

Naturopathic Medicine Intake Form

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____
 Other names/Maiden Name: _____ Birthdate: ____/____/____ Sex: M / F
 Mailing Address: _____ City: _____
 State: _____ Zip Code: _____ Email Address: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Occupation: _____ Full Time: Y/N Marital Status: (S)(M)(D)(W)
 Emergency Contact: _____ Relationship to Patient: _____
 Contact's Phone Number: _____ Contact's Email: _____

Please List any **Life Threatening Allergies:** _____

Referred to Dr. Emily Telfair by: _____

Current Health Care Team:

Primary Care Physician: _____ Office Number: _____
 Specialist Physician: _____ Specialty: _____ Office Number: _____
 Specialist Physician: _____ Specialty: _____ Office Number: _____
 Specialist Physician: _____ Specialty: _____ Office Number: _____

Other Health Care Team Members (Ex: massage therapist, nutritionist, acupuncturist, etc.):

Practitioner Name: _____ Office Number: _____
 Practitioner Name: _____ Office Number: _____

Primary Health Concerns: *Please list you primary health concerns in order of importance.*

	<u>Concern</u>	<u>Onset</u>	<u>Frequency</u>	<u>Severity</u>
	<i>Ex: Headache</i>	<i>June 1978</i>	<i>4 times/week</i>	<i>mild/mod/severe</i>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

What are your goals for this visit?

Name: _____

DOB: ___/___/___

Date: ___/___/___

PERSONAL MEDICAL HISTORY

Please check the following conditions that apply to you. If a choice is given, please circle the appropriate one.

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism or Substance Abuse | <input type="checkbox"/> Lung Disease (Asthma, COPD, etc) |
| <input type="checkbox"/> Anemia (Iron deficiency, etc) | <input type="checkbox"/> Mental Trouble/Depression/Anxiety, etc |
| <input type="checkbox"/> Arthritis/Joint Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Blood Clots/Phlebitis | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatic Fever |
| Type: _____ | <input type="checkbox"/> Seizures, Epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Serious Injury or Accident |
| <input type="checkbox"/> Digestive (UC, Crohns, IBS, etc) | Type: _____ |
| <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Frequent Sinusitis | Specify: _____ |
| <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Hay Fever, Allergy, Eczema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Attack/Disease/Failure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Urinary Difficulties (Incontinence, UTI, etc) |
| <input type="checkbox"/> Headaches (Migraines, etc) | <input type="checkbox"/> Vision/Eye Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease, Hepatitis, etc. |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Infection/Stones |
| <input type="checkbox"/> History of Infertility | <input type="checkbox"/> Other: _____ |

Please list any **operations / surgical procedures / blood transfusions / major injuries** (with dates):

Immunizations/vaccinations: _____

Date of last Physical Exam: _____ Date of last Blood Tests: _____

FAMILY MEDICAL HISTORY

Place appropriate letter(s) in blank if someone in your family has/had any of the following.

(F=Father, M=Mother, S=Sibling, G=Grandparent)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism or Substance Abuse | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung Disease (Asthma, CHF, etc) |
| Type: _____ | <input type="checkbox"/> Mental Illness/Depression/Anxiety |
| _____ | <input type="checkbox"/> Seizure, Epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hay Fever, Allergy, Eczema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other: _____ |

HEALTH HABITS

Sleep: Hours per night: _____ Sleep Quality: *Poor Fair Good*

List **Physical Activities** and Frequency: _____

Describe your Relationship with **FOOD**: _____

List any **Dietary Restrictions**: _____

Water Intake: # 8 oz glasses per day _____

Circle any of the following you use regularly: *Tobacco Alcohol Coffee/ Black Tea/ Cola Rec Drugs*

MEDICATIONS

What medications are you taking now? (Include prescription and over-the-counter drugs.)

Medication	Reason	When Started	Dosage Per Day	Prescribed By
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Describe any history of drug reaction/allergy: _____

SUPPLEMENTS

What Vitamin / Herbal / Nutritional Supplements are you taking?

Supplement + Brand	Reason	When Started	Dosage Per Day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What are the major stressors in your life?

What are your interests/hobbies?

Overall level of satisfaction with current position in life: *Unsatisfied* *Somewhat Satisfied* *Moderately Satisfied* *Very Satisfied*

Please list any other information that you would like me to know about you and your health:

I understand that Naturopathic Medicine is not a substitute for standard medical care in Maryland and I have indicated all of my known medical conditions above. I will alert the practitioner to any changes in my health status. It is my choice to receive naturopathic care.

Signature: _____

Date: _____

EMILY TELFAIR, N.D.***Informed Consent for Naturopathy/Homeopathy Consultation***

I, _____, seek and consent to the services of Emily Telfair, ND to provide supportive, naturopathic care for myself or my minor child or children _____. Naturopathic services use natural means and remedies to further health and wellness, including assessment and patient education and counseling about nutritional interventions; herbal and homeopathic remedies; lifestyle modifications and a range of other natural interventions/consultation.

Non-Medical and Complementary Nature of Services

I understand that Dr. Telfair is not a medical doctor and that naturopathy is not a medical specialty but a separate and distinct health care tradition. I understand that Dr. Telfair is a licensed, board-certified naturopathic physician in the State of Washington, based upon her four year graduate training in an accredited institution as a naturopathic physician. Naturopathic physicians are licensed in 14 states, and in the District of Columbia, but the State of Maryland does not currently offer such licensing. Where naturopathic physicians are not licensed, their scope of practice does not encompass the diagnosis and treatment of disease, but is focused upon consultations regarding natural remedies. Dr. Telfair's consultations include discussion of nutritional issues and of diet, nutrition and supplementation, such as the use of dietary supplements and botanical substances; homeopathic remedies; mind-body supportive counseling; promotion of healthy lifestyles and wellness,

Dr. Telfair's work in Maryland does not allow her to offer the full range of services within her training, but the educational consultations she provides are at the core of the naturopathic approach to health. I understand that her assessments and recommendations are intended to assist me in using natural means to support my health and are not intended to provide medical diagnosis or treatment. I should not avoid any diagnostic work-ups or change or discontinue any medical treatment based upon my consultation with Dr. Telfair, and if I believe that modifications may be sensible in the light of these natural approaches, I agree to first discuss such changes with my prescribing medical physician.

If I believe that I have a condition which requires medical care, I will consult my primary care physician or an appropriate specialist. It is important that I maintain regular visits with my primary care physician and medical specialists as appropriate, both to ensure proper medical care and because Dr. Telfair is not affiliated with a local hospital and I should have a medical physician who can provide care in the event of an emergency or hospitalization. When appropriate, Dr. Telfair may communicate with members of my health team regarding my conditions, treatment options, and/or any other health related issues. **I agree to follow-up on referrals for medical care when necessary.**

Naturopathic practice uses methods that are known as complementary, alternative, or holistic care, and may not be accepted by the larger community of medical physicians. Dr. Telfair may suggest laboratory tests, some of which are used by holistic physicians and naturopathic practitioners but which are not in widespread use in the medical community. Further, the interpretation of some tests may be different than in mainstream medicine. It is a good idea for me to get the advice of my medical physician as I make decisions that affect my health.

Dr. Telfair will explain her assessment to me and describe the nature of her recommendations, the expected prognosis without such care, and the anticipated costs, risks, benefits and experience of following various options. I understand that a core approach taken by naturopathy is achieving better health status through improvements in diet and the use of dietary supplements to improve biological function, as well as exercise and other lifestyle modifications. The focus of naturopathic care is to alleviate the underlying conditions that can bring about illness rather than the treatment of symptoms. While I may experience some immediate improvement from the use of herbs, homeopathic remedies and other botanical and naturopathic methods, I understand that the most effective results occur when I make a long-term commitment to rebuild my health. **It is my responsibility as a patient to follow-up with Dr. Telfair within a recommended time period for evaluation of treatment results or to change treatment protocols as necessary.**

I understand that Dr. Telfair does not offer after hour services or provide any hospital-based services. If I have difficulty with any of remedies or other aspects of my work with Dr. Telfair, I understand I should call during business hours to discuss concerns I may have.

Potential Risks

As with any method of care, naturopathy can involve some risk. I understand that I may experience aches, pains, or even new symptoms as the body responds by shifting its balance. This is generally a positive sign and shows the body is making positive movement. Some people may experience a healing crisis, a short period in which symptoms worsen or a period of a flu-like illness with mild fever, chills, dizziness, loss of appetite, or similar symptoms. Such an experience can signal the body detoxifying.

While herbs and botanical products are generally available over-the-counter and are considered safe based upon their long history of use, many of them have not been widely tested. Negative reactions to natural remedies may include rare allergic reactions, including headaches, itching, hives, difficulty breathing, and very rarely, even shock or death. I understand that the interactions between herbs, and between herbs and drugs my medical physician might prescribe, are not yet well known, and that while unlikely, I could have an adverse reaction or experience a reduction or increase in the effect of other medications. This can have serious consequences for some medications, such as for the control of high blood pressure or blood sugar. I understand that I should let my physician know what herbs I am taking, particularly prior to surgery or other procedures. Negative reactions to homeopathy are extremely rare given the doses used; an effective dose may result in a temporary increase in my symptoms or healing crisis. **I understand that it is my responsibility to alert Dr. Telfair of any adverse effects or reactions.**

Notice to Pregnant Women: All female clients must alert Dr. Telfair if they know or suspect that they are pregnant as some of the remedies used could present a risk.

No Guarantees: I am aware that such consultations are an art, that like many medical interventions, many naturopathic efforts have not been subjected to rigorous scientific study, and that there are wide individual differences in responses to these services. No guarantees are made that I will gain any benefit or not suffer any adverse consequences. In the event that a dispute arises that we cannot resolve amicably, I understand that Dr. Telfair is not practicing medicine and that if a legal case is brought, I agree that Dr. Telfair shall be judged by the standards and principles of complementary, alternative, and/or holistic care and not the standards of consensus conventional medicine.

Supplement Purchases: I understand I am not obligated to purchase nutritional or herbal products recommended by Dr. Telfair, from this office or from any specific vendor, and I will be given the same level of attention without regard to my purchases. I understand that Emily Telfair, ND may profit from the sale of supplements and other products made available to patients.

Privacy Policy: My privacy is important and my records will be held confidential unless I request in writing that they be released to myself or to other care givers. The HIPAA privacy regulations I have seen in other offices do not apply to Dr. Telfair, as I do not submit claims to insurers, which must be done electronically before HIPAA regulations apply.

Important Insurance and Payment Notices:

Dr. Telfair's services are, with few exceptions, not reimbursed by insurance or Medicare and she does not accept insurance. Insurance generally provides services only when delivered by individuals licensed to provide health care services in the state in which care is delivered. Dr. Telfair is therefore unable to accept insurance payment and does not provide billing statements for insurance reimbursement.

- Payment in full is required at each visit. I understand I am responsible for payment even if I submit and am denied reimbursement, even if my insurer determines that services are not medically necessary.
- **Dr. Telfair requests 24-hours notice for canceling or rescheduling appointments. For any visits canceled with less than 24-hours notice, the patient will be charged half of the original visit fee except in the case of family or medical emergency. This charge will be applied to the following visit or billed directly to the client. No-show appointments will be charged the full visit fee.**
- Late arrivals will not receive an extension of scheduled service times and will be charged the full service fee.
- In the event legal action is required to collect payment, I agree to be responsible for attorney fees and costs.
- In the event of a bounced check the patient will be charged a \$25 fee.

Informed Consent for Naturopathic Consultation

I hereby authorize naturopathic assessment and consultation and certify that I understand the nature of this health care method, including the risks of possible adverse reactions and choices I may have about other approaches. I understand that no recommendations are being made to me to discontinue any treatment being provided by any other health care professional. I understand that Dr. Telfair does not function as a primary care or medical physician, and that she offers her services as a complement to other services I receive. I have been adequately informed, and questions I have asked have been satisfactorily answered. I represent that I am seeking assessment and consultation in order to further my own health and for no other reason and do not represent a third party. I sign this voluntarily and am aware that I may withdraw this consent and discontinue following the recommendations at any time.

Date: _____

Signature of Client or Legal Guardian Witness

Client's Printed Name