



Emily Telfair, N.D.

Adult Naturopathic Medicine Intake Form

Last Name: ..... First Name: ..... MI: .....
Other Names/Maiden Name: ..... Birthdate: ..... Gender: .....
Mailing Address: .....
City: ..... State: ..... Zip Code: .....
Email: ..... 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: ..... Contact's Email: .....

Please List Any Life Threatening Allergies: .....

Referred to Dr. Emily Telfair by: .....

CURRENT HEALTH CARE TEAM

Primary Care Physician: ..... Phone: .....
Specialist: ..... Specialty: ..... Phone: .....
Specialist: ..... Specialty: ..... Phone: .....
Specialist: ..... Specialty: ..... Phone: .....

OTHER HEALTH CARE TEAM MEMBERS (MASSAGE THERAPIST, NUTRITIONIST, ACUPUNCTURIST, ETC.)

Practitioner: ..... Specialty: ..... Phone: .....
Practitioner: ..... Specialty: ..... Phone: .....

PRIMARY HEALTH CONCERNS (Please list your primary health concerns in order of importance.)

Table with 4 columns: CONCERN, ONSET, FREQUENCY, SEVERITY. Includes example row: Ex: Headache, June 1978, 4 times/week, mild/mod/severe.

What are your goals for this visit?
.....
.....
.....
.....

Today's Date: .....

**PERSONAL MEDICAL HISTORY**

Please mark any of the following you have now or have significant history of in the past. If a choice is given, circle the appropriate one.

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

Hours of sleep per night: ..... Quality of sleep: Poor / Fair / Good

List physical activities and frequency: .....

List any dietary restrictions: .....

Describe your relationship with food: .....

..... Number of 8 oz glasses of water per day: .....

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

**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)

- ..... Alcoholism or Substance Abuse
- ..... Anemia
- ..... Arthritis
- ..... Cancer **TYPE:** \_\_\_\_\_
- ..... Diabetes
- ..... Digestive Disorder
- ..... Easy Bleeding
- ..... Glaucoma
- ..... High Blood Pressure
- ..... Hay Fever, Allergy, Eczema
- ..... Headaches
- ..... Heart Disease
- ..... High Cholesterol
- ..... Kidney Disease
- ..... Liver Disease
- ..... Lung Disease (Asthma, CHF, etc.)
- ..... Mental Illness/Depression/Anxiety
- ..... Seizures, Epilepsy
- ..... Stroke
- ..... Suicide
- ..... Thyroid Disease
- ..... Tuberculosis
- ..... Ulcers
- ..... Osteoporosis
- ..... Other: \_\_\_\_\_

**MEDICATIONS**

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

MEDICATION	REASON	WHEN STARTED	DOSAGE PER DAY	PRESCRIBED BY
1. ....				
2. ....				
3. ....				
4. ....				
5. ....				
6. ....				

Describe any history of drug reaction/allergy: .....

**SUPPLEMENTS**

What vitamin / herbal / nutritional supplements are you taking?

SUPPLEMENT + BRAND	REASON	WHEN STARTED	DOSAGE PER DAY	PRESCRIBED BY
1. ....				
2. ....				
3. ....				
4. ....				
5. ....				

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 Naturopathic Consultation

A naturopathic doctor is a practitioner trained in the prevention, diagnosis, and treatment of human health conditions, injury, and disease by the use of natural means. While NDs do not act as primary care physicians, they can play an important role in the natural treatment of disease as well as in enhancing health and wellness.

Naturopathic doctors may provide a full range of counseling services, including lifestyle modification and health coaching; promotion of wellness through support of exercise, good sleep, detoxification, stress reduction and other lifestyle modifications; advise about diet, nutritional issues, nutritional supplementation including herbal and botanical substances; offer homeopathic remedies, highly dilute naturally occurring plant, animal, and mineral substances to gently stimulate healing responses; massage and body work therapies; and use other natural remedies, such as the application of hot or cold, hydrotherapy, the use of water applications to the body, electromagnetic therapy, phototherapy or light therapy and corrective and orthopedic gymnastics.

### **NATURE OF SERVICES**

A naturopathic doctor is not a medical doctor and naturopathy is not a medical specialty but a separate and distinct health care tradition. Dr. Telfair graduated from an accredited four year residential graduate program and is licensed in Maryland as a naturopathic doctor. The scope of practice is limited to specific practices set forth in Health Occupations Article, Section 14-5F-14. This scope includes complete physical examination, laboratory and physiologic testing and the ordering of diagnostic imaging but does not include prescribing, administering or injecting drugs, surgery or high-velocity osteopathic/chiropractic adjustments.

In the event of a life threatening condition, a potential referral to an appropriate medical physician will be reviewed with the patient. A potential referral to a medical physician, physical therapist or other appropriate health care professional will also be reviewed when a patient's condition requires on-going rehabilitation. Patients are encouraged to inform their medical physicians about their care and to request copies of records to share, or other communication or consults as needed, to ensure that care is coordinated.

Naturopathic medicine is not intended to substitute for diagnosis or treatment by medical physicians or used as an alternative to necessary medical care, and a patient should not avoid any diagnostic work-up suggested by your medical physician as a result of naturopathic diagnosis or treatment. If a patient wishes to discontinue or avoid any medical treatment in favor of naturopathic care, this should be discussed with both Dr. Telfair and the treating physician. Patients are encouraged to have a primary care physician in place familiar with their medical history.

After the initial intake and on an ongoing basis, Dr. Telfair will explain her assessment and describe the nature of her recommendations, expected health progress, and the anticipated costs, risks, benefits and experience of following various options. The focus of naturopathic care is to alleviate the underlying conditions that bring about illness rather than the treatment of symptoms. While clients may experience some immediate improvement from the use of supplements, herbs, homeopathic remedies or other botanical and naturopathic methods, the most effective results occur when clients make a long-term commitment to rebuild their health.

### **EMERGENCY NOTICE**

Dr. Telfair does not offer after hour services or provide any hospital-based services. If a difficulty occurs with any of remedies or other aspects of naturopathic work, patients should contact her during business hours to discuss any concerns. In the event of an emergency, patients should contact 911 or their primary care physician as needed.

### **POTENTIAL RISKS**

As with any method of care, naturopathic medicine can involve some risk. Patients may experience an aggravation of pre-existing symptoms, or have aches, pains, or even new symptoms as the body responds to treatment. 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. Interactions between herbs, and between herbs and drugs my physician might prescribe are not yet well known, and while unlikely, clients can have an adverse reaction or experience a reduction or increase in the effect of other medications. 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. Massage, craniosacral therapy and other bodywork may exacerbate muscle and joint pain, which is generally but not always temporary and part of the healing process.

**GOOD COMMUNICATION**

Even the gentlest methods may cause complications, particularly in certain physiological conditions such as pregnancy, lactation, or in very young children, very elderly patients, those on multiple medications, or those with specific diseases such as diabetes or of the heart, liver, or kidney. It is important that patients inform, and continue to fully inform their doctor and physicians of any medical history, family history, medications and/or supplements being taken currently (prescription and over-the-counter). Supplements and remedies or significant lifestyle changes could have serious consequences for some medications, such as for the control of high blood pressure or blood sugar. It is particularly important to let your medical physician know about herbs and supplements prior to surgery or other procedures.

**NOTICE TO PREGNANT WOMEN**

All female clients must alert Dr. Telfair if they know or suspect that they are pregnant, could become pregnant, or are nursing to ensure that remedies are not used that could present a risk.

**NO GUARANTEES**

Consultations, as in any matter regarding health, are an art as well as science, and no guarantees can be made as to any positive outcomes or the absence of side effects. Dr. Telfair will attempt to educate clients about the risks, benefits and alternatives to proposed therapies but cannot anticipate and explain all possible risks and complications.

**INSURANCE NOTICE AND FINANCIAL RESPONSIBILITY**

Naturopathic medicine is not a covered service or recognized by Medicare, private insurance, or other third-party payors. Reimbursement is not usually available for these services. Fees can also be paid from the patient’s FSA or HSA medical savings accounts. Patients are financially responsible for payment at the time of service. In the event I ever have a balance on my account that exceeds 30 days, I agree to pay interest at an annual rate of 10% and the pay reasonable attorney’s fees and costs for collection.

**SUPPLEMENT SALES**

I understand that dietary supplements and remedies are available for sale, both for patient convenience and to make high-quality products available to patients. Dr. Telfair makes a usual and customary mark-up on these products, and patients are free to purchase similar products from the source of their choosing. Doing so will not affect the quality of care provided.

**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 caregivers. The HIPAA privacy regulations I have seen in other offices do not apply to Dr. Telfair, as she does not submit claims to insurers, which must be done electronically before HIPAA regulations apply.

**CANCELLATION POLICY**

All Initial Naturopathic consult visits are secured with a valid credit card. Initial Adult Naturopathic visits cancelled with less than 48 hours notice will be charged \$100 and all Initial Pediatric visits cancelled with less than 48 hours notice will be charged \$50 — except in the case of family or medical emergency or inclement weather.

Patients who cancel their massage, craniosacral, or follow-up naturopathic visit with less than 24 hours notice will be billed for half of the visit fee except in the case of family or medical emergency. No-show appointments will be billed for the full price of the visit. For Monday appointments, cancellations after 12pm on the preceding Friday will be subject to a cancellation fee. Late cancellation fees will be applied to the credit card on file.

**INFORMED CONSENT FOR NATUROPATHIC CONSULTATION**

I have read and understood the foregoing and hereby authorize naturopathic medical assessment and treatment by Dr. Telfair. I understand that she is not a medical physician, the nature of this health care method including the potential risks of possible adverse reactions to products that may be suggested, and which I chose to take, over the course of naturopathic care. I agree to assume the risks of care, whether known or unknown. I understand and agree to the above stated office policies and the financial agreement.

Signature: ..... Date: .....

Client’s Printed Name: .....