** | 0 1 | Recovering alcoholic (0=no, 1=yes) |
| **88.** | 0 1 | History of drug or alcohol abuse (0=no,1=yes) |
| **89.** | 0 1 | History of hepatitis(0=no, 1=yes) |
| **90.** | 0 1 | Long term use of prescription or rec'l drugs (0=no, 1=yes) |
| **91.** | 0 1 2 3 | Sensitive to chemicals (perfume, cleaning agents, etc.) |
| **92.** | 0 1 2 3 | Sensitive to tobacco smoke |
| **93.** | 0 1 2 3 | Exposure to diesel fumes |
| **94.** | 0 1 2 3 | Pain under right side of rib cage |
| **95.** | 0 1 2 3 | Hemorrhoids or varicose veins |
| **96.** | 0 1 2 3 | Nutrasweet (aspartame) consumption |
| **97.** | 0 1 2 3 | Sensitive to Nutrasweet(aspartame) |
| **98.** | 0 1 2 3 | Chronic fatigue or Fibromyalgia |

## Section3

| | | |
|---|---|---|
| **99.** | 0 1 2 3 | Food allergies |
| **100.** | 0 1 2 3 | Abdominal bloating 1 to 2 hours after eating |
| **101.** | 0 1 | Specific foods make you tired or bloated (0=no, 1=yes) |
| **102.** | 0 1 2 3 | Pulse speeds after eating |
| **103.** | 0 1 2 3 | Airborne allergies |
| **104.** | 0 1 2 3 | Experience hives |
| **105.** | 0 1 2 3 | Sinus congestion, "stuffy head" |
| **106.** | 0 1 2 3 | Crave bread or noodles |
| **107.** | 0 1 2 3 | Alternating constipation and diarrhea |
| **108.** | 0 1 2 3 | Crohn's disease (0 =no,1=yes in the past, 2=currentlymildcondition,3=severe) |
| **109.** | 0 1 2 3 | Wheat or grain sensitivity |
| **110.** | 0 1 2 3 | Dairy sensitivity |
| **111.** | 0 1 | Are there foods you could not give up(0=no, 1=yes) |
| **112.** | 0 1 2 3 | Asthma, sinus infections, stuffy nose |
| **113.** | 0 1 2 3 | Bizarre vivid dreams, nightmares |
| **114.** | 0 1 2 3 | Use over-the-counter pain medications |
| **115.** | 0 1 2 3 | Feel spacey or unreal |

## Section4

| | | |
|---|---|---|
| **116.** | 0 1 2 3 | Anus itches |
| **117.** | 0 1 2 3 | Coated tongue |
| **118.** | 0 1 2 3 | Feel worse in moldy or musty place |
| **119.** | 0 1 2 3 | Taken antibiotic for a total accumulated time of (0=never, 1=<1month,2= <3 months, 3=>3 months) |
| **120.** | 0 1 2 3 | Fungus or yeast infections |
| **121.** | 0 1 2 3 | Ringworm, "jock itch", "athletes foot", nail |
| **122.** | 0 1 2 3 | Yeast symptoms increase with sugar, starch or alcohol |
| **123.** | 0 1 2 3 | Stools hard or difficult to pass |
| **124.** | 0 1 | History of parasites (0=no,1=yes) |
| **125.** | 0 1 2 3 | Less than one bowel movement per day |
| **126.** | 0 1 2 3 | Stools have corners or edges, are flat or ribbon shaped |
| **127.** | 0 1 2 3 | Stools are not well formed(loose) |
| **128.** | 0 1 2 3 | Irritable bowel or mucus colitis |
| **129.** | 0 1 2 3 | Blood in stool |
| **130.** | 0 1 2 3 | Mucus in stool |
| **131.** | 0 1 2 3 | Excessive foul smelling lower bowel gas |
| **132.** | 0 1 2 3 | Bad breath or strong body odors |
| **133.** | 0 1 2 3 | Painful to press along outer sides of thighs(Iliotibial Band) |
| **134.** | 0 1 2 3 | Cramping in lower abdominal region |
| **135.** | 0 1 2 3 | Dark circles under eyes |

## Section5

| | | |
|---|---|---|
| **136.** | 0 1 | History of carpal tunnel syndrome(0=no,1=yes) |
| **137.** | 0 1 | History of lower right abdominal pains or ileocecal valve problems (0=no,1=yes) |
| **138.** | 0 1 | History of stress fracture(0=no, 1=yes) |
| **139.** | 0 1 2 3 | Bone loss(reduced density on bone scan) |
| **140.** | 0 1 | Are you shorter than you used to be? (0=no, 1=yes) |
| **141.** | 0 1 2 3 | Calf, foot or toe cramps at rest |
| **142.** | 0 1 2 3 | Cold sores, fever blisters or herpes lesions |
| **143.** | 0 1 2 3 | Frequent fevers |
| **144.** | 0 1 2 3 | Frequent skin rashes and/or hives |
| **145.** | 0 1 | Herniated disc(0=no,1=yes) |
| **146.** | 0 1 2 3 | Excessively flexible joints, "double jointed" |
| **147.** | 0 1 2 3 | Joints pop or click |
| **148.** | 0 1 2 3 | Pain or swelling in joints |
| **149.** | 0 1 2 3 | Bursitis or tendonitis |
| **150.** | 0 1 | History of bone spurs (0=no,1=yes) |
| **151.** | 0 1 2 3 | Morning stiffness |
| **152.** | 0 1 2 3 | Nausea with vomiting |
| **153.** | 0 1 2 3 | Crave chocolate |
| **154.** | 0 1 2 3 | Feet have a strong odor |
| **155.** | 0 1 2 3 | History of anemia |
| **156.** | 0 1 2 3 | Whites of eyes(sclera)blue tinted |
| **157.** | 0 1 2 3 | Hoarseness |
| **158.** | 0 1 2 3 | Difficulty swallowing |
| **159.** | 0 1 2 3 | Lump in throat |
| **160.** | 0 1 2 3 | Dry mouth, eyes and/or nose |
| **161.** | 0 1 2 3 | Gag easily |
| **162.** | 0 1 2 3 | White spots on fingernails |
| **163.** | 0 1 2 3 | Cuts heal slowly and/or scar easily |
| **164.** | 0 1 2 3 | Decreased sense of taste or smell |

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## Section6

**165.** 0 1 Experience pain relief with aspirin (0=no,1=yes)
**166.** 0 1 2 3 Crave fatty or greasy foods
**167.** 0 1 2 3 Low- or reduced-fat diet (0=never, 1=years ago, 2=withinpastyear,3=currently)
**168.** 0 1 2 3 Tension headaches at base of skull
**169.** 0 1 2 3 Headaches when out in the hot sun
**170.** 0 1 2 3 Sunburn easily or suffer sun poisoning
**171.** 0 1 2 3 Muscles easily fatigued
**172.** 0 1 2 3 Dry flaky skin or dandruff

## Section7

**173.** 0 1 2 3 Awaken a few hours after falling asleep, hard to Get back to sleep
**174.** 0 1 2 3 Crave sweets
**175.** 0 1 2 3 Binge or uncontrolled eating
**176.** 0 1 2 3 Excessive appetite
**177.** 0 1 2 3 Crave coffee or sugar in the afternoon
**178.** 0 1 2 3 Sleepy in afternoon
**179.** 0 1 2 3 Fatigue that is relieved by eating
**180.** 0 1 2 3 Headache if meals are skipped
**181.** 0 1 2 3 Irritable before meals
**182.** 0 1 2 3 Shaky if meals delayed
**183.** 0 1 2 3 Family with diabetes(0=none, 1=1or 1=2, 2=3 or4, 3=more than 4)
**184.** 0 1 2 3 Frequent thirst
**185.** 0 1 2 3 Frequent urination

## Section8

**186.** 0 1 2 3 Muscles become easily fatigued
**187.** 0 1 2 3 Feel exhausted or sore after moderate exercise
**188.** 0 1 2 3 Vulnerable to insect bites
**189.** 0 1 2 3 Loss of muscle tone, heaviness in arms/legs
**190.** 0 1 2 3 Enlarged heart or congestive heart failure
**191.** 0 1 2 3 Pulse below65perminute(0=no,1=yes)
**192.** 0 1 2 3 Ringing in the ears(Tinnitus)
**193.** 0 1 2 3 Numbness, tingling or itching in hands and feet
**194.** 0 1 2 3 Depressed
**195.** 0 1 2 3 Fear of impending doom
**196.** 0 1 2 3 Worrier, apprehensive, anxious
**197.** 0 1 2 3 Nervous or agitated
**198.** 0 1 2 3 Feelings of insecurity
**199.** 0 1 2 3 Heart races
**200.** 0 1 2 3 Can hear heartbeat on pillow at night
**201.** 0 1 2 3 Whole body/ limb jerk as falling asleep
**202.** 0 1 2 3 Night sweats
**203.** 0 1 2 3 Restless leg syndrome
**204.** 0 1 2 3 Cracks at corner of mouth (Cheilosis)
**205.** 0 1 2 3 Fragile skin, easily chaffed
**206.** 0 1 2 3 Polyps or warts
**207.** 0 1 2 3 MSG sensitivity
**208.** 0 1 2 3 Wake up without remembering dreams
**209.** 0 1 2 3 Small bumps on back of arms
**210.** 0 1 2 3 Strong light at night irritates eyes
**211.** 0 1 2 3 Nose bleeds and/tend to bruise easily
**212.** 0 1 2 3 Bleeding gums when brushing teeth

## Section9

**213.** 0 1 2 3 Tend to be a "night person"
**214.** 0 1 2 3 Difficulty falling asleep
**215.** 0 1 2 3 Slow starter in the morning
**216.** 0 1 2 3 Tend to be keyed up, trouble calming down
**217.** 0 1 2 3 Blood pressureabove120/80
**218.** 0 1 2 3 Headache after exercising
**219.** 0 1 2 3 Feeling wired or jittery after drinking coffee
**220.** 0 1 2 3 Clench or grind teeth
**221.** 0 1 2 3 Calm on the outside, troubled on the inside
**222.** 0 1 2 3 Chronic low back pain, worse with fatigue
**223.** 0 1 2 3 Become dizzy when standing up suddenly
**224.** 0 1 2 3 Difficulty maintaining manipulative correction
**225.** 0 1 2 3 Pain after manipulative correction
**226.** 0 1 2 3 Arthritic tendencies
**227.** 0 1 2 3 Crave salty foods
**228.** 0 1 2 3 Salt foods before tasting
**229.** 0 1 2 3 Perspire easily
**230.** 0 1 2 3 Chronic fatigue, or get drowsy often
**231.** 0 1 2 3 Afternoon yawning
**232.** 0 1 2 3 Afternoon headache
**233.** 0 1 2 3 Asthma, wheezing/difficulty breathing
**234.** 0 1 2 3 Pain on the medial or inner side
**235.** 0 1 2 3 Tendency to sprain ankles
**236.** 0 1 2 3 Tendency to need sunglasses
**237.** 0 1 2 3 Allergies and/or hives
**238.** 0 1 2 3 Weakness, dizziness

## Section10

**239.** 0 1 Height over6' 6"(0=no,1=yes)
**240.** 0 1 Early sexual development (before age10)(0=no, 1=yes)
**241.** 0 1 2 3 Increased libido
**242.** 0 1 2 3 Splitting type headache
**243.** 0 1 2 3 Memory failing
**244.** 0 1 Tolerate sugar, feel fine when eating sugar(0=no, 1=yes)
**245.** 0 1 Height under4'10"(0=no,1=yes)
**246.** 0 1 2 3 Decreased libido
**247.** 0 1 2 3 Excessive thirst
**248.** 0 1 2 3 Weight gain around hips or waist
**249.** 0 1 2 3 Menstrual disorders
**250.** 0 1 Delayed sexual development(after age (0=no, 1=yes)
**251.** 0 1 2 3 Tendency to ulcers or colitis

## Section11

48

**252.** 0 1 2 3 Sensitive/allergic to iodine
**253.** 0 1 2 3 Difficulty gaining weight, even with large appetite
**254.** 0 1 2 3 Nervous, emotional, can't work under pressure
**255.** 0 1 2 3 Inward trembling
**256.** 0 1 2 3 Flush easily
**257.** 0 1 2 3 Fast pulse at rest
**258.** 0 1 2 3 Intolerance to high temperatures
**259.** 0 1 2 3 Difficulty losing weight
**260.** 0 1 2 3 Mentally sluggish, reduced initiative
**261.** 0 1 2 3 Easily fatigued, sleepy during the day
**262.** 0 1 2 3 Sensitive to cold, poor circulation(cold hands and feet)
**263.** 0 1 2 3 Constipation, chronic
**264.** 0 1 2 3 Excessive hair loss and/or coarse hair
**265.** 0 1 2 3 Morning headaches, wear off during the day
**266.** 0 1 2 3 Loss of lateral1/3 of eyebrow
**267.** 0 1 2 3 Seasonal sadness

## Section12 – Men Only

27

**268.** 0 1 2 3 Prostate problems
**269.** 0 1 2 3 Difficulty with urination, dribbling
**270.** 0 1 2 3 Difficult to start and stop urine stream
**271.** 0 1 2 3 Pain or burning with urination
**272.** 0 1 2 3 Waking to urinate at night
**273.** 0 1 2 3 Interruption of stream during urination
**274.** 0 1 2 3 Pain on inside of legs or heels
**275.** 0 1 2 3 Feeling of incomplete bowel evacuation
**276.** 0 1 2 3 Decreased sexual function

## Section13 –Women Only

60

**277.** 0 1 2 3 Depression during periods
**278.** 0 1 2 3 Mood swings associated with periods(PMS)
**279.** 0 1 2 3 Crave chocolate around periods
**280.** 0 1 2 3 Breast tenderness associated with cycle
**281.** 0 1 2 3 Excessive menstrual flow
**282.** 0 1 2 3 Scanty blood flow during periods
**283.** 0 1 2 3 Occasional skipped periods
**284.** 0 1 2 3 Variations in menstrual cycles
**285.** 0 1 2 3 Endometriosis
**286.** 0 1 2 3 Uterine fibroids
**287.** 0 1 2 3 Breast fibroids, benign masses
**288.** 0 1 2 3 Painful intercourse(dysparenia)
**289.** 0 1 2 3 Vaginal discharge
**290.** 0 1 2 3 Vaginal dryness
**291.** 0 1 2 3 Vaginal itchiness
**292.** 0 1 2 3 Gain weight around hips, thighs and buttocks
**293.** 0 1 2 3 Excess facial or body hair
**294.** 0 1 2 3 Hot flashes
**295.** 0 1 2 3 Night sweats(in menopausal females)
**296.** 0 1 2 3 Thinning skin

## Section14

30

**297.** 0 1 2 3 Aware of heavy and/or irregular breathing
**298.** 0 1 2 3 Discomfort at high altitudes
**299.** 0 1 2 3 "Air hunger" or sigh frequently
**300.** 0 1 2 3 Compelled to open windows in a closed room
**301.** 0 1 2 3 Shortness of breath with moderate exertion
**302.** 0 1 2 3 Ankles swell, especially at end of day
**303.** 0 1 2 3 Cough at night
**304.** 0 1 2 3 Blush or face turns red for no reason
**305.** 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
**306.** 0 1 2 3 Muscle cramps with exertion

## Section15

13

**307.** 0 1 2 3 Pain in mid-back region
**308.** 0 1 2 3 Puffy around the eyes, dark circles under eyes
**309.** 0 1 History of kidney stones (0=no, 1=yes)
**310.** 0 1 2 3 Cloudy, bloody or darkened urine
**311.** 0 1 2 3 Urine has a strong odor

## Section16

30

**312.** 0 1 2 3 Runny or drippy nose
**313.** 0 1 2 3 Catch colds at the beginning of winter
**314.** 0 1 2 3 Mucus producing cough
**315.** 0 1 2 3 Frequent colds or flu(0=1or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
**316.** 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1or less per year, 1=2 to 3 times per year, 2=4to 5 times per year,3=6 or more times per year)
**317.** 0 1 2 3 Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2years, 2 = not sick in last 4years, 3= not sick in last 7years)
**318.** 0 1 2 3 Acne (adult)
**319.** 0 1 2 3 Itchy skin(Dermatitis)
**320.** 0 1 2 3 Cysts, boils, rashes
**321.** 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1= yes in the past, 2 = currently mild condition, 3=severe)

THE Lakeside Clinic CENTER FOR INTEGRATED MEDICINE

## INFORMED CONSENT FOR NATUROPATHIC SERVICES

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Treatments include diet, nutrition, botanical medicine, acupuncture, physical manipulation, hydrotherapy, homeopathy, counseling, and Intravenous Therapy. These gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. The Naturopathic doctor will take a thorough case history, perform a physical examination and may take blood and urine samples. If your case requires and with your consent, the physical exam may include more specific examinations such as gynecological or prostate.

DEAR PATIENT,

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms. Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture, acupuncture or parenteral therapies
- Fainting with acupuncture needles or parenteral therapies or puncturing of an organ with acupuncture needles
- Muscle strains and sprains, disc injuries from spinal manipulation

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 myself when law requires it.** I also understand the potential risks to treatments as mentioned above.

I understand that my Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I will rely on the Naturopathic Doctor to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above. I also confirm that I have the ability to accept this care of my own free will and choice.

### Office Policies and Fees

New Patient Initial Assessment : $185.00
Follow-up and Assessment: $80.00
Follow-up Treatment : $45.00
Naturopathic Maintenance Visits $35.00
IV Vitamin Therapy $80.00-$250.00

Acupuncture Initial Assessment $ 90.00
Acupuncture Treatment $40.00
Referral Letters for clinic patients: $50.00
Cancelling without 24 hours notice $50.00
(exceptions for inclement weather)

**It is our policy that 24 hours notice is required to cancel/reschedule an appointment otherwise a fee of $50.00 will be charged. PLEASE INITIAL: _____**

I understand that the Naturopathic Doctor ***will not disclose or discuss test results over the phone or email. I understand that this office will not provide treatment options or change the treatment protocol over email or over the phone without an appointment.*** We may send out clinic newsletters to patients who provide an email. We may also contact you over email to change or modify an appointment. I understand that the Lakeside Clinic is not a Walk In Clinic and appointments are necessary.

I declare that I have received a full and complete explanation of the treatment or services that I may receive with my naturopathic doctor and hereby authorize and consent to treatment. I agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as other applicable fees.

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**It is very important that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise**

**your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.**

Patient Name: (please print name): _____

Signature of Patient or Guardian: _____Date:_____

Naturopathic Doctor: _____