Naturopathic Medicine Intake Form

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Other names/Maiden Name: _____ Birthdate: _____/_____/_____ Sex: M / F

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Email Address: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Occupation: _____ Full Time: Y/N Marital Status: (S)(M)(D)(W)

Emergency Contact: _____Relationship to Patient: _____

Contact's Phone Number: _____Contact's Email: _____

Referred to Aloe Wellness by: _____

Current Health Care Team:

Primary Care Physician: _____ Office Number: _____

Specialist Physician: _____Specialty: _____ Office Number: _____

Specialist Physician: _____Specialty: _____ Office Number: _____

Other Health Care Team Members (Ex: massage therapist, nutritionist, acupuncturist, etc.):

Practitioner Name: _____ Office Number: _____

Practitioner Name: _____ Office Number: _____

Primary Health Concerns: *Please list you primary health concerns in order of importance.*

	Concern *Ex: Headache*	Onset *June 1992*	Frequency *4 times/week*	Severity *mild/mod/severe*
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

ALOE WELLNESS

What types of therapies have you tried?

___Diet modification ___Fasting ___Herbs ___Vitamins/minerals ___Homeopathy ___Chiropractic

___Acupuncture ___Conventional drugs ___Other

Cancer-Specific History: *If applicable*

Cancer Type: _____ Date of Diagnosis: _____ Stage: _____ Recurrence: (Y) (N)

Sites of Metastasis: _____

Check all that apply:
___To Prevent Cancer ___Help with conventional treatment ___To manage symptoms/ side effects
___To improve well-being ___Prevention of recurrence ___To slow progression ___To prepare for surgery
___Other: _____

Treatment History	Date	Complications	Drugs Used (if applicable)
__Biopsy	_____/_____/_____	Y / N	_____
__Surgery	_____/_____/_____	Y / N	_____
__Chemotherapy	_____/_____/_____	Y / N	_____
__Radiation	_____/_____/_____	Y / N	_____
__Hormone Therapy	_____/_____/_____	Y / N	_____
__Other: _____	_____/_____/_____	Y / N	_____

Current Treatment: _____

What are your goals for this visit?

_____

_____

Please list any operations/surgical procedures/blood transfusions/major injuries (with dates):

_____

_____

Immunizations/vaccinations: _____

Date of last Physical Exam: _____ Date of last Blood Tests: _____

Screening Tests: *Enter most recent date only*

Mammogram	_____/_____/_____
Thermogram	_____/_____/_____
Bone Density (DEXA)	_____/_____/_____
Colonoscopy	_____/_____/_____
Ultrasound	_____/_____/_____
Other: _____	_____/_____/_____

ALOE
WELLNESS

Please List any Life Threatening Allergies: _____

Other allergies, sensitivities, or intolerances (e.g. food, medication, environmental, chemical, etc.):

_____

_____

What are the major stressors in your life? Do you consider severity of stress low, moderate or high?

_____

_____

What are your interests/hobbies? _____

I have indicated all of my known medical conditions above. I will alert the practitioner to any changes in my health status. It is my choice to receive naturopathic care.

Signature: _____ Date: _____

MEDICAL HISTORY

Check all that apply to you. Please specify the date of diagnosis where applicable.

HEAD
_____ Glaucoma
_____ Dental Problems

RESPIRATORY
_____ Asthma
_____ Bronchitis
_____ Emphysema
_____ Pneumonia
_____ Tuberculosis

GASTRO-INTESTINAL
_____ Colitis/Chron's
_____ Celiac Disease
_____ Reflux
_____ Inflammatory Bowel Disorder
_____ Hepatitis
_____ Gallbladder Disorders
_____ Diverticulitis

CARDIOVASCULAR
_____ High Blood Pressure
_____ Cholesterol, Elevated
_____ Heart Disease
_____ Arrhythmia
_____ Circulatory Problems
_____ Clotting Disorder
_____ Heart Attack
_____ Stroke

NERVOUS SYSTEM
_____ Alzheimer Disease
_____ Epilepsy
_____ Parkinson's
_____ Multiple Sclerosis
_____ Restless Legs Syndrome

MUSCULOSKELETAL
_____ Carpel Tunnel Syndrome
_____ Gout
_____ Osteoporosis
_____ Rheumatoid Arthritis
_____ Osteoarthritis

GENITOURINARY
_____ Kidney or Bladder Disease

SKIN
_____ Easy Bruising
_____ Eczema
_____ Psoriasis
_____ Varicose Veins
_____ Allergies/Hay Fever

ENDOCRINE
_____ Chronic Fatigue Syndrome
_____ Diabetes
_____ Thyroid Disorder
_____ Obesity
_____ Seasonal Affective Disorder
_____ Insomnia

MENTAL/EMOTIONAL/ OTHER
_____ Depression
_____ Anxiety
_____ Drug Addiction
_____ Eating Disorder
_____ Learning
_____ Alcoholism
_____ ADD/ADHD

BLOOD, IMMUNE, INFECTIONS
_____ Autoimmune Disease
_____ Lyme Disease
_____ HIV
_____ Anemia

MALE REPRODUCTIVE
_____ Enlarged Prostate
_____ Prostate Cancer
_____ Decreased Sex Drive
_____ Infertility
_____ Other _____
_____ Sexually Transmitted Disease - *please specify type(s) and dates:*
_____
Date of last prostate exam _____

FEMALE REPRODUCTIVE
_____ Menstrual Irregularities
_____ Endometriosis
_____ Fibrocystic Breasts
_____ Fibroids/ovarian cysts
_____ PCOS
_____ Premenstrual Syndrome (PMS)
_____ Menopausal Symptoms
_____ Breast Cancer
_____ Vaginal Infections
_____ Decreased Sex Drive
_____ Urinary Tract Infection
_____ Infertility
_____ Other _____
_____ Sexually Transmitted Disease - *please specify type(s) and dates:*
_____

Date of last menstrual cycle:
_____
Length of cycle in days: _____
Days between cycles: _____
Age of first period: _____

Date of last GYN exam: _____
PAP + / – Date: _____
Form of Birth Control:
_____
# of children: _____
# of pregnancies: _____
# of miscarriages: _____
# of abortions: _____
Are you pregnant? Y N

List any **PMS symptoms** (e.g. heavy/scanty flow, clots, cramping, breast tenderness, bloating, mood changes, other):
_____
_____

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ALOE
WELLNESS

FAMILY HISTORY

(M/Mother, F/Father, B/Brother, S/Sister, FP/Father's Parents, MP/Mother's parents, C/Children)

_____ Alcoholism
_____ Allergies
_____ Alzheimer's Disease
_____ Autoimmune Diseases
_____ Cancer - please specify type(s):
_____
_____
_____
_____ Crohn's Disease
_____ Diabetes
_____ Drug abuse
_____ Epilepsy, seizures
_____ Hearing Loss
_____ Heart Disease
_____ HIV
_____ High Blood Pressure
_____ Kidney Disease
_____ Liver Disease
_____ Nervous or Mental Disorder
_____ Migraine Headaches
_____ Neurological Disorders
_____ Obesity
_____ Osteoporosis
_____ Thyroid Disorder
_____ Other: _____

YOUR HEALTH HABITS

_____ Tobacco
Cigarettes: #/day _____
Cigars: #/day _____

_____ Alcohol
Wine: # glasses/d or wk _____
Liquor: # glasses/d or wk _____
Beer: # glasses/d or wk _____

_____ Caffeine
Coffee: # glasses/d or wk _____
Tea: # glasses/d or wk _____
Soda: # glasses/d or wk _____
Other caffeine: _____

Water: #oz./d _____

EXERCISE

Total days per week: _____
Duration per workout:
_____ minutes

Type of Exercise	Days/week
_____	_____
_____	_____
_____	_____
_____	_____

Today's Weight _____ lb
Height _____ ft _____ in

SLEEP

Hours per night: _____
Sleep quality:
_____ Poor
_____ Fair
_____ Good

NUTRITION & DIET

_____ Mixed Food Diet (animal and vegetable)
_____ Vegetarian
_____ Vegan
_____ Organic Food
_____ Salt Restriction
_____ Fat Restriction
_____ Starch/ carbohydrate restriction
_____ Calorie Restriction

Please list any Food Restrictions:
(eg. dairy, gluten, soy, meat, etc.)
_____
_____

FOOD FREQUENCY

(# of times per day or week)
Fruits _____
Vegetables _____
Whole Grains _____
Beans, nuts, legumes _____
Dairy _____
Fish _____
Meat, poultry _____
Eggs _____

EATING HABITS

Skip meals – list which one(s):
_____
Eat _____# of meals/day
_____ Graze (small frequent meals)
_____ Generally eat on the run
_____ Eat constantly whether hungry or not

Metabolic Detoxification Questionnaire

Part 1: Symptoms

Name _____ Date _____

Rate each of the following symptoms based on how you've been feeling for the: ☐ Past 48 hours ☐ Past week ☐ Past 30 days

Point Scale

0 — Never or almost never have the symptoms
1 — Occasionally have it; effect is not severe
2 — Occasionally have it; effect is severe
3 — Frequently have it; effect is not severe
4 — Frequently have it; effect is severe

Head
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **Total** _____

Eyes
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near- or farsightedness) **Total** _____

Ears
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **Total** _____

Nose
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation **Total** _____

Mouth/Throat
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, or lips
_____ Canker sores **Total** _____

Skin
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **Total** _____

Heart
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain **Total** _____

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **Total** _____

Digestive Tract
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **Total** _____

Joints/Muscles
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness **Total** _____

Weight
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight **Total** _____

Energy/Activity
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **Total** _____

Mind
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities **Total** _____

Emotions
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression **Total** _____

Other
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge **Total** _____

For Practitioner Use Only:
Urinary pH _____

Grand Total _____

FirstLine Therapy®
Lifestyle Medicine Programs by Metagenics

Metabolic Detoxification Questionnaire

Part 2: Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
☐ Yes (1 pt.) ☐ No (0 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)

2. Are you presently taking one or more of the following over-the-counter drugs?
☐ Cimetidine (2 pts.) ☐ Acetaminophen (2 pts.) ☐ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
☐ Experience side effects; drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
☐ Experience side effects; drug(s) is (are) efficacious at usual dose(s) (2 pts.)
☐ Experience no side effects; drug(s) is (are) usually not efficacious (2 pts.)
☐ Experience no side effects; drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently within the last 6 months have you regularly used tobacco products?
☐ Yes (2 pts.) ☐ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine-containing products?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
☐ Yes (1 pt.) ☐ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

10. Do you have a personal history of:
☐ Environmental and/or chemical sensitivities (5 pts.)
☐ Chronic fatigue syndrome (5 pts.)
☐ Multiple chemical sensitivity (5 pts.)
☐ Fibromyalgia (3 pts.)
☐ Parkinson's type symptoms (3 pts.)
☐ Alcohol or chemical dependence (2 pts.)
☐ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
☐ Yes (1 pt.) ☐ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc.?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

Total _____

Part 3: Alkalizing Assessment

1. Do you have a history of or currently have kidney dysfunction?
☐ Yes (1 pt.) ☐ No (0 pt.)

2. Have you ever been diagnosed with hyperkalemia?
☐ Yes (1 pt.) ☐ No (0 pt.)

3. Are you currently taking diuretics or blood pressure medication?
☐ Yes (1 pt.) ☐ No (0 pt.)

Total _____

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total _____ (High >50; moderate 15-49; low <14)
Part 2: XTT Total _____ (High >10; moderate 5-9; low <4)
Part 3: Alkalizing Assessment Total _____ (High ≥1)
Urinary pH _____

Notes:

- Patients with high Symptoms but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered, such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.
- Recommend non-alkalizing nutrients if patient answers "yes" to any questions in the Alkalizing Assessment.

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Please list any vitamins, minerals, herbal supplements, homeopathics, over-the-counter and prescribed medications and creams that you are taking.

NAME: _____ DATE: _____

SUPPLEMENT	MANUFACTURER	FORM	DOSAGE	FREQUENCY
EXAMPLE: VITAMIN C	*PERQUE*	*powder*	*1500 mg= ½ tsp*	*½ tsp 2 times/day*

MEDICATION	FORM	DOSAGE	FREQUENCY	DATE STARTED

Describe any history of drug reaction/allergy: _____

_____

OTHER COMMENTS:

Aloe Wellness, LLC
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Informed Consent for Consultation and Treatment

I, _____, hereby authorize the practitioners at Aloe Wellness, LLC to perform the following specific procedures and services as necessary to facilitate in the treatment of myself or my minor child:

Physical exam: e.g., general, musculoskeletal, cardiovascular, abdominal, respiratory
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, solid extracts, or suppositories.
Hormone therapies: natural, bio-identical hormone therapies
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plant, animal, and mineral substances to gently stimulate the body's healing responses.
Lifestyle and nutritional counseling and hygiene: diet therapy, recommendations for exercise, sleep, stress reduction, and balancing of work and social activities, mind-body supportive counseling
Acupuncture and Chinese Medicinal Herbs
Holistic Transformational Coaching
Contraception
Physical Medicine: e.g., Colon Hydrotherapy, Craniosacral therapy, Reiki
Venipuncture: blood draw to be submitted for tests ordered

All practitioners at Aloe Wellness are certified or licensed as require by their jurisdiction.

I understand that the doctors at Aloe Wellness are licensed, board-certified naturopathic physicians in the District of Columbia, based upon a four-year graduate training in an accredited university as a naturopathic physician.

The naturopathic physicians will explain to me their assessment, the nature of their recommendations, the expected prognosis without such care, and the anticipated costs, risks, benefits and experience of following various options. I understand that the focus of naturopathic care is to alleviate the underlying conditions that can bring about illness rather than the treatment of symptoms. While I may experience some immediate improvement from the use of naturopathic methods, I understand that the most effective results occur when I make a long-term commitment to rebuild my health. **It is my responsibility as a patient to follow-up with the naturopathic physicians within a recommended time period for evaluation of treatment results or to change treatment protocols as necessary.**

I understand that the practitioners at Aloe Wellness do not offer after hour services or provide any hospital-based services. If I have difficulty with any of the remedies or other aspects of my work with the doctors, I understand I should call during business hours to discuss concerns I may have.

Potential risks: As with any method of care, there may be risks, such as allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes or injury from procedures. I understand that it is my responsibility to alert the practitioner(s) of any adverse effects or reactions.

Notice to Pregnant Women: All female patients must alert the practitioner(s) at Aloe Wellness if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Important Insurance and Payment Notices: Aloe Wellness does not bill insurance companies, but will supply you with all insurance codes necessary to submit your claims for reimbursement at the time of your visit. Our doctors are not preferred providers for any insurance company, but many companies cover our visit fees as "out of network" physicians. Medicare will not reimburse you for services rendered at Aloe Wellness. Payment in full is required at each visit. I understand I am responsible for payment even if I submit and am denied reimbursement, even if my insurer determines that services are not medically necessary. I understand that naturopathic visits by phone are more likely denied reimbursement compared to in-office visits. Both Flex Spending Plans and Health Savings Accounts can often be used to cover any visit fees not covered by your insurance. In addition, they will usually cover any laboratory fees not otherwise covered and most nutritional or herbal supplements prescribed.

Cancellation and Rescheduling of Appointments Policy: Our practitioners request 24-hours notice for canceling or rescheduling appointments. For any visits cancelled with less than 24-hours notice, the patient will be charged the full amount of the original visit fee except in the case of family or medical emergency. This charge will be billed directly to the client. Late arrivals will not receive an extension of scheduled service times and will be responsible for full service fee. In the event legal action is required to collect payment, I agree to be responsible for attorney fees and costs.

With this knowledge, I voluntarily consent to the above procedures, realizing that the doctors at Aloe Wellness or any personnel have given no guarantees to me by regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that it is not being recommended to me to discontinue any other treatment or care being provided by any other health care professional. I understand that this care not replace the service of my primary care physician. When appropriate, our doctors may communicate with members of my health team regarding my conditions, treatment options, and/or any other health related issues. **I agree to follow-up on referrals for medical care when necessary.**

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 unless so directed by myself or my representative or unless required by law. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that full disclosure of information has been made to me and all my questions have been answered to my full satisfaction.

I have read and understand the above statements.

Patient Name _____ Signature _____

Legal Guardian Name (if needed) _____Signature _____

Date _____

5840 MacArthur Blvd NW, Suite 2
Washington, DC 20016

CREDIT CARD AUTHORIZATION FORM

I herby authorize Aloe Wellness, LLC to record and keep on record the following credit card information. Aloe Wellness is fully committed to the safety and security of our patient's private information and agrees to only preserve this information in our encrypted Electronic Medical Records system.

_____

Print your name as it appears on card

_____ _____

Card Holder Signature Date

Aloe Wellness will never use credit card information without prior permission from the cardholder.

FOR OFFICE USE ONLY – DO NOT ENTER PERSONAL INFO BELOW

_____ _____

Credit Card Number Exp. Date

_____

Last Updated