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**PLEASE PRINT CLEARLY** Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (First, Middle, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please circle: single /   married, partnered   /   divorced   /   widowed   /   other

CELL phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate phone # (home / work) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of referring provider (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*It is valuable for our facility and provider(s) to be able to contact you via phone, text message or email. Choose the following option(s):**

( ) YES you may leave a voicemail ( ) YES you may send me a text message to confirm my appointment

( ) YES you may email me.

**\*\*If none selected, then no voicemail, text message or emails will be sent. \*\***

Primary reason(s) for today’s appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What types of therapy have you tried for this problem(s) (i.e. medical doctor visit, medications, diet modification, supplements, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Personal Medical & Family Medical History:**

Please indicate with an “**X” if yourself** or an “**F” if an immediate family member** has been diagnosed with any of the following conditions:

\_\_\_ Active or Past Eating Disorder \_\_\_ Ear, Nose, Throat Problems

\_\_\_ Anxiety \_\_\_ Epilepsy (Seizures)

\_\_\_ Arthritis \_\_\_ Fertility Challenges

\_\_\_ Asthma/Allergies \_\_\_ Fibromyalgia

\_\_\_ Autoimmune Disease \_\_\_ Heart Disease

\_\_\_ Bleeding/Clotting Disorders      \_\_\_High Cholesterol

\_\_\_ Blood Pressure (High or Low) \_\_\_ Irritable Bowels/Digestive Disorders

\_\_\_ Cancer \_\_\_Kidney or Liver Disease(s)

\_\_\_ Chronic Fatigue \_\_\_ Osteopenia/Osteoperosis

\_\_\_ Circulation Problems \_\_\_ Overweight/Obesity

\_\_\_ Congenital/Birth Differences \_\_\_ Sinus Problems

\_\_\_ Dementia, Neurological Changes \_\_\_ Skin Problems

\_\_\_ Depression \_\_\_ Substance Use Disorder

\_\_\_ Diabetes/Insulin Resistance \_\_\_Thyroid Disorders

Are there any other conditions that you have been diagnosed with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications (Prescription & Over-The-Counter): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Natural supplements/herbs/vitamins (include dosage and how often you take): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Operations or hospitalizations (please include dates):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Allergies (medications, supplements, foods, seasonal, animal, ): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Do you experience any of the following symptoms** **almost daily or daily?**

\_\_\_\_ Extreme fatigue \_\_\_\_ Shortness of breath \_\_\_\_ Insomnia \_\_\_\_ Nausea

\_\_\_\_ Depression \_\_\_\_ Panic attacks \_\_\_\_ Vomiting \_\_\_\_ Diarrhea

\_\_\_\_ Disinterest in eating \_\_\_\_ Headaches \_\_\_\_ Incontinence \_\_\_\_Itching/Rash

\_\_\_\_ Disinterest in sex \_\_\_\_ Dizziness \_\_\_\_ Chronic pain

**Please list your other health care providers (primary care, specialists, chiropractor, etc.):**

Name: Field/Specialty:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Foundations of Health & Lifestyle Information:**

**Energy & Stress Levels (On a scale of 1-to-10)**

Rank your energy on a typical day (10 is best energy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rank the stress level of your (10 is highest) : **work** environment? \_\_\_\_\_\_\_\_\_\_**home** environment? \_\_\_\_\_\_\_\_\_\_

Identify the major cause(s) of stress (work, home, finances, legal): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Household/Daily Routines:**

Do you have children/dependents? Y / N Age(s) (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you follow any type of modified diet (vegan, vegetarian, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise?   Y / N If yes, frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours, on average, do you sleep per night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your sleep disturbed?   Y  /   N Do you wake feeling rested?    Y  /  N

**Substances:**

Do you consume caffeine? Y  /  N What type(s)? \_\_\_\_\_\_\_\_\_\_\_     How often? \_\_\_\_\_\_\_\_\_\_

Do you use tobacco?  Y / N Do you use recreational drugs?   Y / N

Do you drink alcohol? Y  /  N If yes, what type(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_

How many drinks? \_\_\_\_\_\_\_\_\_ Do you have trouble managing your alcohol use? Y / N

**Relationships:**

Do you currently feel safe in your home and/or relationships?   Y / N

Have you experienced physical/mental abuse (domestic violence, sexual, verbal, physical, etc.)?  Y / N

Is your job associated with potentially harmful chemicals (pesticides, solvents, etc) or health and/or life-threatening activities (police, fire fighter, farmer, miner, etc.)?      Y  /  N

Current Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consider yourself underweight, overweight or just right? \_\_\_\_\_\_\_\_\_\_\_Have you had unintentional weight loss or gain of 10# or more in the past 3 months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Female-Specific Information:***Please indicate if you experience/experienced any of the following:*

(   )  PMS/PMDD  (   ) breast changes (cysts, fibrocystic tissue)

(   )  Infertility  (   ) uterine fibroids, ovarian cysts (   )  loss/change in libido

(   )  bloating/water retention  (   ) irregular menstrual cycles (   ) bladder function changes

(   )   hot flashes/ night sweats (  ) excessive menstrual bleeding (   ) unusual changes in vaginal discharge

(   )  itching/burning with urination or intercourse

Age of first menstrual cycle:\_\_\_\_\_\_\_\_  Age of menopause (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or actively trying to conceive?   Y / N

# of pregnancies: \_\_\_\_\_\_\_ # children: \_\_\_\_\_\_\_ # of pregnancies lost: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Male-Specific Information:***Please indicate if you experience/have experienced any of the following:*

(   )  urinary changes (   )  excessive moodiness

(   ) frequent nighttime urination (   )  unusual discharge from penis

(   )  loss/change in libido (   )  itching or burning with urination or intercourse

(   ) erectile dysfunction (   )  pain or swelling in penis or testicle(s)

**Consents & Acknowledgements:**

**Accuracy of Information:** I certify that the above medical information is correct to my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Client Signature) (Date)*

**Privacy and Sharing of Information:**I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my written permission.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Client Signature) (Date)*

**Appointment Fees & Cancellations:** I am responsible for paying all appointment fees at the time of service and for appointments I fail to cancel with less than a 24-hour notice. All service fees are visible on the online scheduling page and can also be provided to me at my request. Published service fees are subject to change at any time. I have the right to request more information and consider the cost of any additional recommendations (testing, supplements, etc.) prior to proceeding. No insurance billing will be completed by this facility.

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Client Signature) (Date)*

**Complimentary Care:** I understand that the care I receive today is complimentary to my existing healthcare plan. In North Dakota, Naturopathic Doctors (NDs) do not act as primary care providers (PCPs) and cannot prescribe or change dosing of any pharmaceutical medications. I am responsible for notifying my PCP about the changes I choose to implement.

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Client Signature) (Date)*