

Young Naturopathic Center for Wellness

WOMEN'S HEALTH INTAKE FORM

PATIENT INFORMATION

Name:		Date:															
Date of Birth:	Age:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male															
Address:																	
City, State, Zip:																	
Phone 1: May we leave messages at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone 2: May we leave messages at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No																
Email: May we email you information about our office? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
Emergency Contact (name and phone): Relationship to you:																	
Who is your current Primary Care Doctor? What is the name and number of their clinic?																	
Please list other health care professionals from whom you receive care (Name, specialty, phone):																	
When were you last seen by a medical professional and for what condition?																	
How did you find our office?																	
<p>WHAT ARE YOUR CURRENT HEALTH CONCERNS? PLEASE LIST IN ORDER OF IMPORTANCE.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1.</td> <td style="width: 50%;">4.</td> </tr> <tr> <td>2.</td> <td>5.</td> </tr> <tr> <td>3.</td> <td>6.</td> </tr> </table>			1.	4.	2.	5.	3.	6.									
1.	4.																
2.	5.																
3.	6.																
<p>PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE INTERESTED IN:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Food Allergy Testing</td> <td style="width: 33%;">Hormone Testing</td> <td style="width: 33%;">Heavy Metal Testing</td> </tr> <tr> <td>Nutritional Testing</td> <td>Fertility Testing</td> <td>Wellness Screening</td> </tr> <tr> <td>Testing for Depression</td> <td>Complete Cardiovascular Panel</td> <td>Gynecologic & Breast Exam</td> </tr> <tr> <td>Anxiety or Mental Health</td> <td>Anti-aging/Preventive Medicine Testing</td> <td>Digestive Analysis</td> </tr> <tr> <td colspan="3">Non-hormonal Birth Control Naturopathic Pain Management Detoxification Diet</td> </tr> </table>			Food Allergy Testing	Hormone Testing	Heavy Metal Testing	Nutritional Testing	Fertility Testing	Wellness Screening	Testing for Depression	Complete Cardiovascular Panel	Gynecologic & Breast Exam	Anxiety or Mental Health	Anti-aging/Preventive Medicine Testing	Digestive Analysis	Non-hormonal Birth Control Naturopathic Pain Management Detoxification Diet		
Food Allergy Testing	Hormone Testing	Heavy Metal Testing															
Nutritional Testing	Fertility Testing	Wellness Screening															
Testing for Depression	Complete Cardiovascular Panel	Gynecologic & Breast Exam															
Anxiety or Mental Health	Anti-aging/Preventive Medicine Testing	Digestive Analysis															
Non-hormonal Birth Control Naturopathic Pain Management Detoxification Diet																	

MEDICAL AND FAMILY HISTORY

Please list your current and past diagnoses (if any):

Please list past hospitalizations and surgical procedures (include date and hospital):

Have you been fully vaccinated? Yes No Unsure

List any known allergies to medications, foods or other substances as well as your reaction:

Have you traveled outside the United States in the past two years? Yes No. If yes, where?

MEDICATIONS AND SUPPLEMENTS

List all current medications, vitamins, herbs and other supplements you take, including dosages.

Medications:

Vitamins, Herbs, Other Supplements:

FAMILY HISTORY

List any serious health conditions your family members have experienced. Include diabetes, heart disease, autoimmune disease, cancer, additions, eating disorders, mental disorders, allergies, genetic disorder or any other major concerns.

Condition:

Family Member:

Age of onset/age of death:

SOCIAL HISTORY AND LIFESTYLE

Please list all persons and pets currently living with you:

HABITS	Yes	No	Details	
Current tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day:	
Past tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>When did you quit?</td></tr></table>	When did you quit?
When did you quit?				
Alcohol consumption	<input type="checkbox"/>	<input type="checkbox"/>	How often? Types:	
Recreational drug use	<input type="checkbox"/>	<input type="checkbox"/>	Types:	
Exposure to toxic chemicals, solvents, other harmful toxins	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain:	
Caffeine use (circle all): Coffee, tea, soda, energy drinks	<input type="checkbox"/>	<input type="checkbox"/>	Cups per day?	
Regular exercise	<input type="checkbox"/>	<input type="checkbox"/>	How often? Activities:	
STRESS				
Current stress level: <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High				
Source of stress: <input type="checkbox"/> Job <input type="checkbox"/> Financial <input type="checkbox"/> Family/Relationship <input type="checkbox"/> Other				
SLEEP				
Problems falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	What keeps you awake?	
Problems staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you wake feeling refreshed?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you snore or have sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>		
NUTRITION				
Do you follow a particular diet?		Are there foods that you avoid eating? Why?		
How many meals do you typically eat in a day?		Where do you buy food? Who cooks the food you eat?		
Describe your typical breakfast: Lunch: Dinner: Snacks & Sweets: Drinks:				
Are you thirsty?	<input type="checkbox"/>	<input type="checkbox"/>	How much water do you drink a day:	
Mark any of the following that you consume regularly: <input type="checkbox"/> Highly seasoned foods <input type="checkbox"/> Processed foods <input type="checkbox"/> Soda <input type="checkbox"/> Candy				
List foods you crave:		List foods to which you have a reaction:		
Are you satisfied with your diet?	<input type="checkbox"/>	<input type="checkbox"/>	If no, why not?	

FEMALE HEALTH INFORMATION

DO HAVE A HISTORY OF ANY OF THE FOLLOWING:	Yes	No		Yes	No
Pelvic Inflammatory Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fibroids	<input type="checkbox"/>	<input type="checkbox"/>
Chronic yeast or vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>
Loss of bladder control	<input type="checkbox"/>	<input type="checkbox"/>	Breast cancer or benign tumors	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Chronic vaginal itching or burning	<input type="checkbox"/>	<input type="checkbox"/>	History or current STD If yes, which ones?	<input type="checkbox"/>	<input type="checkbox"/>

MENSTRUAL HISTORY

Date of last period:			Age at first period:		
Did you have a normal puberty?	<input type="checkbox"/>	<input type="checkbox"/>	If no, why?		
Are your periods currently regular?	<input type="checkbox"/>	<input type="checkbox"/>	Days between periods:	Length of flow:	
			Days of heavy bleeding:	light:	spotting:
Date of last PAP:			Date of last breast exam:		
Were the results normal?	<input type="checkbox"/>	<input type="checkbox"/>	Date of last mammogram:		
History of abnormal PAPs?	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal findings:		
Have you had your bone density checked?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when?		
			Results:		

MENSTRUATING WOMEN: Please mark any of the following symptoms you experience before (B), during (D) or after (A) your menstrual cycle. If you do not have a cycle, please mark symptoms you are currently experiencing.

B	D	A	Symptom	B	D	A	Symptom	B	D	A	Symptom	B	D	A	Symptom
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramping or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweet cravings
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood changes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crying
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart pounding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia

Mother's age at menopause: _____ Sister(s): _____ Mother's age if she has not yet begun menopause: _____

MENOPAUSAL WOMEN: If you are currently peri-menopausal or menopausal, do you experience any of the following symptoms? Please indicate yes (Y), no (N) or past (P).

B	D	A	Symptom	B	D	A	Symptom	B	D	A	Symptom	B	D	A	Symptom
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood changes

OBSTETRIC HISTORY

Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you trying to conceive?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had problems with infertility?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain:
Any pregnancy complications?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain:
# of pregnancies:	Births:		Miscarriages: Abortions:
Are you currently breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how often:

SEXUAL HEALTH		Yes	No		Yes	No
Are you currently sexually active?		<input type="checkbox"/>	<input type="checkbox"/>	If yes, current contraception?		
Have you ever used birth control pills?		<input type="checkbox"/>	<input type="checkbox"/>	If yes, how long?		
Have you ever used and IUD?		<input type="checkbox"/>	<input type="checkbox"/>	If yes, how long and what kind?		
Are you content with your libido/sex life?		<input type="checkbox"/>	<input type="checkbox"/>	Any vaginal dryness or painful intercourse?	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL HEALTH						
Number of bowel movements per day:			Is your stool loose or formed?			
Do you tend to constipation or diarrhea?			Stool have an unusual color or odor?		<input type="checkbox"/>	<input type="checkbox"/>
			If yes, explain:			
Recent changes in bowel habits?		<input type="checkbox"/>	<input type="checkbox"/>	Any blood or mucous in stool?	<input type="checkbox"/>	<input type="checkbox"/>
Recent changes in appetite?		<input type="checkbox"/>	<input type="checkbox"/>	Any abdominal pain or upset stomach?	<input type="checkbox"/>	<input type="checkbox"/>
Any excessive gas or bloating?		<input type="checkbox"/>	<input type="checkbox"/>	Any heartburn? Or Reflux?	<input type="checkbox"/>	<input type="checkbox"/>
Any loss of bowel control?		<input type="checkbox"/>	<input type="checkbox"/>	Any nausea or vomiting?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hemorrhoids?		<input type="checkbox"/>	<input type="checkbox"/>	Have you had a colonoscopy? When?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with IBS?		<input type="checkbox"/>	<input type="checkbox"/>	Do you have Inflammatory Bowel Disease?	<input type="checkbox"/>	<input type="checkbox"/>
WEIGHT HISTORY						
Are you content with your current weight?		<input type="checkbox"/>	<input type="checkbox"/>	If no, what is your ideal weight?		
Does your weight fluctuate?		<input type="checkbox"/>	<input type="checkbox"/>	If yes, give highs and lows:		
Any family history of weight problems?		<input type="checkbox"/>	<input type="checkbox"/>	If yes, who?		
What factors do you feel contribute to your changes in weight if any (nutrition, exercise, hormones, etc.)?						
EARS, EYES, NOSE AND THROAT						
Please indicate (C) or past (P) symptoms		C	P		C	P
Loss of consciousness		<input type="checkbox"/>	<input type="checkbox"/>	Vertigo or dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing		<input type="checkbox"/>	<input type="checkbox"/>	Ringing or buzzing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems		<input type="checkbox"/>	<input type="checkbox"/>	Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>
Chronic congestion or nasal discharge		<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Frequent sore throats		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Eye glasses or contacts		<input type="checkbox"/>	<input type="checkbox"/>	Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>
Excessive tearing or dry eyes		<input type="checkbox"/>	<input type="checkbox"/>	Double or blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Light sensitivity		<input type="checkbox"/>	<input type="checkbox"/>	Sores in mouth, lips or gums	<input type="checkbox"/>	<input type="checkbox"/>
Tooth pain		<input type="checkbox"/>	<input type="checkbox"/>	Mercury fillings	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY HEALTH						
Chronic cough		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis		<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or pneumonia		<input type="checkbox"/>	<input type="checkbox"/>	Date of last chest x-ray:		

CARDIOVASCULAR HEALTH					
Please indicate (C) or past (P) symptoms	C	P		C	P
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Cold extremities	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Date of last ECG / EKG:		
MENTAL EMOTIONAL HEALTH					
Tension	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Inability to concentrate	<input type="checkbox"/>	<input type="checkbox"/>
Chronic procrastination	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE HEALTH					
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Excessive hunger or thirst	<input type="checkbox"/>	<input type="checkbox"/>	Fever or excessive sweating	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Adrenal Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid conditions	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	Please Explain:		
MUSCULOSKELETAL HEALTH					
Chronic Headaches	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how often?		
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	If yes, where?		
Metal implants	<input type="checkbox"/>	<input type="checkbox"/>	If yes, where		

The above information is true to the best of my knowledge.

X _____ Date _____

Signature of Patient or Person Legally Responsible

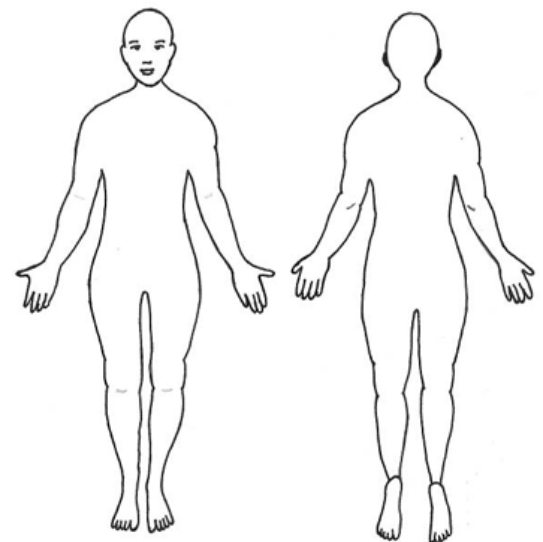
If you are interested in a focused initial consultation only and you would not like to discuss your health history, please complete the following:

I _____ understand the doctors of Young Naturopathic Center for Wellness will not assess or address any extensive health issues. I am here solely on an acute care or informational visit. The doctors will not be responsible for anything we have not discussed. I understand I will need to make additional appointments to address any other health concerns

X _____ Date _____

Signature of Patient or Person Legally Responsible

Please use an X to indicate all areas you are experiencing pain or swelling:



Young Naturopathic Center for Wellness Informed Consent & Office Policies

Our commitment here at the Young Naturopathic Center for Wellness is to serve our patients with professionalism and genuine concern, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving you it may be necessary to share pertinent information with other Health Care Providers or Associates for the purpose of ordering laboratory tests, determination of fees, collection of fees, scheduling of your appointments or to obtain a second opinion. If any other uses or disclosures other than the ones listed above are needed, information will be released only with your written consent, as provided for by law.

All health and laboratory information will be given at scheduled office or phone appointments. Please be aware when scheduling phone appointments our normal fee's for service apply. If you need your labs and are unable to make an appointment we will fax them to another doctor, but will not send them to you directly unless you have already discussed them with the doctor.

Please be aware that Health and Safety Code section 109250, et seq., specifically prohibits the use of any unconventional remedy in the diagnosis, treatment, alleviation, or cure of cancer. If you have been diagnosed with cancer, we will be unable to treat you for this diagnosis.

We do not accept insurance. We ask that you know your insurance coverage prior to visiting us. Labs, supplements, medical devices and prescriptions are not included as part of our office fee's and maybe billed by other parties. It is your responsibility to make payment arrangements with them. All payment is expected at the time of service. Debit Cards, MasterCard, VISA, cash, and checks are acceptable forms of payment.

Please be advised that if for any reason you cannot keep your scheduled procedure or appointment, we require that you cancel at least 24 hours prior to your appointment. Failure to cancel within that time frame or failure to show for the appointment will result in a \$50 fee. This fee may change without notice.

Thank you for your cooperation. We look forward to assisting you on your path to wellness.

Sincerely,

Renee Young, N.D. and Associates

I have read and understand this form.

Signed: _____

Print Name: _____ Date: _____

Young Naturopathic Center for Wellness
Informed Consent to Naturopathic Treatment and Care

I have had an opportunity to discuss the nature and purpose for naturopathic care and its procedures with the Doctor of Naturopathic Medicine named below and/or other office or clinic personnel.

I hereby request and consent to Naturopathic Medicine as an alternative treatment for my health conditions (or for those of the patient named below, for whom I am legally responsible) as performed by the Doctor of Naturopathic Medicine named below and/or other licensed Doctors of Naturopathic Medicine who may now, or in the future, treat me while employed by, working or associated with, serving as back-up for the Doctor of Naturopathic Medicine named below, whether they work at the clinic or office listed below or any other office or clinic. Treatments may include- but are not limited to- herbal medicine, homeopathic medicine, life style and nutritional counseling, naturopathic manual therapy, physical therapy, injection therapy, and hormone replacement.

I have been informed that in the practice of medicine there are some risks to treatment, including -but not limited to- side effects of medication, allergic reactions, anaphylaxis, fractures, disc injuries, strokes, dislocation, and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely on the Doctor's judgment based upon the facts then known, to provide me with any care and procedures considered to be in my best interest during the course of my treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by it I agree to the procedures mentioned above. I indent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:
the

Print Patient's Name

Signature of Patient

Signature of Patients Representative

Date Signed

To be completed by patient's representative, if necessary, e.g. if
patient is a minor or physically or legally incapacitate.

Print Name of Patient

Print Name of Patients Representative

(Include Relationship or Authority of Representative.)

Date Signed

Name of Doctor treating this patient: Dr. Renee Young or Dr. Jennifer Larsen