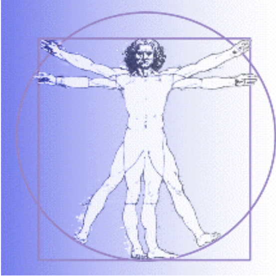


Naturopathic Wisdom, Inc.
David Hogg, ND Naturopathic Doctor

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.

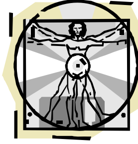
Remember to bring copies of any recent lab work or medical records as well as any supplements or medications you are currently taking.

We look forward to supporting you in your healing journey.

In Health,

Naturopathic Wisdom

Naturopathic Wisdom, Inc



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_________ Health Profs___________________
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

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?

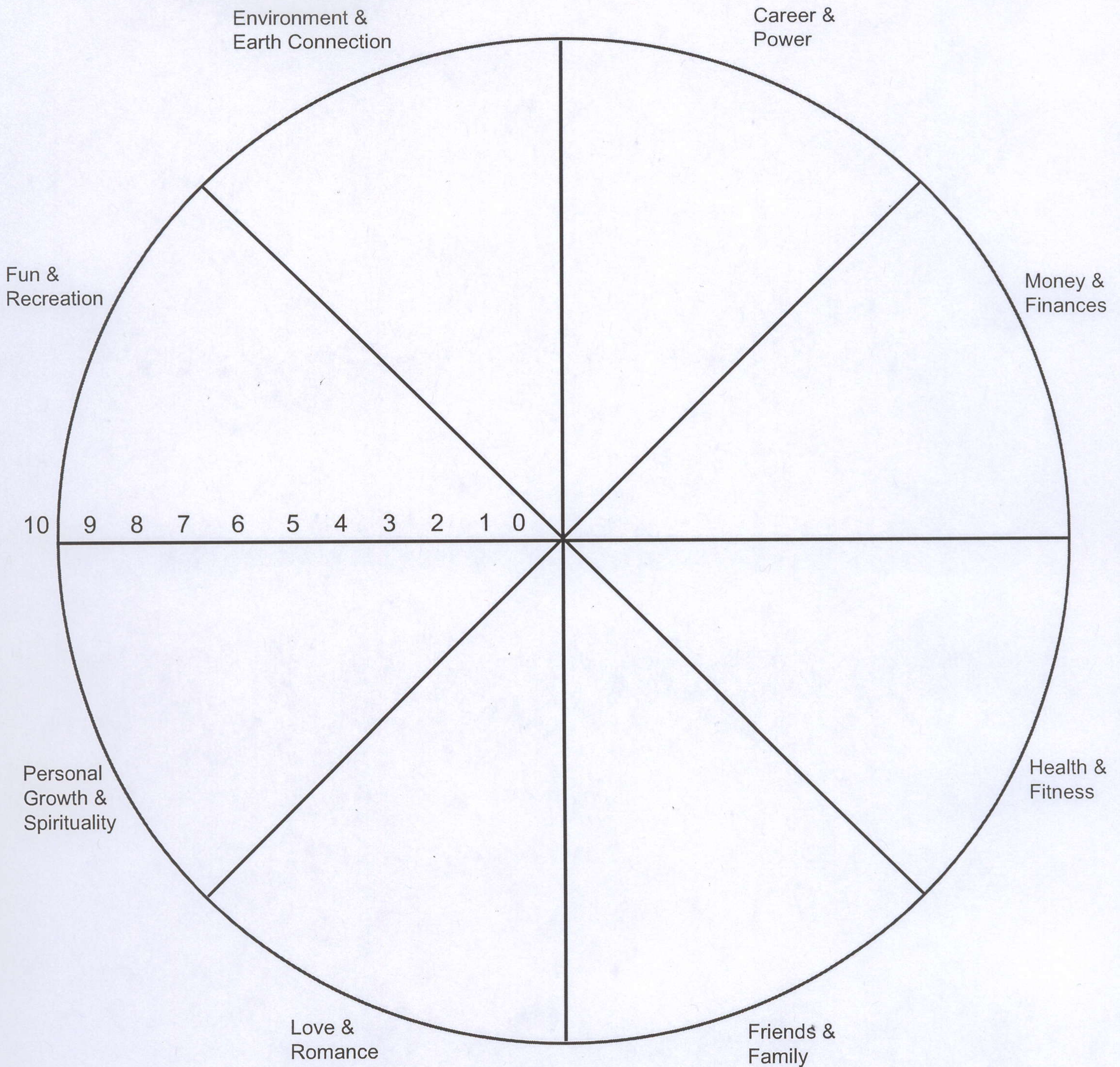
10. Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

11. What do you love to do?

Name ____ Date ___/___/___

Wheel of Life Inventory

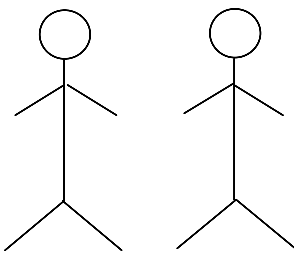
Directions: The Wheel of Life represents balance. Seeing the center of the wheel as 0 and the outer edge as 10, rank your level of satisfaction with each life area by coloring in to the level you see yourself at for each area of life. This then represents your wheel of life.



Naturopathic Wisdom Name: ________________________________ Date: _____________________

Current Health Problems	
1	
2	
3	
4	
5	
Surgery/Hospital Stay /Year	
1	
2	
3	
4	
Rate current Stress 0-10	
Mild 1-3, Mod. 4-6, Severe 7-9	
Job or School	
Financial/Money	
Primary Relationship	
Family, Parents, Children	
Divorce/Separation/Death	
Chemical, Allergy	
Overall Stress Level	
Have you ever used:	
Vitamin Therapy	
Herbal Medicines	
Homeopathic Medicine	
Acupuncture	
Spinal Manipulation	
Colonic Therapy -	
Therapeutic Fasting	
Massage Therapy	
Naturopathic Physician	
List your Health Goals:	
Indicate problem areas:	

Front Back



Family Disease History	Self	Par	GP
(Please Check Box)			
Asthma			
Arthritis			
Alcoholism			
Epilepsy			
Thyroid			
Obesity			
Heart Attack			
High Blood Pressure			
Mental disorder			
Diabetes			
Cancer			
Other:			

Personal Health Hist	Now/Past	
Fatigue		
Low Blood Sugar		
Poor Sleep		
Anxiety		
Depression		
Overweight		
Headache		
Neck Pain		
Back Pain		
Joint Pain		
Allergies, Hay Fever		
Sinusitis		
Recurrent Colds, Flu		
Infections		
Ear/Eye Problems		
Poor Digestion, Gas		
Recurrent Diarrhea		
Constipation		
Abdominal Bloating		
High Blood Pressure		
Fat		
Premenstrual Symptoms		
Menstrual Problems		
Menopausal		
Hot Flashes		
Breast Problems		
Alcoholism		
Drug Addiction		
History of Abuse		
Sexual Dysfunction		

Current Medications
1
2
3
4
5
6
Drug Allergies
1
2
3

Airborne Allergies	Yes
Dust	
Pollen	
Weeds	
Grass	
Trees	
Molds	
Smoke	
Other	
Food Sensitivities	**Yes**
Dairy	
Wheat	
Alcohol	
Other: 1	
2	
3	
Chemical Sensitivities	**Yes**
Odors	
Solvents	
Soaps	
Other:	

List Medical Providers -
Family Physician:-
Chiropractor:
Psychologist:
OB/Gyn:
Naturopathic Dr.:
Nutritionist:
How did you hear about Us?
Name of Doctor:
Name of Friend:
Yellow Pages
Article in Media
Clinic Sign
Other Ad

Current Vitamins or Herbs
1
2
3
4
5
6

Diet and Nutrition

Estimate how often you use

Per Day or Week	D	W
Sugar, Sweets, Chocolate		
Soda Pop		
Coffee/Black Tea		
Tobacco/Cigarettes		
Beer/Wine		
Alcohol		
Aspirin/Tylenol		
Nutrasweet, etc.		
Cheese		
Milk		
Fried Foods		
Margarine or Butter		
Beef/ Ham burger/Steak		
etc.		
Turkey, Chicken		
Tuna, Fish		
Beans, Peas		
Salad		
Fresh Fruit		
Juice, Bottled or Frozen		
Fruit		
Fresh Vegetables		
Potatoes, Squash, Carrots		
Other Cooked Vegetables		
Wheat, Bread, Muffins		
Pasta		
Rice, Oatmeal, Barley		

Blood Type	

Exercise	Day	Wk
Walk/Run		
Swim		
Bike		
Aerobics		
Other		