



General Patient Information

Full Name: _____ Today's Date: _____
mm / dd / yy

Date of Birth: _____ Age: _____ Gender: _____
mm/ dd / yy

Home Address:

Home Telephone: _____ Cell: _____

Emergency contact: _____ Phone: _____

Email Address:

How did you find out about us?

- Referral: _____
 Web
 Social Media
 Other: _____

Family Physician: _____ Phone: _____

Other Health Care Provider(s):

Name: _____ Type: _____ Phone: _____

Name: _____ Type: _____ Phone: _____

Name: _____ Type: _____ Phone: _____

I authorize communication between Dr. Hamid Tajbakhsh, ND and my other health care providers.



INFORMED CONSENT TO TREATMENT

I understand that the practice of naturopathic medicine requires taking a thorough case history and may require a physical exam. Some cases may require diagnostic testing which may include the collection of blood, urine, and/or saliva.

I understand that if after an initial course of treatment, results are not as expected or if my practitioner is concerned that I need additional assessment, further workup may be recommended.

I confirm that the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy, the use of all current medications and supplements, and any past/current serious health condition(s).

I understand that naturopathic medicine carries a risk of complications and that a resolution of symptoms is not guaranteed. Health risks of some naturopathic treatments include but are not limited to: temporary aggravation of pre-existing symptoms, allergic reactions and/or other adverse effects, pain, fainting, fatigue, irritability, bruising or injury from venipuncture, acupuncture, cupping, or moxibustion.

I confirm that I have the ability to accept or reject the recommended treatment(s) of my own free will. I understand that I have the ability to seek and/or continue medical care from another qualified health care practitioner. I recognize that I am encouraged to speak freely regarding the treatments received and recommendations made to me with the rest of my health care team.

I understand that a record of my visits and medical history will be kept, that this record will be strictly confidential and will not be released to any person or entity without my written consent except if ordered by a court of law.

I acknowledge that naturopathic medicine is only partially covered by certain extended health plans and therefore I am responsible for payment of goods and services in full at each visit.

I understand that I will be charged a late fee equal to the full cost of my scheduled appointment for appointments missed or cancelled with less than 24 hours' notice.

I acknowledge that if I arrive late for my scheduled appointment, the visit will be shortened to ensure that other patients' visits are kept on time.

I understand that my naturopathic doctor reserves the right to determine which cases fall outside their scope of practice in which case the appropriate referral will be recommended.

Patient (or legal guardian) Signature: _____ Date: _____



Chief Health Concerns

What are your health concerns:

1. _____
2. _____
3. _____

Please list treatments tried:

Medical History

How would you describe your general state of health?

Excellent

Good

Fair

Poor

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations? Include approximate date(s).

Do you have any allergies (medications, environmental, foods, etc.)?

Please list ALL current medications and supplements (prescription, over-the-counter, vitamins, herbs, etc.):

Have you been vaccinated? Please list known vaccinations:

Are you currently pregnant or possibly pregnant? Y N



Are you menopausal? Y N Date of last period: _____

Do you use any of the following?

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Antacids |
| <input type="checkbox"/> Diet pills | <input type="checkbox"/> Pain medication |
| <input type="checkbox"/> Sweets | <input type="checkbox"/> Caffeine |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Other recreational drugs: _____ |

Do you get regular screening tests done by a doctor? (blood tests, etc.) Y N

Diet

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

List any food cravings you have:

Describe your typical diet:

Breakfast

Lunch

Dinner

Snacks

Beverages



Family History

Please check any that your relatives are affected by:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> PMS | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Neurological Disease |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Addiction |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Liver Disease |

Others: _____

Social History

Occupation(s):

Please list any known toxins you may be exposed to:

How would you rate your stress level?

High

Average

Low

How do you deal with stress:

How would you rate your energy level?

High

Average

Low

Do you exercise regularly? Y N