Hello and Welcome

Thank you for choosing Naturopathic Wisdom. We know you have choices when it comes to your healthcare and we are dedicated to providing our patients with the best care possible.

Enclosed you will find new patient forms. Before your scheduled appointment, please carefully read and fill out the enclosed forms. We know your time is valuable and bringing your completed patient information forms with you will maximize the amount of time spent with the doctor.

Your first visit will be an assessment of your health lasting approximately 1 hour or more. The fee varies and is based on time; feel free to call the office if you need more information.

If you are unable to keep your scheduled appointment time please call as soon as possible so that we may reschedule your visit.

Remember to bring copies of any recent lab work or medical records as well as any supplements or medications you are currently taking.

We look forward to supporting you in your healing journey.

In Health,

Sonora Naturopathic

Sonora Naturopathic, Inc

CONFIDENTIAL PATIENT INFORMATION

PLEASE FILL IN ALL PORTIONS OF THIS FORM. IF YOU NEED HELP, PLEASE ASK

Today's Date_____

How did you hear about us? Yellow pages_____ Newspaper_____ Health Profs_____

Internet_____ Location/Sign_____ Referred by (name)_____

Weekender_____ Meetup _____Whole Food Depot (name)_____

First Name _____ M_____ Last Name_____ Age _____ Marital Status _____

Permanent Address _____ Apt. _____ City_____ State _____ Zip _____

Temporary Address _____ Apt. _____ City_____ State _____ Zip _____

Phone (Permanent) _____ (Cell) _____(Work) _____

Email _____ Email (alt.) _____

SS# _____ Birth date _____ Sex _____ Driver's License # _____

Occupation _____ Employed by _____

Work Address _____ Suite_____ City_____ State _____ Zip _____

Name of nearest relative not living with you _____Phone_____

Name of spouse (or parent for minor child) _____SS # _____

Occupation _____Employed by _____ Work # _____

Whom may we contact in case of emergency? _____Phone _____

CLINIC POLICY REQUIRES PAYMENT AT TIME OF SERVICES. I WILL BE PAYING TODAY BY:

CASH _____ CHECK _____ VISA _____ MASTERCARD _____

At time of payment, you will be given a copy of your superbill from our office. This will show the services and charges for that day.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and services, any fees for professional services rendered me will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance.

Releases may be requested prior to specific procedures being performed

_____ _____ _____

Patient's Signature Parent or Guardian's Signature Date

Name _____ Date _____

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1. Why did you choose to come to this clinic?

2. What do you know about our approach?

3. What *three* expectations do you have from *this* visit to our clinic?

4. What *long-term* expectations do you have from working with our clinic?

5. What expectations do you have of me personally as your health care provider?

6. What obstacles do you see to achieving optimal wellness?

7. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

8. What behaviors or lifestyle habits do you currently engage in regularly that you believe; Supports your health?

   Are self-destructive?

9. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

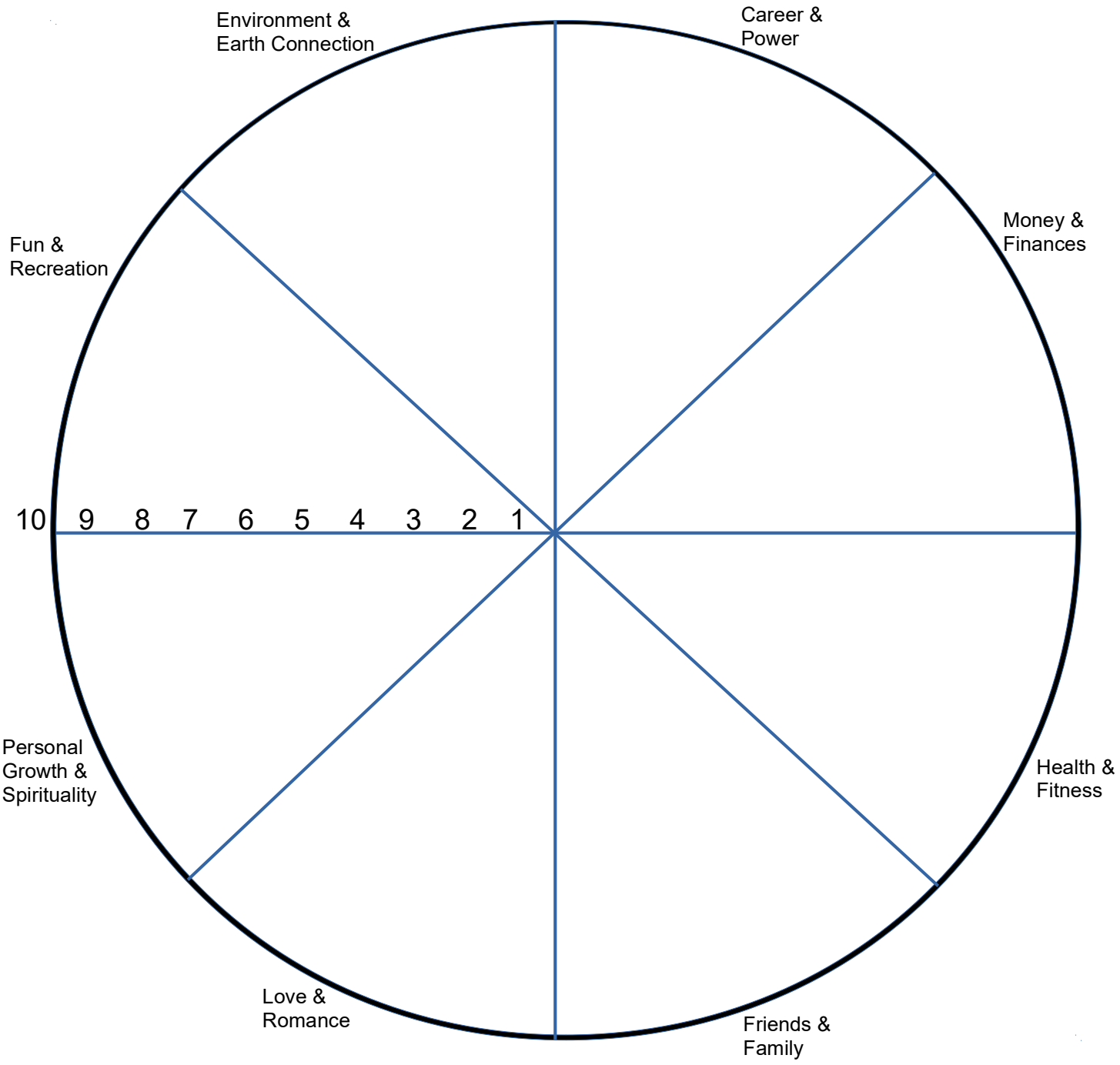
10. Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

11. What do you love to do?

Name _____ Date: ___/___/___

Wheel of Life Inventory

Directions: The Wheel of Life represents balance. Seeing the center of the wheel as 0 (zero) and the outer edge as 10, rank your level of satisfaction with each life area by coloring in to the level you see yourself at for each area of life. This then represents your wheel of life.



Sonora Naturopathic **Name:** _____ **Date:** _____

Current Health Problems		Family Disease History	Self	Par	GP	Current Medications		Current Vitamins or Herbs		
1		(Please Check Box)				1		1		
2		Asthma				2		2		
3		Arthritis				3		3		
4		Alcoholism				4		4		
5		Epilepsy				5		5		
		Thyroid				6		6		
Surgery/Hospital Stay /Year		Obesity								
1		Heart Attack				Drug Allergies		Diet and Nutrition		
2		High Blood Pressure				1		Estimate how often you use		
3		Mental disorder				2		Per Day or Week	D	W
4		Diabetes				3		Sugar, Sweets, Chocolate		
		Cancer				Airborne Allergies	Yes	Soda Pop		
Rate current Stress 0-10		Other:				Dust		Coffee/Black Tea		
Mild 1-3, Mod. 4-6, Severe 7-9						Pollen		Tobacco/Cigarettes		
Job or School		Personal Health Hist	Now	Past		Weeds		Beer/Wine		
Financial/Money		Fatigue				Grass		Alcohol		
Primary Relationship		Low Blood Sugar				Trees		Aspirin/Tylenol		
Family, Parents, Children		Poor Sleep				Molds		Nutrasweet, etc.		
Divorce/Separation/Death		Anxiety				Smoke		Cheese		
Chemical, Allergy		Depression				Other		Milk		
Overall Stress Level		Overweight						Fried Foods		
		Headache				Food Sensitivities	Yes	Margarine or Butter		
Have you ever used:		Neck Pain				Dairy		Beef/ Ham burger/Steak		
Vitamin Therapy		Back Pain				Wheat		etc.		
Herbal Medicines		Joint Pain				Alcohol		Turkey, Chicken		
Homeopathic Medicine		Allergies, Hay Fever				Other: 1		Tuna, Fish		
Acupuncture		Sinusitis				2		Beans, Peas		
Spinal Manipulation		Recurrent Colds, Flu				3		Salad		
Colonic Therapy -		Infections						Fresh Fruit		
Therapeutic Fasting		Ear/Eye Problems				Chemical Sensitivities	Yes	Juice, Bottled or Frozen		
Massage Therapy		Poor Digestion, Gas				Odors		Fruit		
Naturopathic Physician		Recurrent Diarrhea				Solvents		Fresh Vegetables		
		Constipation				Soaps		Potatoes, Squash, Carrots		
List your Health Goals:		Abdominal Bloating				Other:		Other Cooked Vegetables		
		High Blood Pressure						Wheat, Bread, Muffins		
		Fat				List Medical Providers -		Pasta		
		Premenstrual Symptoms				Family Physician:-		Rice, Oatmeal, Barley		
		Menstrual Problems				Chiropractor:				
		Menopausal				Psychologist:				
Indicate problem areas:		Hot Flashes				OB/Gyn:		Blood Type		
Front Back		Breast Problems				Naturopathic Dr.:				
		Alcoholism				Nutritionist:		Exercise	Day	Wk
		Drug Addiction								
		History of Abuse				How did you hear about Us?		Walk/Run		
		Sexual Dysfunction				Name of Doctor:		Swim		
						Name of Friend:		Bike		
						Yellow Pages		Aerobics		
						Article in Media		Other		
						Clinic Sign				
						Other Ad