

## *Young Naturopathic Center for Wellness*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone# Home: (\_\_\_\_) \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Marital Status:  Single  Married  Widowed  Divorced

Please give the name and number of a person to contact in case of an emergency.

\_\_\_\_\_

Referred By:

\_\_\_\_\_

May we e-mail you with information about our office?  Yes  No E-Mail address \_\_\_\_\_

When were you last seen by a medical professional and for what condition? \_\_\_\_\_

\_\_\_\_\_

What are your most important health concerns? Please list from most to least important.

1. \_\_\_\_\_ 4. \_\_\_\_\_  
 2. \_\_\_\_\_ 5. \_\_\_\_\_  
 3. \_\_\_\_\_ 6. \_\_\_\_\_

### **PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU ARE INTERESTED IN:**

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 Options for Birth Control	Detoxification Diet	Naturopathic Pain Management Therapy

**PAST MEDICAL HISTORY:**

Have you ever been vaccinated?  Yes  No What childhood illnesses have you had?

- Rubella (German 3-day Measles)  Measles (2 week)  Mumps  Chickenpox  Whooping cough  Polio  
 Rheumatic Fever  Scarlet Fever  Asthma  Others \_\_\_\_\_

**FAMILY HISTORY:** Please use the following chart to indicate any health disorders your family has had. Please note the age at which a condition began; and indicate age of death if a relative is deceased.

Condition:	Mom or Her Siblings	Dad or His Siblings	Siblings (indicate age and gender)	Grandmother (indicate Mom or Dad's Side)	Grandfather (indicate Mom or Dad's Side)	Your Children & Other Relatives
Allergies						
Alcoholism						
Anemia						
Arthritis						
Asthma						
Autoimmune Disease						
Cancer (indicate type)						
Candida						
Celiac Disease						
Coronary Artery Disease						
Crohn's Disease						
Depression						
Digestive Complaints						
Diabetes						
Eating Disorder						
Eczema						
Endometriosis/ Fibroids/Infertility						
Glaucoma						
Gout						
Heart Attack/Stroke						
Mental Disorder						
Thyroid Condition						
Ulcerative Colitis						
Genetic or Other Issues						

**PERSONAL HEALTH HISTORY:****HOSPITALIZATIONS & SURCAL PROCEDURES:**

Indicate illness, operation and or procedure performed.

Date

Hospital

Indicate illness, operation and or procedure performed.	Date	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MEDICATIONS:** List all the drugs, vitamins, and herbs you take, including dosages.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES:**Are you allergic to any medicines or other substances?  Yes  No

If yes, please list: \_\_\_\_\_

What happens when you have an "allergy attack"? \_\_\_\_\_

\_\_\_\_\_

**HEALTH HABITS:**Do you drink?  No  Yes How often? \_\_\_\_\_ Wine \_\_\_\_\_ Beer \_\_\_\_\_ Other Alcohol \_\_\_\_\_Do you use tobacco or have you in the past?  No  Yes, how long? \_\_\_\_\_ How many? \_\_\_\_\_

Total years since you have stopped smoking? \_\_\_\_\_

Do you now or have you in the past used recreational drugs?  Yes  No

You may state which ones if you so choose. \_\_\_\_\_

Have you ever been exposed to toxic chemicals, solvents or other possible harmful toxins?  Yes  No

If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

Do you exercise?  Yes  No What form(s)? \_\_\_\_\_

How often? \_\_\_\_\_

Which of the following do you do regularly:  Jogging  Swimming  Walking  Biking  Gardening  Yoga Breathing Exercises  Meditation  Weightlifting  Other \_\_\_\_\_Have you traveled outside the U.S. in the past two years?  No  Yes If yes, where? \_\_\_\_\_**DIET:**How many meals do you generally eat each day?  One  Two  Three  More than three

Where do you usually buy your food? \_\_\_\_\_ Who cooks the food you eat? \_\_\_\_\_

Describe your typical breakfast, lunch, dinner and snacks per day. \_\_\_\_\_

\_\_\_\_\_

Mark which of these you consume regularly.  Coffee  Caffeinated teas  Highly seasoned foods Processed foods  Preservatives  Refined foods  Soda  Candy

How many cups of coffee, tea, or caffeinated drinks do you consume per day? \_\_\_\_\_

List foods you eat which you suspect may be harmful to your health. \_\_\_\_\_

\_\_\_\_\_

List any foods you crave (include sweets, chocolate, bread, salty, sour, rich, fatty foods, etc.):

\_\_\_\_\_

List any foods to which you have a bad reaction: \_\_\_\_\_

Are you thirsty?  Yes  No Amount of water you drink each day: \_\_\_\_\_

Are you satisfied with your diet as it is now?  Yes  No If no, why not? \_\_\_\_\_

### GASTROINTESTINAL HEALTH:

How many bowel movements are you having per day? \_\_\_\_\_ Do you have a history of hemorrhoids?  Yes  No

Describe any recent change in bowel habits. \_\_\_\_\_

Please mark any of the following that apply to your stool:  blood  mucus  undigested food  light color

looks like rabbit pellets  loose  well formed normal stool  other: \_\_\_\_\_

**SLEEP:** Do you have trouble falling asleep?  Yes  No If yes, what keeps you up? \_\_\_\_\_

Do you sleep straight through the night?  Yes  No Do you wake feeling refreshed?  Yes  No

Do you snore?  Yes  No Have you ever been tested for sleep apnea?  Yes  No

### FEMALE REPRODUCTIVE HEALTH:

Date of last period \_\_\_\_\_ Age of first menstruation \_\_\_\_\_

Did you have a normal puberty?  Yes  No If no, explain: \_\_\_\_\_

Periods occur every \_\_\_\_\_ days. Regular?  Yes  No Periods usually last \_\_\_\_\_ days (average).

Days of heavy bleeding \_\_\_\_\_ medium bleeding \_\_\_\_\_ light bleeding \_\_\_\_\_ spotting \_\_\_\_\_

If you experience the following symptoms, please mark **B** if before, **D** if during or **A** if after your menstrual cycle.

If you are not having a cycle place a **check mark** next to the symptoms you are currently experiencing.

_____ Nervous tension	_____ Depression	_____ Headache	_____ Weight gain
_____ Irritability	_____ Forgetful	_____ Craving for sweets	_____ Bloating
_____ Mood changes	_____ Crying	_____ Increased appetite	_____ Extremity swelling
_____ Anxiety	_____ Confusion	_____ Heart pounding	_____ Breast tenderness
_____ Insomnia		_____ Dizziness or fainting	_____ Fatigue

Date of last **PAP** Smear \_\_\_\_\_ Was it normal?  Yes  No Did you have a breast exam?  Yes  No

Have you ever had or do you currently have problems with infertility?  Yes  No

\_\_\_\_\_ # of pregnancies \_\_\_\_\_ # of births \_\_\_\_\_ # of miscarriages \_\_\_\_\_ # of abortions

History of complications of pregnancy?  Yes  No If yes, please explain. \_\_\_\_\_

Indicate your Mother's age when she started menopause? \_\_\_\_\_ Female Siblings? \_\_\_\_\_

If she has not began menopause, what is her current age? \_\_\_\_\_

Have you ever used **birth control** pills?  Yes  No If yes, how long? \_\_\_\_\_

Have you ever used an **I.U.D.**?  Yes  No How long? \_\_\_\_\_ What kind? \_\_\_\_\_

What is your current form of contraception? \_\_\_\_\_

Please check Y for Yes, N for No, and P for Past for any of the following health conditions:

<b>GENERAL INFORMATION:</b>	<b>Y</b>	<b>N</b>	<b>P</b>	<b>EYES:</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Recent Weight Gain/Loss				Wear Eye Glasses/Contacts			
Weakness				Double Vision			
Fatigue				Blurred Vision			
Fever				Loss of Vision			
Fainting				Eyes Sensitive to Light			
Nausea				Excessive Tearing			
Vomiting				Dry Eyes			
Balance Problems				<b>EARS:</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Jaw Pain (TMJ)				Loss of Hearing			
Neck Pain				ringing/Buzzing in Ears (Tinnitus)			
Neck Stiffness				Ear Infections			
Shoulder Pain				Vertigo (Dizziness)			
Arm Pain				Any Discharge from Ears			
Wrist/Hand Pain				<b>NOSE:</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Numbness in your Arms or Hands				Sinus Problems			
Upper Back Pain				Nosebleeds			
Lower Back Pain				Loss of Smell			
Hip Pain				Any Discharge from Nose			
Leg Pain				<b>MOUTH/THROAT:</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Knee Pain				Tooth Pain			
Ankle/Foot Pain				Sores in Mouth, Lips or Gums			
Numbness in your Legs or Feet				Frequent Sore Throats			
Joint Swelling				Difficulty Swallowing			
Tension				Mercury Fillings			
Nervousness				<b>RESPIRATORY (LUNGS):</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Anxiety				Difficulty Breathing			
Irritability				Chronic Cough			
Sleeping Problems/Insomnia				Asthma			
Depression				Bronchitis			
Liver Problems				Emphysema			
Cancer				Tuberculosis or Pneumonia			
Metal Implants				Date of last Chest Radiograph?			
Headaches				<b>CARDIO (HEART PROBLEMS):</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Loss of Consciousness				Chest Pain			
Dizziness				Difficulty Breathing			
Memory Problems				Palpitations			
Seizures/Convulsions				Night Sweats			
				Cold Extremities			
				High Blood Pressure			
				Low Blood Pressure			
				Heart Murmur			
				Date of last ECG/EKG?			

Please check Y for Yes N for No and P for Past for any of the following health conditions:

<b>GI (GASTROINTESTINAL):</b>	<b>Y</b>	<b>N</b>	<b>P</b>	<b>GU (GENITOURINARY):</b>			
Upset Stomach				<b>FEMALES:</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Loss of Appetite				Pelvic Inflammatory Disease			
Indigestion				Urinary Tract Infections			
Constipation				Breast Cancer &/or Benign Tumors			
Diarrhea				Blood in Urine			
Bloody Stool				Painful Urination			
Abdominal Pain				Vaginal Discharge or Chronic Yeast			
Excessive Gas				Fibroids			
Loss of Bowel Control				Breast Tenderness			
Hemorrhoids				Hot Flashes			
Have You Had A Colonoscopy				Loss of Bladder Control			
<b>ENDOCRINE:</b>	<b>Y</b>	<b>N</b>	<b>P</b>	Currently Pregnant			
Cold or Heat Intolerance				Have you had a Pelvic Ultrasound			
Excessive Sweating				Have You Had A Mammogram			
Excessive Thirst or Hunger				<b>MALES:</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Diabetes				Prostate Problems			
Thyroid Conditions				Hernias			
Kidney Conditions				Penile Discharge			
<b>OTHER:</b>	<b>Y</b>	<b>N</b>	<b>P</b>	Blood in Urine			
Currently Sexually Active				Painful Urination			
Currently Trying to Become Pregnant				Frequent Urination			
				Testicular Pain			
				Loss of Bladder Control			
				Do you have children? If yes, how many?			
				Name Current form of Contraception:			

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

**Signature of Patient or Person Legally Responsible**

X \_\_\_\_\_ Date \_\_\_\_\_

## 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.

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. 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 request 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.

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.

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To be completed by the patient:

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

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Print Patient's Name

---

Print Name of Patient

---

Signature of Patient

---

Print Name of Patients Representative

---

Date Signed

---

Signature of Patients Representative  
(Include Relationship or Authority of Representative.)

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Date Signed

Name of Doctor treating this patient: **Dr. Renee Young**