New Patient Information Form

Organic Living and Wellness

Today's Date: ____________________

Patient Information					
First Name			MI	Last Name	
Birth Date (mm/dd/yyyy)	Gender ☐ Male ☐ Female ☐ Other / Unspecified			Marital Status ☐ Single ☐ Married / Partner ☐ Divorced / Separated ☐ Widowed	
Street Address					
City		State	Zip	Phone Number: ☐ Cell phone?	
Email:					
Responsible party (If patient is a minor)				Relation to patient	☐ Father ☐ Mother ☐ Other:
How did you learn about us?	☐ Doctor / Professional ☐ Friend / Family ☐ Internet ☐ Drive by ☐ Other:				

Patient Medical Information			
Reason for visit:			
Are you working with any other doctors on these problems? ☐ Yes ☐ No What kinds of doctors? What have they said?			
Height (feet/inches)	Weight (lbs.)	Blood type	☐ O ☐ A ☐ B ☐ AB ☐ Positive ☐ Negative
How long ago was your last… Physical exam? ____________ Bloodwork done? ____________		Have you… Seen a Naturopath before? ☐ Yes ☐ No Had Acupuncture before? ☐ Yes ☐ No	
Please list any prescription or over the counter medication you are currently taking:		Please list any herbal medicine or supplements you are currently taking:	
Please list any allergies you have (environmental, food, medications):			

Patient Lifestyle					
How often do you use the following?	Daily	Once a week	Some-times	Rarely/ Never	How much water do you drink per day?
Soft drinks					Dietary restrictions ☐ Yes ☐ No ☐ Vegetarian ☐ Vegan ☐ Diet program Please explain further if needed:
Coffee					
Alcohol					
Tobacco					
Marijuana					
Recreational Drugs					
How many hours of sleep do you get per night? __________ hours Do you have any trouble sleeping? ☐ Yes ☐ No					Have you ever had environmental exposure (mold, chemicals)? ☐ Yes ☐ No If yes, please explain:
Occupation: Please explain your duties and stress levels involved.					
Personal impact: Please explain any personal stresses in your life.					

Medical Symptoms, Conditions & History

Instructions: Check off any symptoms you are currently experiencing. Place a "P" next to any you have had in the past.

	Nose and Sinuses		**Blood/Lymph**		**Muscles & Bones**
	Hay fever		Bleeding		Chronic pain
	Nose bleeds		Bruise/bleed easily		Joint problems
	Congestion		Anemia		Arthritis
	Loss of smell		Iron deficient/excess		Gout
	Sinus infection		Leukemia		Muscle pain / cramps
			Lymphoma		
	Infections		**Skin**		**Circulation / Veins**
	Abscess		Acne		Cold hands / feet
	Frequent colds		Open sore / ulcer		Raynaud's syndrome
	Influenza		Hives		Cyanosis (blue lips, skin, nails)
	COVID-19		Itching		Hemorrhoids
	Strep Throat		Fungal infection		Deep leg pain / cramps
	Lyme disease		Warts		Wounds slow to heal
	HIV / AIDS		Eczema / dermatitis		Swollen ankles
	Hepatitis		Psoriasis		Varicose veins
	Herpes		Rashes		
	Tuberculosis		Changes in moles		**Nervous System**
	Chicken pox		Skin cancer		Seizures / epilepsy
	Mononucleosis		Nail problems		Stroke
	Whooping cough				Paralysis / impairment
	Scarlet fever		**Head and Hair**		Local weakness
	Mumps		Headaches		Tremors
	Measles		Migraines		Numbness / tingling
	Malaria/Yellow Fever		Hair loss (excessive)		Fainting / blackout
	Typhoid Fever		Hair growth (excessive)		Memory problems
	Rheumatic Fever		Head injury / concussion		Learning difficulties
			Dizziness / vertigo		ADD / ADHD
					Multiple Schlerosis
	Urinary		**Mind and Mood**		**Heart**
	Wake up to urinate		Tension		High blood pressure
	Kidney infections		Mood swings		Low blood pressure
	Kidney stones		Anxiety / nervousness		High cholesterol
	Kidney disease		Depression		Low cholesterol
	Bladder infections		Seasonal depression		Heart disease
	Excessive urination		Excess anger / irritability		Heart attack
	Frequent urination		Difficulty expressing emotion		Heart murmur
	Urgency		Foggy thinking		Chest pains
	Painful urination		Lack of concentration		Angina
	Slow / difficult stream		Mania / hyperactivity		Palpitations
	Leaking / loss of urine		Panic attacks		Irregular heartbeat
			Diagnosed mental illness		Pacemaker
					Heart surgery

	Digestion		Sexual (Male & Female)		Female Reproductive
	Difficulty swallowing		Increased / decreased libido		Irregular period
	Heartburn / acid reflux		Painful intercourse		Excessive flow
	Appetite up / down		Sexual difficulties		Bleeding between periods
	Indigestion		Sexually transmitted infections		Cramping / painful periods
	Excess bloating				Mood changes
	Excess belching		**Breast (Male & Female)**		Clots
	Excess passing gas		Breast tenderness		Pain while ovulating
	Constipation		Breast lumps		Bleeding after intercourse
	Diarrhea		Fibrocystic breasts		Vaginal discharge
	Abdominal pain		Nipple discharge		Itch
	Pale stool				Yeast infections
	Black stool		**Male Reproductive**		Breast implants
	Blood in stool		Testicular pain		Endometriosis
	Jaundice		Testicular lump		Fibroids
	Intolerant of fatty foods		Jock itch		Ovarian cysts
	Stomach ulcer		Discharge from penis		Polycystic ovarian syndrome (PCOS)
	Persistent vomiting		Enlarged prostate		Cervical dysplasia
	Loss of bowel control		Prostatitis		Difficulty conceiving
	Irritable bowel syndrome		Hernia		Infertility
	Gallstones		Erectile dysfunction		Problems during pregnancy
	Gall bladder removed		Infertility		Problems during delivery
	Food poisoning				Miscarriage
	Appendicitis				Tubal ligation
	Appendix removed				Hysterectomy
			Lung		Menopause
			Chronic cough		Vaginal dryness
			Asthma		Hot flashes
			Difficulty breathing		Pelvic inflammatory disease
	Hormones		Excessive mucous		
	Diabetes		Wheezing		**Inflammatory / Autoimmune**
	Hypoglycemia		Tuberculosis		Frequent infections
	Excessive thirst		Chronic sinutitis		Chronic fatigue syndrome
	Excessive sweating		Sleep apnea		Rheumatoid arthritis
	Heat/cold intolerance		Bronchitis / emphysema		Lupus SLE
	Thyroid problems		COPD		Gout
	Thyroid removed		Frequent lung infection		Herpes
	Metabolic syndrome		Pneumonia		Severe infectious disease

Please describe any other symptoms, medical conditions, or procedures you have had that were not covered above.

NATUROPATHIC MEDICINE INFORMED CONSENT FORM

By signing below, you consent to the Services of a Naturopathic Doctor ("ND") at Organic Living and Wellness, LLC, and agree to the following:

1. I understand that my ND is a trained healthcare provider who uses non-invasive, holistic practices to stimulate the body's natural healing mechanisms. NDs assess the whole person, and consider the physical, mental and emotional expression of wellness and disease. Therapies used by an ND may include, but are not limited to:
    a. Physical medicine
    b. Clinical nutrition
    c. Homeopathic medicine
    d. Herbal medicine
    e. Lifestyle counseling
2. I confirm that I am seeking consultation from my ND, which may yield treatment recommendations. I acknowledge that I am solely responsible for making decisions and taking action on my health. I am free to carry out or refuse any of the recommendations offered by my ND.
3. I understand that that my ND and I are working to restore the body's natural healing mechanisms. Improvement is typically seen gradually, rather than immediately. I understand that I may need to take action in order to achieve positive results.
4. I confirm that I will inform my ND of all my symptoms, conditions, medical history, family history, treatments, medications, and supplements. I will also continue to inform my ND of my progress and of changes to my conditions.
5. I understand that the State of Georgia currently does not consider Naturopathic Medicine an official medical practice and does not regulate/license it. As a result, NDs in Georgia cannot do the following on their own:
    a. Order prescription medication
    b. Be considered as Primary Care Providers
    c. Be covered by medical insurance
6. I understand that the Services are intended to supplement the work of the medical community. The Services are not intended to replace or bypass those offered by a licensed medical practitioner (MD, DO, etc.).
7. I agree to continue to see my medical doctor(s). I will consult my doctor(s) regarding any changes to my treatments and medications.
8. I understand that there may be risks associated with any treatment, and there are no guaranteed results. The risks may include, but are not limited to:
    a. Aggravation of pre-existing symptoms
    b. Reactions to supplements or herbs
    c. Reactions to conditions that were not shared with the ND or were previously unknown

PATIENT NAME:

PATIENT SIGNATURE: DATE:

If patient is a minor, indicate relationship of signing person to patient: ____________________

FINANCIAL & CANCELLATION POLICY

1. Typical Naturopathic Medicine treatment involves the following components:
   - Initial consultation
   - Lab tests (optional)
   - Supplements and/or herbs (optional)
   - Other treatment modalities such as acupuncture or cupping (optional)
   - Follow-up visit(s), as needed

2. I understand there are costs for each component. Full payment is due at the time of service. I acknowledge that I am responsible for paying for these costs.

3. I agree to provide my credit card to the office for filing with my records. I understand that my appointment will not be confirmed without providing my credit card.

4. If I need to reschedule or cancel my appointment, I must notify the office with at least 24 hours advance notice. If I cancel less than 24 hours notice ("Late Cancellation"), I will be charged 50% of the visit fee.

5. If I do not arrive for my appointment and have not notified the office of my cancellation ("No show"), I will be charged the full price of the missed appointment.

6. I understand that fees for Late Cancellations and No-shows will be charged immediately, against the provided credit card on file.

By voluntarily signing below, I show that I have read and understand the policy stated above.

PATIENT NAME:	
PATIENT SIGNATURE:	DATE:

If patient is a minor, indicate relationship of signing person to patient: ______________________________