North Coast Natural Health and Acupuncture Clinic

Naturopathic Visit Form

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General Information

Name *First* *Middle* *Last*

Preferred Name

Date of Birth

Age

Gender ○ Male ○ Female

Highest Education Level ○ High School ○ Undergraduate ○ Post-Graduate

Job Title

Nature of Business

Primary Address *Number, Street* *Apt. #*

City *State* *Zip*

Home Phone 1

Work Phone

Cell Phone

Email

I am willing to support the licensure of Naturopathic Doctors in Ohio. This will entail receiving emails when it is time to contact my Legislators to support the bill. *Check one:* Yes ___ No ___

May the Ohio Naturopathic Association send you quarterly emails? *Check one:* Yes ___ No ___

Emergency Contact *Name* *Phone Number*

Number, Street *Apt. #*

City *State* *Zip*

Physician(s) *Name* *Phone Number*

Name *Phone Number*

Name *Phone Number*

Referred by: ○ Provider ○ Website ○ Friend or Family Member ○ Other _____

Medical Questionnaire

Allergies

Medication/Supplement/Food	Reaction

Complaints/Concerns

What do you hope to achieve in your visit with us? _____

Reason for your visit today:

_____

_____

_____

When was the last time you felt well? _____

Did something trigger your change in health? _____

_____

What makes you feel worse? _____

_____

What makes you feel better? _____

_____

Medical History

☑ = Past Condition ☑ = Ongoing Condition

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide data of onset*

GASTROINTESTINAL

- ☐ ☐ Irritable Bowel Syndrome _____
- ☐ ☐ Inflammatory Bowel Disease_____
- ☐ ☐ Crohn's _____ _____
- ☐ ☐ Ulcerative Colitis _____
- ☐ ☐ Gastritis or Peptic Ulcer Disease _____
- ☐ ☐ GERD (reflux) _____
- ☐ ☐ Celiac Disease _____
- ☐ ☐ Other _____

CARDIOVASCULAR

- ☐ ☐ Heart Attack_____
- ☐ ☐ Other Heart Disease _____
- ☐ ☐ Stroke _____
- ☐ ☐ Elevated Cholesterol _____
- ☐ ☐ Arrythmia (irregular heart beat) _____
- ☐ ☐ Hypertension (high blood pressure) _____
- ☐ ☐ Rheumatic Fever _____
- ☐ ☐ Mitral Vale Prolapse _____
- ☐ ☐ Other _____

METABOLIC/ENDOCRINE

- ☐ ☐ Type 1 Diabetes _____
- ☐ ☐ Type 2 Diabetes _____
- ☐ ☐ Hypoglycemia _____
- ☐ ☐ Metabolic Syndrome _____
  Insulin Resistance or Pre-Diabetes
- ☐ ☐ Hypothyroidism (low thyroid) _____
- ☐ ☐ Hyperthyroidism (overactive thyroid) ____
- ☐ ☐ Endocrine Problems _____
- ☐ ☐ Polycystic Ovarian Syndrome _____
- ☐ ☐ Infertility _____
- ☐ ☐ Weight Gain _____
- ☐ ☐ Weight Loss _____
- ☐ ☐ Frequent Weight Fluctuations _____
- ☐ ☐ Bulimia _____
- ☐ ☐ Anorexia _____
- ☐ ☐ Binge Eating Disorder _____
- ☐ ☐ Night Eating Syndrome _____
- ☐ ☐ Eating Disorder (non-specific) _____
- ☐ ☐ Other _____

CANCER

- ☐ ☐ Lung Cancer _____
- ☐ ☐ Breast Cancer _____
- ☐ ☐ Colon Cancer_____
- ☐ ☐ Ovarian Cancer _____
- ☐ ☐ Prostate Cancer _____
- ☐ ☐ Skin Cancer _____
- ☐ ☐ Other _____

GENITAL AND URINARY SYSTEMS

- ☐ ☐ Kidney Stones _____
- ☐ ☐ Gout _____
- ☐ ☐ Interstitial Cystitis _____
- ☐ ☐ Frequent Urinary Tract Infections _____
- ☐ ☐ Frequent Yeast Infections _____
- ☐ ☐ Erectile Dysfunction _____
  or Sexual Dysfunction _____
- ☐ ☐ Other _____

MUSCULOSKELETAL/PAIN

- ☐ ☐ Osteoarthritis _____
- ☐ ☐ Fibromyalgia _____
- ☐ ☐ Chronic Pain _____
- ☐ ☐ Other _____

INFLAMMATORY/AUTOIMMUNE

- ☐ ☐ Chronic Fatigue Syndrome _____
- ☐ ☐ Autoimmune Disease _____
- ☐ ☐ Rheumatoid Arthritis _____
- ☐ ☐ Lupus SLE _____
- ☐ ☐ Immune Deficiency Disease _____
- ☐ ☐ Herpes-Genital _____
- ☐ ☐ Severe Infectious Disease _____
- ☐ ☐ Poor Immune Function _____
- ☐ ☐ Frequent Infections _____
- ☐ ☐ Food Allergies _____
- ☐ ☐ Environmental Allergies _____
- ☐ ☐ Multiple Chemical Sensitivities _____
- ☐ ☐ Latex Allergy _____
- ☐ ☐ Other _____

RESPIRATORY DISEASES

- ☐ ☐ Asthma _____
- ☐ ☐ Chronic Sinusitis _____
- ☐ ☐ Bronchitis _____
- ☐ ☐ Emphysema _____
- ☐ ☐ Pneumonia _____
- ☐ ☐ Tuberculosis _____
- ☐ ☐ Sleep Apnea _____
- ☐ ☐ Other _____

SKIN DISEASES

- ☐ ☐ Eczema _____
- ☐ ☐ Psoriasis _____
- ☐ ☐ Acne _____
- ☐ ☐ Melanoma _____
- ☐ ☐ Skin Cancer _____
- ☐ ☐ Other _____

MEDICAL HISTORY (continued)

☑ = *Past Condition* ☑ = *Ongoing Condition*

NEUROLOGIC/MOOD

- ☐ ☐ Depression _____
- ☐ ☐ Anxiety _____
- ☐ ☐ Bipolar Disorder _____
- ☐ ☐ Schizophrenia _____
- ☐ ☐ Headaches _____
- ☐ ☐ Migraines _____
- ☐ ☐ ADD/ADHD _____
- ☐ ☐ Autism _____
- ☐ ☐ Mild Cognitive Impairment _____
- ☐ ☐ Memory Problems _____
- ☐ ☐ Parkinson's Disease _____
- ☐ ☐ Multiple Sclerosis _____
- ☐ ☐ ALS _____
- ☐ ☐ Seizures _____
- ☐ ☐ Other Neurological Problems

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam _____
- ☐ Bone Density _____
- ☐ Colonoscopy _____
- ☐ Cardiac Strees Test _____
- ☐ EBT Heart Scan _____
- ☐ EKG _____
- ☐ Hemoccult Test—stool test for blood _____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____
- ☐ Ultrasound _____

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy _____
- ☐ Hysterectomy +/- Ovaries _____
- ☐ Gall Bladder _____
- ☐ Hernia _____
- ☐ Tonsillectomy _____
- ☐ Dental Surgery _____
- ☐ Joint Replacement—Knee/Hip _____
- ☐ Heart Surgery—Bypass Valve _____
- ☐ Angoplasty or Stent _____
- ☐ Pacemaker _____
- ☐ Other _____
- ☐ None _____

INJURIES

Check box if yes

- ☐ Back Injury ☐ Head Injury
- ☐ Neck Injury ☐ Broken Bones
- ☐ Other _____

BLOOD TYPE

○ A ○ B ○ O ○ Rh+ ○ Unknown

HOSPITALIZATIONS ☐ None

Date	Reason

COMMENTS

Gynecologic History (for women only)

OBSTETRIC HISTORY *Check box if yes and provide number of*

☐ Pregnancies _____ ☐ Caesarean ☐ Vaginal Deliveries
☐ Miscarriage _____ ☐ Abortion ☐ Living Children
☐ Post Partum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby over 8 Pounds
☐ Breast Feeding For how long: _____

MENSTRUAL HISTORY

Age at First Period: _____ Menses Frequency: _____ Length: _____ Pain: ○ Yes ○ No
Clotting: ○ Yes ○ No Has your period ever skipped? _____ For how long? _____
Last Menstrual Period: _____
Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long? _____
Do you use contraception? ○ Yes ○ No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility
☐ Painful Periods ☐ Heavy Periods ☐ PMS
Last Mammogram: _____ ☐ Breast Biopsy/Date: _____
Last PAP Test: _____ ○ Normal ○ Abnormal
Last Bone Density: _____ Results? ○ High ○ Low ○ Within Normal Range
Are you in menopause? ○ Yes ○ No
Age at menopause? _____
☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems ☐ Decreased Libido
☐ Vaginal Dryness ☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain
☐ Palpitations ☐ Loss of Control of Urine
☐ Use of hormone replacement therapy How long? _____

Men's History *(for men only)*

Have you had a PSA done? ○ Yes ○ No
PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10
☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence
☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection
☐ Nocturia (urination at night) How many times a night? _____
☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

PLEASE COMPLETE IF YOU ARE SEEKING TREATMENT FOR PAIN:

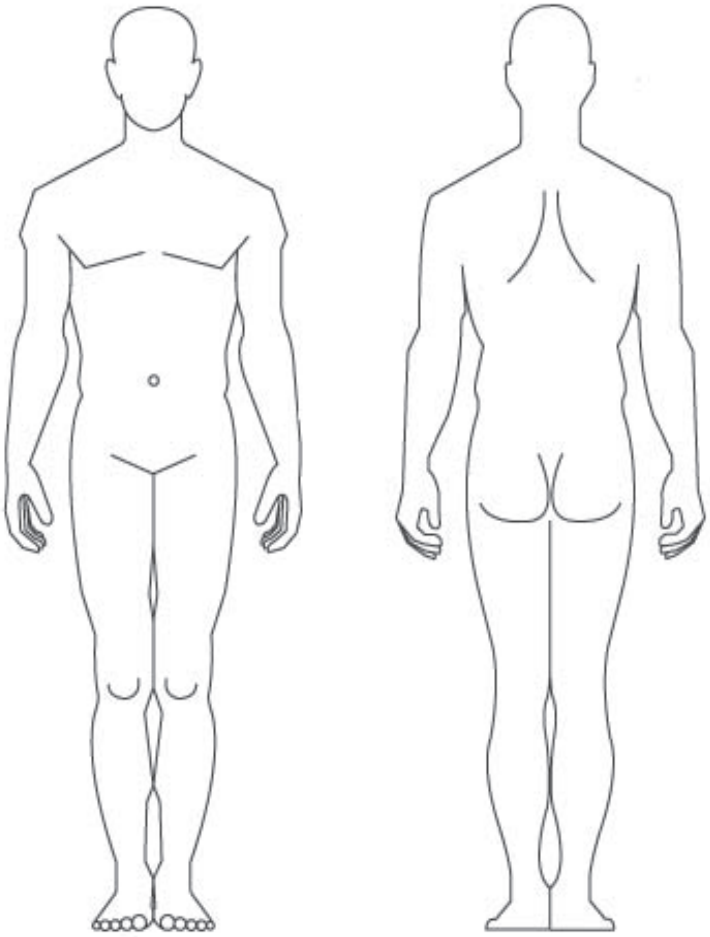
Please describe your pain level 0 no pain at all to 10 being the worst

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

How long have you had pain? _____ years _____ months _____ days

Has surgery been performed on the site(s) ○ Yes ○ No

Using the letters at the bottom of the page to describe your discomfort, indicate directly on the figures in the exact area you are experiencing discomfort.



D - Dull	**S - Sharp**	**C - Cramping**	**B - Burning**
R - Radiating	**M - Moves About**	**N - Numbness**	**T - Tingling**
X - Scars from injury or surgery	**A - Acne**	**O - Rashes, Skin Disorders**	**Other**

GI History

Foreign Travel? ○ Yes ○ No Where? _____

Wilderness Camping? ○ Yes ○ No Where? _____

Have you ever had severe: ○ Gastroenteritis ○ Diarrhea

Do you feel like you digest your food well: ○ Yes ○ No

Do you feel bloated after meals? ○ Yes ○ No

Patient Birth History

○ Term ○ Premature

Pregnancy Complications: _____

Birth Complications: _____

☐ Breast Fed? How long? _____ ☐ Bottle-fed

Dental History

DENTAL SURGERY

☐ Silver Mercury Fillings How Many? _____

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Problems with Chewing

Do you floss regularly? ○ Yes ○ No

Medications

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason for Use

MEDICATIONS (continued)

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY

Supplement	Dose	Frequency	Start Date (month/year)	Reason for Use

Have your medications or supplements ever caused you unusual side effects or problems? ○ Yes ○ No

Describe _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin ○ Yes ○ No

Have you had prolonged or regular use of Tylenol? ○ Yes ○ No

Have you had prolonged or regular use of a Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)? ○ Yes ○ No

Frequent antibiotics? >3 times/year ○ Yes ○ No

Long term antibiotics? ○ Yes ○ No

Use of steroids (prednisone, nasal allergy inhalers) in the past? ○ Yes ○ No

Use of oral contraceptives? ○ Yes ○ No

Family History

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Other Relative	
Age (if still alive)							
Age at death (if deceased)							
ADHD							
ALS or Motor Neuron Diseases							
Asthma							
Autism							
Autoimmune Diseases (such as lupus)							
Bipolar Disease							
Breast or Ovarian Cancer							
Cancers (other)							
Celiac Disease							
Colon Cancer							
Dementia							
Depression							
Diabetes							
Eczema							
Environmental Sensitivities							
Food Allergies							
Genetic Disorders							
Heart Disease							
Hypertension							
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis							
Inflammatory Bowel Disease							
Irritable Bowel Syndrome							
Multiple Sclerosis							
Obesity							
Osteoporosis							
Parkinson's							
Psychiatric							
Schizophrenia							
Stroke							
Substance Abuse							

NUTRITION HISTORY

Height (feet/inches) _____	Current Weight _____
Usual Weight Range +/- 5 lbs _____	Desired Weight Range +/- 5 lbs _____
Highest Adult Weight _____	Lowest Adult Weight _____
Weight Fluctuations _____	Body Fat % _____

Do you avoid any particular foods? ○ Yes ○ No If yes, types and reason: _____

_____

If you could only eat a few foods a week, what would they be? _____

_____

Do you grocery shop? ○ Yes ○ No If no, who does the shopping? _____

Do you read food labels? ○ Yes ○ No _____

Do you cook? ○ Yes ○ No If no, who does the cooking? _____

How many meals do you eat out per week? ☐ 0-1 ☐ 2-3 ☐ 3-5 ☐ >5 meals per week

SMOKING

Currently smoking? ○ Yes ○ No How many years? _____ Packs per day? _____

Number of attempts to quit: _____

Previous Smoking: How many years? _____ Packs per day? _____

Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits*

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 *If "None," skip to Other Substances*

OTHER SUBSTANCES

Caffeine Intake: ○ Yes ○ No | Coffee-cups/day: ○ 1 ○ 2-4 ○ > 4 | Tea-cups per day: ○ 1 ○ 2-4 ○ > 4

Caffeinated Soda or Diet Soda Intake: ○ Yes ○ No

12-ounce can/bottle ☐ 1 ☐ 2-4 ☐ > 4 per day

List favorite type (ex. Diet Coke, Pepsi, etc.) _____

Are you currently using any recreational drugs? ○ Yes ○ No If yes, what? _____

EXERCISE

Current Exercise Program: *(list type of activity, number of sessions/week, and duration)*

Activity	Type	Frequency per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, etc)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

EXERCISE (cont'd)

Rate your level of motivation for including exercise in your life? ○ Low ○ Medium ○ High
List problems that limit activity _____

_____

Do you feel unusually fatigued after exercise? ○ Yes ○ No
If yes, please describe: _____

_____

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ○ Yes ○ No
Are you happy? ○ Yes ○ No
Do you feel your life has meaning and purpose? ○ Yes ○ No
Do you believe stress is presently reducing the quality of your life? ○ Yes ○ No
Do you like the work you do? ○ Yes ○ No
Have you ever experienced major losses in your life? ○ Yes ○ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations? ○ Yes ○ No
Would you describe your childhood as happy and secure? ○ Yes ○ No

STRESS COPING

Have you ever sought counseling? ○ Yes ○ No Describe _____
Are you currently in therapy? ○ Yes ○ No
Do you feel you have an excessive amount of stress in your life? ○ Yes ○ No
Do you feel you can easily handle the stress in your life? ○ Yes ○ No
Daily Stressors: Rate on scale of 1-10
Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____
Do you practice meditation or relaxation techniques? ○ Yes ○ No
Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other
Have you ever been abused, a victim of crime, or experienced a significant trauma? ○ Yes ○ No

SLEEP REST

Average number of hours you sleep per night: ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6
Do you have trouble falling asleep? ○ Yes ○ No
Do you feel rested upon awakening? ○ Yes ○ No
Do you have problems with insomnia? ○ Yes ○ No
Do you snore? ○ Yes ○ No
Do you use sleeping aids? ○ Yes ○ No Explain: _____

ROLES/RELATIONSHIP

Marital Status ○ Single ○ Married ○ Divorced ○ Gay/Lesbian ○ Long-Term Partnership ○ Widow(er)

List Children

Child's Name	Age	Gender

ROLES/RELATIONSHIP (cont'd)

Who is Living in Household? Number _____ Names: _____

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other _____

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At school				
in your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children				
With your parents				
With your spouse				

Environmental and Detoxification Assessment

Do you have any adverse food reactions or sensitivities? ○ Yes ○ No If yes, describe symptoms _____

Do you adversely react to: *(check all that apply):*

☐ Monosodium Glutamate ☐ Aspartame (Nutrasweet) ☐ Caffeine ☐ Bananas ☐ Garlic ☐ Onion

☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine ☐ Preservatives (ex. sodium benzoate)

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Other _____

Which of these significantly affect you? *(check all that apply)*

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other _____

In your work or home environment, are you exposed to: ☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides ☐ Organic Solvents

☐ Heavy Metals ☐ Other _____

Chemical Name, Date, Length of Exposure _____

Do you dry clean your clothes frequently: ○ Yes ○ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? ○ Yes ○ No

Do you have any pets or farm animals? ○ Yes ○ No

Symptom Review

Please check all current symptoms occurring or present in the past 6 months

GENERAL
- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

HEAD, EYES & EARS
- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Red/Inflamed Eyelid
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision Problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MUSCULOSKELETAL
- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness
- ☐ Muscle Twitches
  - ☐ Around Eyes
  - ☐ Arms or Legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES
- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression

Difficulty
- ☐ Concentrating
- ☐ With Balance
- ☐ With Thinking
- ☐ With Judgment
- ☐ With Speech
- ☐ With Memory

- ☐ Dizziness (spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-Headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

EATING
- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (breads, pastas)
- ☐ Sweet Cravings (candy, cookies, cakes)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION
- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums

Bloating of:
- ☐ Lower Abdomen
- ☐ Whole Abdomen
- ☐ Bloating After Meals

- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Coldsores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/ Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting

Intolerance to:
- ☐ Lactose
- ☐ All Dairy Products
- ☐ Wheat
- ☐ Gluten (Wheat, Rye, Barley)
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast

- ☐ Liver Disease/Jaundice (Yellow Eyes or Skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools

SKIN PROBLEMS
- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athletes Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/ Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN
- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat
- ☐ Lackluster Skin

SKIN, DRYNESS OF
- ☐ Eyes
- ☐ Feet
  - Any Cracking?
  - Any Peeling?
- ☐ Hair
  - ☐ Dry?
- ☐ Hands
  - Any Cracking:
  - Any Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - Any Dandruff
- ☐ Skin in General

LYMPH NODES
- ☐ Enlarged Neck
- ☐ Tender Neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

NAILS
- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus Fingers
- ☐ Fungus Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft

Thickening of:
- ☐ Fingernails
- ☐ Toenails

- ☐ White Spots/Lines

RESPIRATORY
- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat

Hay Fever
- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Change of Season

- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR
- ☐ Angina/Chest Pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veinss

URINARY
- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

MALE REPRODUCTIVE
- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps in Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE
- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:
- ☐ Bloating
- ☐ Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual
- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

Readiness Assessment

I WOULD LIKE TO:

Energy, Vitality

- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be less tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- ☐ Stop using laxatives and stool softeners
- ☐ Improve sex drive

Body Composition

- ☐ Lose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

Stress: Mental and Emotional

- ☐ Learn how to reduce stress
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Feel more motivated

Life Enrichment

- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from a “treating-illness” orientation to creating a wellness lifestyle

Readiness Assessment

Rate on a scale of 5 (very willing) to (not willing):

In order to improve your health, how willing are you to:

Significantly modify your diet . . . . . ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

Take nutritional supplements each day . . . . . ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

Keep a record of everything you eat each day . . . . . ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

Modify your lifestyle (e.g., work demands, sleep habits) . . . . . ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

Practice a relaxation technique . . . . . ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

Engage in regular exercise . . . . . ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

Have periodic lab tests to assess your progress . . . . . ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

Comments _____

_____

_____

Rate on a scale of 5 (very confident) to 1 (not confident at all)

How confident are you of your ability to organize and follow through on the above health related activities? ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? _____

_____

_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive)

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

Comments _____

_____

_____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact)

How much on-going support and contact (e.g., telephone consults, email correspondence) from me would be helpful to you as you implement your personal health program? ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

Comments _____

_____

_____

Medical Symptom/Toxicity Questionnaire

NAME _____ DATE _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over tme. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for the last 48 hours ONLY.

POINT SCALE
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT
____ Nausea or Vomiting
____ Diarrhea
____ Constipation
____ Bloated Feeling
____ Belching or Passing Gas
____ Heartburn
____ Intestinal/Stomach Pain
Total _____

EARS
____ Itchy Ears
____ Earaches, Ear Infections
____ Drainage From Ear
____ Ringing in Ears, Hearing Loss
Total _____

EMOTIONS
____ Mood Swings
____ Anxiety, Fear or Nervousness
____ Anger Irritability or Aggressiveness
____ Depression
Total _____

ENERGY/ACTIVITY
____ Fatigue, Sluggishness
____ Apathy, Lethargy
____ Hyperactivity
____ Restlessness
Total _____

EYES
____ Watery or Itchy Eyes
____ Swollen, Reddened or Sticky Eyelids
____ Bags or Dark Circles Under Eyes
____ Blurred or Tunnel Vision (does not include near or far-sightedness)
Total _____

HEAD
____ Headaches
____ Faintness
____ Dizziness
____ Insomnia
Total _____

HEART
____ Irregular or Skipped Hearbeat
____ Rapid or Pounding Heartbeat
____ Chest Pain
Total _____

JOINTS/MUSCLES
____ Pain or Aches in Joints
____ Arthritis
____ Stiffness or Limitation of Movement
____ Pains or Aches in Muscles
____ Feeling of Weakness or Tiredness
Total _____

LUNGS
____ Chest Congestion
____ Asthma, Bronchitis
____ Shortness of Breath
____ Difficult Breathing
Total _____

MIND
____ Poor Memory
____ Confusion, Poor Comprehension
____ Poor Concentration
____ Poor Physical Coordination
____ Difficulty in Making Decisions
Stuttering or Stammering
Slurred Speech
Learning Disabilities
Total _____

MOUTH/THROAT
____ Chronic Coughing
____ Gagging, Frequent Need to Clear Throat
____ Sore throat, Hoarseness, Loss of Voice
____ Swollen, Discolored Tongue, Gum, Lips
____ Canker Sores
Total _____

NOSE
____ Stuffy Nose
____ Sinus Problems
____ Hay Fever
____ Sneezing Attacks
____ Excessive Mucus Formation
Total _____

SKIN
____ Acne
____ Hives, Rashes, or Dry Skin
____ Hair Loss
____ Flushing or Hot Flushes
____ Excessive Sweating
Total _____

WEIGHT
____ Binge Eating/Drinking
____ Craving Certain Foods
____ Excessive Weight
____ Compulsive Eating
____ Water Retention
____ Underweight
Total _____

OTHER
____ Frequent Illness
____ Frequent or Urgent Urination
____ Genital Itch or Discharge
Total _____

KEY TO QUESTIONNAIRE
Add individual scores and total each group. Add each group score and give a grand total.
• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

Informed Consent and Financial Policies

1. **Consent for Healthcare**: I, the undersigned, voluntarily seek healthcare services provided by Dr. Tamara Macdonald ND, LAc. I am, in good faith, exercising my free will and following the dictates of my own conscience, which allows me to contract for what I believe to be most beneficial for me. I am not obligated to continue utilizing the services of Dr. Macdonald, ND, LAc, and may discontinue the use of these services at any time. The choice I make in contracting for these services is not to be overridden by any family member, court of law, medical facility or other physician, and I charge same to honor this contract.
2. **I understand that Dr.** Tamara Macdonald, ND, LAc is not a Medical Doctor (MD), an Osteopathic Doctor (DO) or Chiropractor (DC). I also understand that Dr. Macdonald attended Bastyr University, a well-known Natural Medical School in Kenmore, WA, completing all academic and clinical requirements as well as passing National Board exams. Dr. Macdonald holds and maintains her license as a primary care physician in the State of Washington. The State of Ohio does not currently license Naturopathic Physicians. I understand that the lack of licensure in the state of Ohio prevents her from diagnosing, treating or curing any specific disease I may have. I also understand that Dr. Macdonald can however, help me to improve my health in order to allow my body to heal itself. I agree to hold harmless and waive any claim of present or future liability or negligence against Tamara A. Macdonald, and/or North Coast Natural Health for recommendations, services rendered or products purchased. I understand that the recommendations and services rendered by Dr. Macdonald may differ from those usually offered by a conventional medical doctor or other health care provider. I understand that like all medicine, Natural health care is not an exact science and understand that no guarantees have been made as to the results of services.
3. **I have read, understand and signed** the non-medical & complementary nature of services document that has been made available to me.
4. **Confidentiality**: All information provided on the health/questionnaire/intake form or during office visits is confidential. Information will only be released with the patient's written and signed request, or if requested by the proper legal authorities.
5. **Fees and Payment**: Fees for office visits and phone consultations are based on a rate of $165 per hour for Naturopathic Physician services and $125 per hour for Acupuncture services. Full payment is expected at time of service for office visits, supplements, lab fees and/or products sold. Cash, personal checks and major credit cards are accepted.
6. **Insurance**: Most insurance coverage is limited to those states that offer licensure to Naturopathic doctors. Currently, Ohio is not a licensed state and therefore it is unlikely your insurance provider will cover services rendered by a Naturopathic doctor. Ohio does license Acupuncture, and again, depending on your coverage, your visit may or may not be covered. Although Dr. Macdonald does not bill the insurance companies directly, we will be happy to supply you with the appropriate forms for you to submit to your insurance provider for reimbursement.
7. **Cancellation Policy**: Dr. Macdonald requires that cancellations for scheduled appointments be received 24 hours in advance during regular office hours (M-F, 9am – 5pm). We reserve the right to charge for missed or cancelled appointments that do not follow this policy. Fees are based on a rate of $165 per hour.

I fix my signature to certify **that I,** _____ am voluntarily seeking the services of **Dr. Tamara Macdonald, ND, LAc,** and have read, understand, and agree to the above statements and policies.

Signature _____ Date: _____

Consent for Treatment, Payment, and Healthcare Operations

1. **Consent**: I consent to the use or disclosure of my protected health information by employees of Dr. Tamara Macdonald for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or conducting healthcare operations. I understand that diagnosis or treatment of me by Dr. Macdonald may be conditioned upon my consent as evidenced by my signature on this document.

2. **Rights**: I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Dr. Macdonald is not required to agree to the restrictions that I may request. However, if Dr. Macdonald agrees to a restriction that I request, the restriction is binding on Dr. Macdonald. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Macdonald has taken action in reliance on this consent.

3. **Protected Health Information**: My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

4. **Notice of Privacy Practices**: I understand I have a right to review the Notice of Privacy Practices of Advanced Medicine Clinic prior to signing this document. The Notice of Privacy Practices has been made available to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations by Dr. Macdonald. The Notice of Privacy Practices is provided at Dr. Macdonald's place of business.

   The Notice of Privacy Practices also describes my rights and the duties of Dr. Macdonald with respect to my protected health information. Dr. Macdonald reserves the right to change the practices that are described in the Notice of Privacy Practices.

   I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy, or asking for one at the time of my next appointment.

Name of Patient (please print) _____

Signature _____ Date _____