

**5583 N Glenwood St  
Garden City, ID 83714  
(208) 370-2343**

Thank you for scheduling with us, we strive to provide the best possible integrative care for our clients. During your initial evaluation your practitioner will do their best to do a thorough evaluation and give you a treatment plan. You can assist us in that by making sure you have fully completed the intake paperwork enclosed.

Please be aware that we ask patients to give us 48 hours notice if they need to reschedule or cancel an appointment. Late cancellation or missed appointments will incur a fee, as we are unable to reschedule the appointment with another patient without sufficient notice.

It will be a pleasure to support you on your path towards wellness.

## Informed Consent and Request for Care

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with practitioners of RegeneratePDX having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, \_\_\_\_\_, hereby request and consent to examination and treatment with RegeneratePDX practitioners.

I understand that I have the right to ask questions and discuss to my satisfaction with the above mentioned providers and/ or with the allied health care provider providing backup:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/ or nothing is done

Medical and Naturopathic Evaluation information:

I understand that Medical evaluation and/or Naturopathic evaluation treatment may include, but is not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory)
- Evaluation of blood, urine, stool and saliva
- Soft tissue and osseous manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, pregnancy massage (to relieve muscular discomfort associated with pregnancy), muscle energy technique and cranio-sacral therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Trigger point injection therapy with or without vitamin substances
- Botanical/ herbal 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 which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians with regards to NDs)

## Notices

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor- stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. Any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider of these conditions.

Please INITIAL the following:

\_\_\_\_\_ I understand that the above mentioned providers are not licensed to prescribe any controlled substances or for those providers who are licensed to prescribe controlled substances, they do not prescribe these types of medication at this facility.

\_\_\_\_\_ I understand that the above mentioned providers will only prescribe medications if they believe that they are in the best interest of myself, the patient. Referrals will be provided to manage my prescriptive medication needs when appropriate.

\_\_\_\_\_ I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.

\_\_\_\_\_ I understand that the above mentioned providers are not psychologists or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect the above mentioned providers and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the above mentioned providers explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. 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 understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

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Printed Name of Patient

Signature of Patient

Date

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Printed Name of Guardian

Signature of Guardian

Date

## Basic Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Telephone # (home) \_\_\_\_\_ (work) \_\_\_\_\_

(cell) \_\_\_\_\_ Email Address \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Relationship Status: Single Married Partnership Separated Divorced Widowed

Live with: Spouse Partner Parents Children Friends Alone Roommates

Occupation \_\_\_\_\_ Hours per week \_\_\_\_ Retired \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

What are your most important health concerns? List in order of importance and for how long you have had each of these concerns or conditions.

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

Are you currently under the care of a medical professional? Y N

If yes, whom and where from? \_\_\_\_\_

If no, when and where did you last receive medical or health care and for what reason? \_\_\_\_\_

## General Information

Weight \_\_\_\_\_ lbs. Weight one year ago \_\_\_\_\_ lbs. Maximum Weight \_\_\_\_\_ lbs.

When? \_\_\_\_\_ Height \_\_\_\_\_

Significant Traumas (auto accidents, falls, etc) \_\_\_\_\_

Birth history (prolonged labor, forceps delivery, etc) \_\_\_\_\_

Occupational Stresses (chemical, physical, psychological) \_\_\_\_\_

Exercise \_\_\_\_\_

Please list any prescription medications, over the counter medications, vitamins, or supplements you are currently taking or have taken **within the past 2 months including dosage** (attach additional sheet if necessary):

1) \_\_\_\_\_ Dosage \_\_\_\_\_ 2) \_\_\_\_\_ Dosage \_\_\_\_\_  
3) \_\_\_\_\_ Dosage \_\_\_\_\_ 4) \_\_\_\_\_ Dosage \_\_\_\_\_  
5) \_\_\_\_\_ Dosage \_\_\_\_\_ 6) \_\_\_\_\_ Dosage \_\_\_\_\_  
7) \_\_\_\_\_ Dosage \_\_\_\_\_ 8) \_\_\_\_\_ Dosage \_\_\_\_\_

Do you have allergies? If yes, what kind?

Drugs \_\_\_\_\_

Foods \_\_\_\_\_

Environmentals \_\_\_\_\_

What hospitalizations, surgeries, or traumas have you had?

\_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_  
\_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_  
\_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_

How many hours of screen time (TV, Phone, Computer) per day/week? \_\_\_\_\_ / \_\_\_\_\_

Habits: Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other \_\_\_\_\_

Average Daily Diet:

Morning \_\_\_\_\_

Afternoon \_\_\_\_\_

Evening \_\_\_\_\_

Snacks/Desserts \_\_\_\_\_

### Please check any that apply to you currently

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Poor appetite                         | <input type="checkbox"/> Heavy appetite                       | <input type="checkbox"/> Poor sleep        | <input type="checkbox"/> Heavy sleep        |
| <input type="checkbox"/> Insomnia                              | <input type="checkbox"/> Fatigue                              | <input type="checkbox"/> Tremors           | <input type="checkbox"/> Vertigo            |
| <input type="checkbox"/> Cold hands                            | <input type="checkbox"/> Cold feet                            | <input type="checkbox"/> Cold back         | <input type="checkbox"/> Cold abdomen       |
| <input type="checkbox"/> Fevers                                | <input type="checkbox"/> Chills                               | <input type="checkbox"/> Night sweats      | <input type="checkbox"/> Sweat easily       |
| <input type="checkbox"/> Cravings (sweet/salty)                | <input type="checkbox"/> Localized weakness                   | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Sudden energy drop at _____ (time)    | <input type="checkbox"/> Peculiar tastes/smells _____         |  |   |
| <input type="checkbox"/> Strong thirst (cold/hot drinks) _____ | <input type="checkbox"/> Bleed or bruise easily (where) _____ |  |   |

## Family History

Please indicate if a close relative (parent, grandparent, sibling) has any of the following:

Condition	Relative	Condition	Relative
<input type="checkbox"/> Allergies/Hay fever		<input type="checkbox"/> Eczema/Psoriasis	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Food Intolerances	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Asthma		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Autoimmune Disease		<input type="checkbox"/> Juvenile Arthritis	
<input type="checkbox"/> Birth Defects		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Bleeding Disorder		<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Depression/Anxiety		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	

I don't know the family medical history

## For the following sections (please circle)

Y = a condition you have now   N = never had   P = a condition you had previously

<b>Childhood Illnesses</b>					
Scarlet Fever	Y	N	P	Diphtheria	Y N P
Mumps	Y	N	P	Measles	Y N P
Chicken Pox	Y	N	P		
<b>Immunizations</b>					
Polio	Y	N	P	Pertussis	Y N P
Tetanus	Y	N	P	Diphtheria	Y N P
Measles/Mumps/Rubella	Y	N	P	Hep B	Y N P
<b>Head</b>					
Headaches	Y	N	P	Migraines	Y N P
Jaw/TMJ problems	Y	N	P		
<b>Eyes</b>					
Spots in Eyes	Y	N	P	Cataracts	Y N P
Glasses or contacts	Y	N	P	Blurriness	Y N P
	Y	N	P	Tearing or dryness	Y N P
Color blindness					
Glaucoma	Y	N	P		
<b>Ears</b>					
Impaired hearing	Y	N	P	Ringing	Y N P
Dizziness	Y	N	P		
<b>Nose and Sinuses</b>					
Frequent colds	Y	N	P	Nose bleeds	Y N P
Hay fever	Y	N	P	Sinus problems	Y N P
<b>Neck</b>					
Lumps	Y	N	P	Swollen glands	Y N P
Pain or stiffness	Y	N	P		

<b>Mouth and Throat</b>					
Frequent sore throat	Y N P	Copious saliva	Y N P	Teeth grinding	Y N P
Sore tongue/lips	Y N P	Gum problems	Y N P	Hoarseness	Y N P
Dental cavities	Y N P	Jaw clicks	Y N P		
<b>Cardiovascular</b>					
Heart disease	Y N P	Angina	Y N P	Murmurs	Y N P
High/Low blood pressure	Y N P	Blood clots	Y N P	Fainting	Y N P
Palpitations/fluttering	Y N P	Phlebitis	Y N P	Rheumatic fever	Y N P
Swelling in hands/feet	Y N P	Chest pain	Y N P		
<b>Blood/Peripheral Vasc.</b>					
Easy bleeding/bruising	Y N P	Varicose veins	Y N P	Cold hands/feet	Y N P
Deep leg pain	Y N P	Anemia	Y N P	Thrombophlebitis	Y N P
<b>Gastrointestinal</b>					
Trouble swallowing	Y N P	Heartburn	Y N P	Change in thirst	Y N P
Change in appetite	Y N P	Nausea	Y N P	Vomiting	Y N P
Vomiting blood	Y N P	Blood in stool	Y N P	Pain or cramps	Y N P
Belching or passing gas	Y N P	Constipation	Y N P	Diarrhea	Y N P
Gall bladder disease	Y N P	Black stools	Y N P	Ulcer	Y N P
Jaundice (yellow skin)	Y N P	Liver disease	Y N P	Hemorrhoids	Y N P
Sensitive Abdomen	Y N P	Bloody Stools	Y N P	Laxative Use	Y N P
Bowel movements:	Frequency?				
	Color?				
	Formed?				
<b>Respiratory</b>					
Cough	Y N P	Sputum	Y N P	Spitting up blood	Y N P
Wheezing	Y N P	Asthma	Y N P	Bronchitis	Y N P
Short of breath lying down	Y N P	Pleurisy	Y N P	Emphysema	Y N P
Difficulty breathing	Y N P	Pain on breathing	Y N P	Shortness of breath	Y N P
Short of breath at night	Y N P	Tuberculosis	Y N P	Pneumonia	Y N P
History of smoking	Y N P				
<b>Urinary</b>					
Pain on urination	Y N P	Incr. frequency	Y N P	Incontinence	Y N P
Frequency at night	Y N P	Frequent infections	Y N P	Kidney stones	Y N P
Condyloma (genit. warts)	Y N P	Chlamydia	Y N P	Gonorrhea	Y N P
Herpes	Y N P	Syphilis	Y N P	Blood in Urine	Y N P
<b>Female Reprod./Breast</b>					
Age of first menses		Are cycles regular?	Y N	Length of cycle	
Age of last menses		Duration of menses		Clotting	Y N P
First day of most recent menses?		Date of last Pap?			
Bleeding between cycles	Y N P	Painful menses	Y N P	Discharge	Y N P
Heavy or excessive flow	Y N P	Light flow	Y N P	PMS	Y N P

PMS symptoms	Y N P	Endometriosis	Y N P	Ovarian cysts	Y N P
Pain during intercourse	Y N P	Abnormal PAP	Y N P	Breast self-exams	Y N P
Are you sexually active	Y N P	Breast pain/tenderness	Y N P	Nipple discharge	Y N P
Breast lumps	Y N P	Mastitis	Y N P	Sexual orientation?	
Breast feeding	Y N P	Menop. symptoms	Y N P	# of Live births	
Birth control	Y N P	What type?		# of miscarriages	
Menopause	Y N P	# of Abortions		#of pregnancies	
<b>Male Reproduction</b>					
Testicular masses	Y N P	Hernias	Y N P	Prostate disease	
Testicular pain	Y N P	Discharge	Y N P	Sores	Y N P
Premature ejaculation	Y N P	Impotence	Y N P		Y N P
Are you sexually active?	Y N	Sexual orientation?		Birth control type?	
<b>Musculoskeletal</b>					
Joint pain or stiffness	Y N P	Broken bones	Y N P	Weakness	Y N P
Muscle spasms/cramps	Y N P	Arthritis	Y N P	Sciatica	Y N P
<b>Immune</b>					
Chronic Fatigue Synd.	Y N P	Chronic Infections	Y N P	Slow wound healing	Y N P
Chronic swollen glands	Y N P				
<b>Neurologic</b>					
Seizures	Y N P	Paralysis	Y N P	Muscle weakness	Y N P
Numbness or Tingling	Y N P	Loss of memory	Y N P	Vertigo or dizziness	Y N P
Loss of balance	Y N P	Concussion	Y N P		
<b>Endocrine</b>					
Hypothyroid	Y N P	Diabetes	Y N P	Heat/Cold intoler.	Y N P
Hyperthyroid	Y N P	Excessive thirst	Y N P	Weight loss/gain	Y N P
Hypoglycemia	Y N P	Fatigue	Y N P	Seasonal Depression	Y N P
<b>Skin</b>					
Rashes	Y N P	Acne, Boils	Y N P	Hives	Y N P
Itching	Y N P	Color Change	Y N P	Dandruff	Y N P
Perpetual hair loss	Y N P	Ulcerations	Y N P	Acne	Y N P
<b>Psychological</b>					
Depression	Y N P	Bad temper	Y N P	Easily Stressed	Y N P
Anxiety	Y N P	Considered Suicide	Y N P	Attempted Suicide	Y N P
Eating Disorder	Y N P	Treated for psychological problems	Y N P	History of abuse?	Y N P
Treated for emotional problems	Y N P				