



Personal Information

Legal Name: _____ Preferred Name: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Primary phone: _____ Secondary phone: _____
Emergency contact: _____ Relationship: _____ Phone: _____
Preferred Pharmacy (including cross streets): _____
Insurance: _____
How did you hear about EVND? _____
Occupation: _____

Health Information

What are your current symptoms or conditions that you would like to be addressed?

Past medical history including surgeries, procedures, hospitalizations and previous diagnoses?

Please list all known food and drug allergies:

Family History: (Parents, siblings, grandparents)

List all current medications (including strength and dosing):

List all current supplements (including strength and dosing):

Environmental exposure

Have you worked or lived in an environment where mold was found or water damage occurred? _____

Are you highly sensitive to medications and supplements? _____

Have you lived in what is considered a Lyme endemic area? _____

Have you or a family member been diagnosed with Lyme or other tick-borne illness? _____

Have you traveled outside the U.S.? _____ If so where? _____

Do you or have you consumed sushi, poke bowls often? _____

Do you or have you had more than 4 silver fillings in your mouth? _____

Average antibiotic intake in the past 5 years? _____

Do you have any of the following symptoms? (Check the boxes that apply)

- Fatigue
- Itchy ears
- Hair loss
- Shingles
- Eczema, rosacea, psoriasis or acne
- General skin itching without evidence of a surface rash
- Compulsive eating or cravings
- Inability to lose weight
- Unable to gain weight
- Anxiety and/or depression
- Frequent sinus infections
- Asthma, wheezing or shortness of breath
- Brain fog, confusion, or difficulty focusing
- Headaches or migraines
- Asthma, wheezing, or shortness of breath
- Runny nose or congestion
- Constipation
- Diarrhea
- Alternating between constipation and diarrhea
- Bloating, can be worsened with eating
- Belching
- Excessive flatulence
- Abdominal pain, discomfort or cramps generally or worse with eating
- Nausea
- Vomiting
- Acid Reflux
- Food reactions or sensitivities
- Issues with falling and or staying asleep
- Unexplained fevers, sweats, chills, or flushing
- Recurring or persistent sore throats
- Lightheaded, poor balance, vertigo, or difficulty walking
- Body aches, muscle pain
- Joint pain
- Tingling, burning, numbness that migrates and/or comes and goes
- Received a diagnosis of Chronic Fatigue Syndrome or Fibromyalgia

INFORMED CONSENT and Request for Naturopathic Medicine

I understand and agree that:

·The Naturopathic Physicians at the offices of East Valley Naturopathic Doctors are independent medical practices

·East Valley Naturopathic Doctors assumes no liability arising from treatments administered by such independent Naturopathic Physicians

·Any claims for injuries from treatments administered by such independent Naturopathic Physicians must be brought solely against the independent Naturopathic Physician(s) providing the treatment that caused the injury and not against East Valley Naturopathic Doctors

I understand that naturopathic evaluation and treatment may include, but is not limited to:

- Physical exam (general and female)
- Common diagnostic procedures (pap smears, endometrial biopsies, diagnostic imaging, laboratory evaluation of blood, urine, and stool and saliva)
- Dietary advice and therapeutic nutrition (use of foods, diet plans, nutritional supplements, and intramuscular vitamin injections)
- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the body surface)
- Herbs/natural medicines (prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures, suppositories, which may contain alcohol, topical creams or other forms.
- Homeopathic remedies (often highly diluted quantities of natural occurring substances)
- Over the counter and prescription medications

I understand and I am informed that in the practice of Naturopathic Medicine and Traditional Chinese Medicine there are some risks and benefits with evaluation and treatment including, but not limited to the following:

- Potential risks: pain, discomfort, minor bruising from Acupuncture; allergic reaction to prescribed herbs, supplements, prescription medications; and aggravation of pre-existing symptoms.
- Potential benefits: restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.
- Notice to pregnant women: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explains therapies and procedures to my satisfaction. I further acknowledge that no guarantees or services have been made to me concerning the results intended from the treatment. I consent to receive notifications for scheduled appointments and other reminders pertinent to the continuity of care, via phone, email and/or text. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

Signature

Date

Printed name

Financial Policy of East Valley Naturopathic Doctors

Payment Policy

Payment for services are due at the time services are rendered, including for products and labs not specifically covered by insurance.

Insurance Reimbursement Policy

For your information Medicare does not cover Naturopathic Medicine, including visits and labs ordered by Naturopathic providers. We do not submit directly to any insurances, however if labs are drawn here in the office, we will send a copy of your insurance card to the lab and they will submit to your insurance. If you would like to submit for reimbursement on your own for visits, a superbill a summary of the services rendered, diagnoses and charges applied, will be provided for you upon request to send to your insurance company.

Returned Checks

For checks returned as unpaid by your bank, you will be charged a \$35 returned check fee.

Cancellation Policy

Please provide at least 24 hours notice of cancellation as a courtesy. For any Doctor or IV appointment that is cancelled less than 24 hours of the scheduled time or is missed without any notice, a charge of \$50 will be applied to the card on file.

Credit Card Information

Master card Visa Discover AMEX Other: _____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

CVV code (3 or 4 digit code on back of card): _____

By signing below I am stating that I have read and understand the Financial Policy of East Valley Naturopathic Doctors.

Signature

Date

Printed name
