A WellSpring of Natural Health, PC

Person-Centered Health Care ◦ Natural Medicine for the Whole Family

Health Review and Medical Update

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Name (Patient) _____ Today's date _____

Address_____

City _____ State _____ Zip code _____

Telephone (home) _____ (work) _____ (cell) _____

Email address_____

Changes in family situation? _____

Changes to your place of employment? _____

Current employer _____

Do you have a different medical insurance plan? Yes ____ No ___

Eligible for Medicare coverage/benefits? Yes ____ No ____ Health/Medical savings account? Yes ____ No ___

Overview

Safe, effective and individualized medical treatment and health care requires your clinician to understand you as a whole person in your real life context. Please complete this questionnaire as thoroughly as possible. Print all information, and mark anything you don't understand with a question mark.

What are your most important health and medical concerns? List in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

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Is your health: Excellent ____ Good ____ Average ____ Poor ____ ?

Is your walking pace: Brisk ____ Average ____ Slow ____ ?

When was your last visit at WellSpring? _____

Are you currently being treated by any health care or medical provider(s)? Yes ____ No ____

If yes, where and from whom? _____

_____

If no, when and where did you last receive medical treatment or health care?_____

_____

What was the reason? Did your condition resolve or is it ongoing? _____

_____

_____

What do you do to enhance your health? _____

_____

_____

What are your family, work and social supports and stressors? _____

_____

_____

How has your dysfunction and disease affected your life? _____

_____

_____

_____

Have you experienced any significant stresses, traumas, and/or accidents in the two years before your condition appeared? Please describe. _____

_____

_____

_____

Who in your life deeply inspires you? _____

_____

What relationships are challenging for you? How?

Why are you choosing to focus on improving your health now?

Recent Health History

Weight _____ lb. Height _____ Vitality _____ ABO blood type _____

What time of the day is your energy the highest? _____ Lowest? _____

In broad terms, what are you health strengths and challenges?

What hospitalizations or surgeries have you had? When?

Any significant health patterns or recent medical concerns?

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Family History

☐ Check if adopted

	MOTHER			FATHER			
	Mother	Grandmother	Grandfather	Father	Grandmother	Grandfather	Siblings
Age (if living)							
Health (**R**obust, **C**ompromised, **M**ixed)							
Age at death (if deceased)							

Check (√) those applicable

Please highlight any significant recent changes.

Cancer							
Diabetes /hypoglycemia							
Heart disease							
High blood pressure							
Stroke							
Epilepsy							
Depression/anxiety							
Asthma/hayfever/hives							
Obesity							
Kidney disease							
Tuberculosis							
Chemical/pesticide exposure							
Dysfunctional family							
Sexual abuse/rape							
Addiction/alcoholism							
Violence							
Food deprivation							
Poverty							
Immigration							
War							
Cause of death							

Drugs, Medications, Nutrients, Herbs, Remedies

Which of these substances have you used or been prescribed?

Pain relievers	Y N	Anxiety medication	Y N	Laxative	Y N
Steroid	Y N	Antidepressant	Y N	Antacid	Y N
Anti-inflammatories	Y N	Thyroid medication	Y N	Statin drug	Y N
Sleeping aid	Y N	Hormone replacement	Y N	Antibiotics	Y N

Please list *any and all* prescription drugs, over-the-counter medications, nutrients, herbs or other remedies you are *currently* taking.

Medicines (Drug, vitamin, nutrient, herb, etc.)	How much? How often?	Prescribed by?	Since when?	Take regularly? Y/N

Medical Treatment Coordination and Health Care Collaboration

Do you fully inform your conventional and natural medicine practitioners of all the herbs, nutrients, remedies and drugs that you take? What do you share and with whom? Why? If not, what information do you withhold?

With which healthcare provider(s) do you have the most honest communication and respectful relationship?

Do your medical providers share information and collaborate with each other and you in shaping your medical treatment and health care? If so, how?

Do you have the resources and support to fully implement the health care and medical treatment recommended/ prescribed by the clinicians you see? If not, what are the limiting factors?

Typical Food and Drink Intake

Breakfast: _____

_____

Lunch: _____

_____

_____

_____

Dinner: _____

_____

_____

_____

Between Meals: _____

_____

Liquids: _____

_____

Cravings: _____

Household and Environmental Supports and Stressors

Where do you buy most of your groceries? _____

What household cleaners do you use? _____

What fertilizers, pesticides, weed killers do you use? _____

What shampoo do you use? _____

Do you use hair dye or coloring? _____

What toothpaste do you use? _____

Do you have mercury amalgam dental fillings? Removed? _____

Do you have mold in your home? Previously?_____

Are you sensitive to electromagnetic stressors? _____

Life Situation, Habits and Values

How does your current condition affect you?_____

What do you think is happening? Why?_____

What do you feel needs to happen for you heal?_____

Have you experienced major trauma? If so, please describe?_____

Main creative activities, interests and hobbies?_____

How do you exercise? How often? _____

What is your relationship to family, friends and community? _____

Do you have a religious faith or spiritual practice? Yes ____ No ____ If yes, what? _____

How do you nourish and cultivate yourself? _____

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What is your relationship to the place where you live? _____

_____

What do you know about your birth?_____

_____

_____

Have you made any plans for your dying?_____

_____

_____

What do you enjoy most in your life?_____

_____

_____

Eat three meals a day?	Y N	Read?	Y P N
Eat out often?	Y N	How many hours per day? _____	
Go on diets often?	Y N	Watch television?	Y P N
Cook meals at home?	Y N	How many hours per day? _____	
Drink coffee?	Y N	Use computer?	Y P N
Drink black tea?	Y N	How many hours per day? _____	
Drink cola or other soft drinks?	Y N	Gaming or internet overuse or addiction?	Y P N
Eat sugar or sweets?	Y N	Substance overuse or abuse?	Y P N
Add salt to food?	Y N	Recreational or entheogenic substance use?	Y P N
Have a supportive relationship?	Y N	Alcohol use or abuse?	Y P N
Enjoy your work?	Y N	How often? _____	
Take vacations?	Y N	Smoke or chew tobacco?	Y P N
Sleep well?	Y N	How much? _____	
Average 7-9 hrs. sleep?	Y N	Tobacco use or abuse?	Y P N
Awaken rested?	Y N	How many years? _____	
Spend much time outside?	Y N	How much? _____	

How much are you willing and able to change to address your medical condition and improve your health?

MINIMAL SOME COMPLETE

You are always welcome at WellSpring! We are here to serve you.

Informed Consent for Treatment

I, _____, hereby request and consent to receive naturopathic, acupuncture and/or Chinese medical treatment and health care by the licensed acupuncturist and/or licensed naturopathic physician ("Clinician") at A WellSpring of Natural Health, P.C. ("WellSpring") who now or in the future may treat me while working at or associated with WellSpring. Further, such consent and request applies equally to any other licensed acupuncturist and/or licensed naturopathic physician serving as for medical care back-up or in *locum tenens* for my Clinician at WellSpring, whether signatories to this form or not. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I have also read and understand the attached "Notice of Patient Privacy", which discusses my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Examples of Diagnostic Procedures, Health Care and Medical Treatment:

- Customary diagnostic procedures: including but not limited to general physical exams, venipuncture, PAP smears, blood and urine lab work.
- Traditional naturopathic, Chinese and other natural medicine systems of diagnosis and pattern evaluation, such as pulse and abdominal palpation, tongue and facial appearance, muscular armoring and tension dynamics, gait and postural observation.
- Lab tests and procedures: including referral for x-ray, MRI, or other diagnostic imaging.
- Minor office procedures: e.g., dressing a wound, ear cleaning, incision repair, laceration repair, wart removal, skin biopsy, etc.
- Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, injections of nutrients.
- Botanical therapies: substances may be prescribed as teas, infusions, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
- Homeopathic medicine: the use of diluted quantities of naturally-occurring substances to gently stimulate the body's self-healing responses, given orally, topically, or by injection.
- Prescription of pharmaceuticals or bio-identical hormones.
- Counseling: life choices, psychological processes, self-actualization, creative expression, health promotion including recommendations for exercise, sleep, contraception, and stress reduction.
- Naturopathic manipulative therapies: specific manipulation of muscles, joints (including cranial bones), or soft tissue.;
- Tui na massage, cupping, moxibustion, heating or bleeding of acupuncture points.
  Acupuncture and trigger point needling, including injections such as bee venom therapy, prolotherapy, homeopathic injections.

I have had the opportunity to discuss with my Clinician at WellSpring the nature and purpose of health practices, acupuncture, naturopathic therapies and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic medicine and acupuncture and other practices of Chinese medicine, pose some level of risk. Within the general clinical setting, the possible adverse outcomes of these practices by a naturopathic physician and/or acupuncturist range from minor to potentially fatal.

The health care and medical treatment we provide may or may not be directed at a specific disease or disorder. It may be preventive in nature, designed to improve overall health and well-being, restore your body's innate self-healing processes, and support you in living consciously and creatively. We will always strive to provide full disclosure of all information relevant to your clinical care. I understand that in providing treatment my Clinician is relying on the information that I am providing to them about the Patient, the Patient's health, and the Patient's response to therapies and my own behavior. I agree that the information I provide will be true and accurate and that I will disclose to the physician everything needed for treatment.

The herbs, homeopathic medicines and nutrients (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic and/or Chinese medicines. It is extremely important that the prescribed recommendations be followed when taking herbs, homeopathic medicines and nutritional agents because they may induce adverse effects when taken in excessive amounts or inappropriate situations. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I understand that some herbs and nutrients may be inappropriate during pregnancy, and I will immediately notify those providing my clinical care at WellSpring if I become aware that I may be or am pregnant.

I will immediately inform the Clinician at WellSpring if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), bruising or burns (associated with acupuncture, injections, cupping or moxibustion), or any unanticipated or unpleasant effects associated with treatment or the herbs or other therapies prescribed by the Clinician at WellSpring. I understand that while this document describes the most common risks of treatment, other adverse effects and risks may occur. In order to properly treat my medical condition and support my health and medical progress, the Clinician at WellSpring must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, it is important to seek treatment immediately from an emergency care facility or call 911.

With this knowledge, I voluntarily consent to the above procedures and that I acknowledge that no guarantees have been given to me by my Clinician or the staff of A WellSpring of Natural Health, P.C. regarding cure or improvement of my health and medical condition(s).

I have read, or have had read to me, and understand the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

☑ _____

READ, UNDERSTOOD AND AGREED

PATIENT

_____ _____

Printed Name Date

_____

Signature (or Signature of Legal Guardian)

_____

Print Your Clinician's name (here at WellSpring)