

Hello and Welcome

Thank you for choosing Naturopathic Wisdom. We know you have choices when it comes to your healthcare and we are dedicated to providing our patients with the best care possible.

Enclosed you will find new patient forms. Before your scheduled appointment, please carefully read and fill out the enclosed forms. We know your time is valuable and bringing your completed patient information forms with you will maximize the amount of time spent with the doctor.

Your first visit will be an assessment of your health lasting approximately 1 hour or more. The fee varies and is based on time; feel free to call the office if you need more information.

If you are unable to keep your scheduled appointment time please call as soon as possible so that we may reschedule your visit.

Remember to bring copies of any recent lab work or medical records as well as any supplements or medications you are currently taking.

We look forward to supporting you in your healing journey.

In Health,

Naturopathic Wisdom

Name _____

Date __/__/__

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1. Why did you choose to come to this clinic?
2. What do you know about our approach?
3. What *three* expectations do you have from *this* visit to our clinic?
4. What *long-term* expectations do you have from working with our clinic?
5. What expectations do you have of me personally as your health care provider?
6. What obstacles do you see to achieving optimal wellness?
7. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.
0% 0 1 2 3 4 5 6 7 8 9 10 100%
8. What behaviors or lifestyle habits do you currently engage in regularly that you believe; Supports your health?

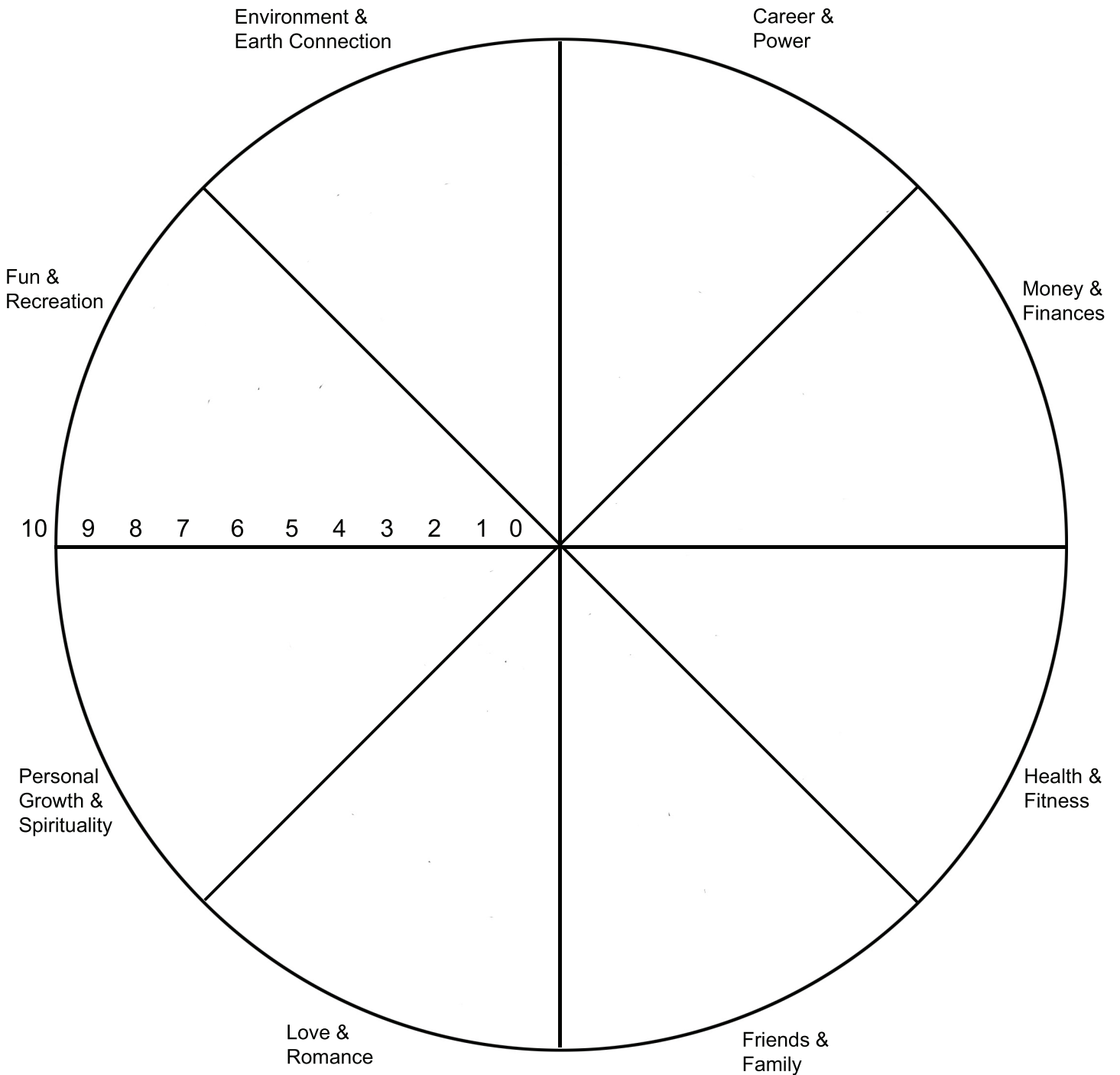
Are self-destructive?
9. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?
10. Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?
11. What do you love to do?

Name _____

Date ___/___/___

Wheel of Life Inventory

Directions: The Wheel of Life represents balance. Seeing the center of the wheel as 0 and the outer edge as 10, rank your level of satisfaction with each life area by coloring in to the level you see yourself at for each area of life. This then represents your wheel of life.



Naturopathic Wisdom



CONFIDENTIAL PATIENT INFORMATION

PLEASE FILL IN ALL PORTIONS OF THIS FORM. IF YOU NEED HELP, PLEASE ASK

Today's Date _____

How did you hear about us? Yellow pages _____ Newspaper _____ Radio/Television _____
Internet _____ Location/Sign _____ Referred by (name) _____
Bay Area Naturally _____ Meetup _____ Whole Foods (name) _____

First Name _____ M _____ Last Name _____ Age _____ Marital Status _____

Permanent Address _____ Apt. _____ City _____ State _____ Zip _____

Temporary Address _____ Apt. _____ City _____ State _____ Zip _____

Phone (Permanent) _____ (Cell) _____ (Work) _____

Email _____ Email (alt.) _____

SS# _____ Birth date _____ Sex _____ Driver's License # _____

Occupation _____ Employed by _____

Work Address _____ Suite _____ City _____ State _____ Zip _____

Name of nearest relative not living with you _____ Phone _____

Name of spouse (or parent for minor child) _____ SS # _____

Occupation _____ Employed by _____ Work # _____

Whom may we contact in case of emergency? _____ Phone _____

CLINIC POLICY REQUIRES PAYMENT AT TIME OF SERVICES. I WILL BE PAYING TODAY BY:

CASH _____ CHECK _____ VISA _____ MASTERCARD _____

At time of payment, you will be given a copy of your superbill from our office. This will show the services and charges for that day.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and services, any fees for professional services rendered me will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance.

Releases may be requested prior to specific procedures being performed

Patient's Signature

Parent or Guardian's Signature

Date

Current Health Problems	Family Disease History	Self	Par	GP	Current Medications	Current Vitamins or Herbs
1	(Please Check Box)				1	1
2	Asthma				2	2
3	Arthritis				3	3
4	Alcoholism				4	4
5	Epilepsy				5	5
	Thyroid				6	6
Surgery/Hospital Stay /Year	Obesity					
1	Heart Attack				Drug Allergies	Diet and Nutrition
2	High Blood Pressure				1	Estimate how often you use
3	Mental disorder				2	Per Day or Week
4	Cancer				3	Sugar, Sweets, Chocolate
	Other:				Airborne Allergies	Yes
Rate current Stress 0-10					Dust	Coffee/Black Tea
Mild 1-3, Mod. 4-6, Severe 7-9					Pollen	Tobacco/Cigarettes
Job or School	Personal Health Hist			Now/Past	Weeds	Beer/Wine
Financial/Money	Fatigue				Grass	Alcohol
Primary Relationship	Low Blood Sugar				Trees	Aspirin/Tylenol
Family, Parents, Children	Poor Sleep				Molds	Nutrasweet, etc.
Divorce/Separation/Death	Anxiety				Smoke	Cheese
Chemical, Allergy	Depression				Other	Milk
Overall Stress Level	Overweight					Fried Foods
	Headache				Food Sensitivities	Yes
Have you ever used:	Neck Pain				Dairy	Beef/ Ham burger/Steak
Vitamin Therapy	Back Pain				Wheat	etc.
Herbal Medicines	Joint Pain				Alcohol	Turkey, Chicken
Homeopathic Medicine	Allergies, Hay Fever				Other: 1	Tuna, Fish
Acupuncture	Sinusitis				2	Beans, Peas
Spinal Manipulation	Recurrent Colds, Flu				3	Salad
Colonic Therapy -	Infections					Fresh Fruit
Therapeutic Fasting	Ear/Eye Problems				Chemical Sensitivities	Yes
Massage Therapy	Poor Digestion, Gas				Odors	Fruit
Naturopathic Physician	Recurrent Diarrhea				Solvents	Fresh Vegetables
	Constipation				Soaps	Potatoes, Squash, Carrots
List your Health Goals:	Abdominal Bloating				Other:	Other Cooked Vegetables
	High Blood Pressure					Wheat, Bread, Muffins
	Fat				List Medical Providers -	Pasta
	Premenstrual Symptoms				Family Physician:-	Rice, Oatmeal, Barley
	Menstrual Problems				Chiropractor:	
	Menopausal				Psychologist:	
Indicate problem areas:	Hot Flashes				OB/Gyn:	Blood Type
Front	Breast Problems				Naturopathic Dr.:	
Back	Alcoholism				Nutritionist:	Exercise
	Drug Addiction					Day
	History of Abuse				How did you hear about Us?	Walk/Run
	Sexual Dysfunction				Name of Doctor:	Swim
					Name of Friend:	Bike
					Yellow Pages	Aerobics
					Article in Media	Other
					Clinic Sign	
					Other Ad	

