COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONER DISCLOSURE

Patient Information Document

Required under NM Stat § 61-35-5

1. Practitioner Information

- **Practitioner Name:** Mike Walker, DNH
- **Title:** Doctor of Natural Health (DNH)
- **Business Address:** Cloudcroft, NM (Zoom Consults Only)
- **Telephone Number:** 414-209-2312

2. State Licensing Status

Mike Walker, DNH, **is not a health care practitioner licensed by the State of New Mexico**. The services, modalities, and treatments provided under the title of Doctor of Natural Health are **complementary or alternative to health care services** provided by medical practitioners licensed by the State of New Mexico.

3. Nature and Expected Results of Services

The alternative health services provided focus on natural health, wellness, and holistic lifestyle education.

- **Nature of Services:** This practice encompasses the broad domain of complementary and alternative healing therapies outlined under NM Stat § 61-35-2, including: anthroposophy, aromatherapy, Ayurveda, traditional healing practices (such as curanderismo), detoxification, energetic healing, folk practices, Gerson therapy, nutritional and physical therapies, healing touch, herbalism, homeopathy, meditation, mind-body techniques, non-regulated naturopathy, iridology, use of noninvasive instruments, and holistic kinesiology.
- **Expected Results:** Services are intended to support the body’s natural wellness processes, optimize vitality, and educate the patient on natural health practices. They do not substitute for conventional medical diagnosis or treatment.

4. Degrees, Education, and Qualifications

- **Degree:** Doctor of Natural Health (DNH)
- **Institution:** Arkansas College of Natural Health
- **Year Awarded:** 2012

5. Financial Policies and Fees

- **Fee Structure:** Fees are determined on a sliding scale based on the patient's weekly gross income.
- **Billing Method:** Cash only. Payment is due at the time of service.
- **Patient Right to Notice:** The patient has a right to **reasonable notice of any changes** in complementary and alternative health care services or charges.

Patient Acknowledgment

By signing below, I acknowledge that I have received, read, and understand this Patient Information Document prior to receiving any services from Mike Walker, DNH. If I am unable to read, this information has been read aloud to me in a language I understand.

Patient Name (Printed): _____

Patient or Representative Signature: _____ Date: _____

PATIENT INTAKE FORM

Please complete all sections accurately prior to your consultation.

1. CONTACT INFORMATION

Full Name: _____ **Date of Birth:** _____

Gender: _____ **Phone Number:** _____

Email Address: _____

Home Address: _____

Emergency Contact Name & Phone: _____

2. VITALS (OFFICIAL USE ONLY)

Height: _____ **Weight:** _____ **BMI:** _____

Blood Pressure: _____ / _____ mmHg **Heart Rate:** _____ bpm

Respiratory Rate: _____ pm **Temperature:** _____ °F/°C

Oxygen Saturation: _____ %

3. MEDICAL HISTORY & HEALTH QUESTIONS

Primary Reason for Visit: _____

Chronic Conditions (Check all that apply):

- ☐ Hypertension
- ☐ Diabetes
- ☐ Asthma/COPD
- ☐ Heart Disease
- ☐ Anxiety/Depression
- ☐ High Cholesterol

Past Surgeries / Hospitalizations (Dates & Reasons): _____

Family Medical History (e.g., Cancer, Heart Attack, Stroke): _____

4. PRESCRIPTIONS & SUPPLEMENTS

Allergies (Medications, Food, Latex): _____

Current Medications (Name, Dosage, Frequency): _____

Vitamins & Over-the-Counter Supplements: _____

5. LIFESTYLE MEDICINE QUESTIONS

Diet & Nutrition (Describe typical daily meals/restrictions):

Physical Activity (Type, frequency, and duration per week):

Sleep Hygiene (Average hours per night / quality of sleep):

Stress Management (Current stress level 1-10 & coping mechanisms):

Substance Use:

Tobacco: ☐ Never ☐ Former ☐ Current (_____ packs/day)

Alcohol: ☐ None ☐ Occasional ☐ Heavy (_____ drinks/week)

Information provided is strictly confidential and protected under HIPAA guidelines.