PATIENT INTAKE FORM

Please print clearly and fill out this form to the best of your ability. It will help to assess your present health and will assist in facilitating the healing process.

Date: _____

Name: _____ Date of Birth: (mm/dd/yy): ____/____/____
Address: _____ Age: _____
City/State_____ Sex: Male/Female
Zip_____ Present weight: _____
Phone (cell) (_____)_____text Yes/No Present height: _____
Phone (work): _(_____)_____ Ethnicity: _____
May we leave messages relating to your visits? Y/N
E-mail Address: _____
Marital Status: (circle one) married / separated / divorced / widowed / single / other: _____
Occupation: _____ (circle one) full time / part time / retired / student

Emergency Contact:
Name: _____ Relation: _____ Phone: (_____)_____
Name: _____ Relation: _____ Phone: (_____)_____

How did you hear about our clinic? _____
Referred by: _____

Names of other health care practitioners (medical doctor, chiropractor, specialist, physiotherapist, etc.) you are seeing:

Name: _____ Name: _____ Name: _____
Practitioner: _____ Practitioner: _____ Practitioner: _____
Address: _____ Address: _____ Address: _____
_____ _____ _____
Phone: (_____)_____ Phone: (_____)_____ Phone: (_____)_____

CHIEF HEALTH CONCERNS

Please describe your primary health concern:

List other health concerns in order of importance to you:
2. _____
3. _____
4. _____
5. _____

BioSalus Naturopathic Health Clinic, LLC
Shauna S. Smith, ND
5840 S. Memorial Drive Ste 333
Tulsa, OK 74145
www.biosalushealth.com
(918) 574-2370 Phone

MEDICAL HISTORY

Describe your present general state of health: _____

Please indicate any serious conditions, illnesses or injuries, and any surgeries or hospitalizations (provide approximate dates):

1. _____
2. _____
3. _____
4. _____
5. _____

List any allergies (medicines, environmental, etc.) you have:

_____

_____

List all names of *prescribed medication* currently being taken. Include dosage, frequency, how long you have been taking it, and any adverse reactions/allergies to medications:

Medication	Dose (i.e. mg)	Frequency (#times/day)	Since How Long	Adverse Reactions/ Allergies (describe)

List all *over the counter medication* that you take (e.g. Aspirin, Tylenol, Tums, etc.). Include dosage and frequency and any adverse reactions/allergies to medications:

1. _____
2. _____
3. _____

List all vitamins, minerals, botanical (herbal) medicines, Asian medicines (Chinese Patent drugs), or homeopathic remedies that you are currently taking. Indicate daily dosage:

1. _____
2. _____
3. _____

Do you use any recreational drugs? Y/N (If yes, indicate what type and frequency of usage):

_____

Do you have regular screening tests done by another doctor? Y/N (blood tests, Pap smear, prostate exam, etc.)

When was your last physical exam? _____

BioSalus Naturopathic Health Clinic, LLC
Shauna S. Smith, ND
5840 S. Memorial Drive Ste 333
Tulsa, OK 74145
www.biosalushealth.com
(918) 574-2370 Phone

Indicate the vaccinations have you received:

- ❑ Chicken pox (Varicella)
- ❑ Cholera
- ❑ DTP (Diphtheria/Tetanus/Pertussis)
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Influenza (flu shot)
- ❑ MMR (Measles/Mumps/Rubella)
- ❑ Meningococcal (meningitis)
- ❑ Pneumococcal
- ❑ Polio
- ❑ Travel Vaccinations
- ❑ Rabies
- ❑ Typhoid
- ❑ BCG (Tuberculosis)
- ❑ Yellow Fever
- ❑ Don't know

Have you ever experienced any adverse reactions to the above vaccinations? Y/N (Describe):

_____

PREVIOUS HEALTH HISTORY/FAMILY HISTORY

Please indicate any significant medical conditions present in your family (e.g. heart disease, stroke, mental illness, thyroid conditions, cancer, diabetes, etc.) and specify which member of your family you are referring to:

_____
_____
_____
_____
_____

LIFESTYLE

Please list what you have had to drink and eat in the past 24 hours:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? Y/N
If yes, describe: _____

Do you drink alcohol? Y/N (If yes, indicate what type of alcohol and how many glasses per week):

_____

Do you smoke? Y/N (If yes, indicate for how long, and how many cigarettes/cigars per day):

_____

Does anyone else in your household smoke? (circle one) Y/N

Do you own any pets? Y/N (Indicate what type): _____

On average, how many hours of sleep do you get per night? _____

On average, how many hours do you work each day? _____

Do you exercise? Y /N (Indicate what type of exercise and how long): _____

_____

List your hobbies: _____

Are you sexually active? Y / N Method of contraception: _____

If you are a female are you: Pregnant? Y/N or Lactating? Y/N

What level of personal stress are you experiencing at the present moment? (circle one):
minimal / average/ considerable/ unbearable
What is/are your major stressor(s)?

- ❑ financial
- ❑ job related
- ❑ relationship
- ❑ personal health
- ❑ family members
- ❑ family issues (i.e. death)
- ❑ interpersonal
- ❑ spiritual
- ❑ other: _____

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc.) while at work, home or traveling?
Yes □ No □

Are there any other medical conditions or health concerns? _____
_____
_____

INFORMED CONSENT

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include: diet, nutritional supplements, botanical medicine, homeopathy, and Biomeridian EDS screening.

Individual diet and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, increased gastrointestinal function, improved immunity, and general well-being.

Botanical medicine is a plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

Homeopathy is a form of medicine based on the Law of Similars – the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal, or mineral origins are used to *stimulate the body's ability to heal itself*. Homeopathy is a powerful tool that affects healing on a physical and emotional level.

During your initial visits, your Naturopathic Doctor will take a thorough case history, do a physical examination, and when indicated, require your most recent laboratory work (i.e. blood and/or urine tests), ideally performed within the last six months.

Even the gentlest therapies may cause complications in certain physiological conditions (e.g. pregnancy, lactation, very young children, or in those taking multiple medications). Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important, therefore, that you inform your doctor immediately of any disease process that you are suffering from, as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding advise your doctor immediately.

There are some slight **risks** associated with Naturopathic Medicine. These include but are not limited to:

Aggravation of pre-existing symptoms
Allergic reactions to supplements or herbs

Please initial the following:

____ I understand that a record will be kept of the health services provided to me. This record will be **kept confidential** and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

____ I understand that the Naturopathic Doctor will answer any questions that I have to the best of his/her ability. I understand that the results are NOT guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

_____

____ I understand that I am at liberty to seek or continue to seek medical care from other health care providers at the same time while seeking Naturopathic care.

____ I understand that charges are to be paid at the time of the visit unless specific arrangements have been made. I understand that fees may be subject to change without prior notice. Consultation fees are $35.00

As the patient, you are responsible for the total charges incurred for each visit. If you have coverage for Naturopathic Medicine through an insurance company, you are responsible for billing your own insurance company – your doctor will provide you with all of the information necessary to send your claim for reimbursement. We accept cash, check, or credit card (Visa, Mastercard, American Express and Discover).

Each appointment time is valuable. Please call the clinic 24 hours in advance if you cannot make the appointment. There will be full charge for missed appointments or cancellations without 24 hours notice.

Your Naturopathic Doctor may prescribe supplements that can be purchased at the clinic or elsewhere. Shauna S. Smith, ND uses only professional quality herbs, homeopathics, and supplements. Most insurance companies DO NOT cover the supplements that we prescribe and dispense.

BioSalus Naturopathic Health Clinic, LLC
Shauna S. Smith, ND
5840 So Memorial Drive, Suite 333
Tulsa, OK 74145
www.biosalushealth.com
(918) 516-0699 Fax (918) 574-2370 Phone

I have read and understood the above-stated information and policies. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw consent and to discontinue participation in these procedures at any time.
Patient Name (please print):_____
Signature of Patient or Guardian: _____
Signature of Naturopathic Doctor:_____
Date: _____

PATIENT CONSENT FOR COLLECTION, USE, AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of providing you with quality naturopathic care. At Biosalus Naturopathic Health Clinic, we understand the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly.

The privacy policy outlines what the clinic is doing to ensure that:

- Only necessary information is collected about you

- We only share your information with your written consent

- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols

- Our privacy protocols comply with privacy legislation, standards of our regulatory body, and The Board of Directors of Drugless Therapy – Naturopathy.

This office will collect, use, and disclose information about you for the following purposes:

-To assess your health concerns and to advise you of treatment options

-To establish and maintain communication with you

-To remind you of upcoming appointments

-To communicate with all other health care providers in your health care team

-To allow us to efficiently follow up for treatment, care, and billing

-To comply with legal and regulatory requirements of our regulatory body, and The Board of Directors of Drugless Therapy-Naturopathy and to comply with the law

By signing this form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed.

I have reviewed the above information that explains how Shauna S Smith, ND and the staff of BioSalus

BioSalus Naturopathic Health Clinic, LLC
Shauna S. Smith, ND
5840 So Memorial Drive, Suite 333
Tulsa, OK 74145
www.biosalushealth.com
(918) 516-0699 Fax (918) 574-2370 Phone

Naturopathic Health Clinic will use my personal information. I understand the policy and how it protects my personal information. I consent to Shauna S Smith, ND collecting, using and disclosing my personal information as set out above in the information about the office's privacy policies.

Signature:_____ Print Name: _____

Date: _____ Signature of Naturopathic Doctor: _____

BioSalus Naturopathic Health Clinic, LLC
Shauna S. Smith, ND
5840 So Memorial Drive, Suite 333
Tulsa, OK 74145
www.biosalushealth.com
(918) 516-0699 Fax (918) 574-2370 Phone