

Confidential Patient Information

Name:

SSN:

Home Phone:

Mobile Phone:

Work Phone:

Email:

Address:

Age:

Birth date:

If child, parent's names:

Referred by:

Emergency Contact and Phone:

Marital status:

Spouse's name and age:

Your Occupation:

Employer:

Spouse's Occupation:

Employer:

Your Children's Names, Ages and Health:

Your Medical Doctor's Name and Location:

What are your main complaints?

When did the symptoms begin?

Other complaints:

Please list any major injuries, surgeries or hospitalizations:

Please circle Yes or No if you currently have any of the following:

- | | | |
|-----|----|--|
| Yes | No | Pain or abnormal sensations in your chest |
| Yes | No | Shortness of breath |
| Yes | No | Aches in the neck, middle or low back |
| Yes | No | Pain, numbness or tingling in the arms or legs |
| Yes | No | Heartburn or nausea |
| Yes | No | Distress in the upper abdomen or stomach |
| Yes | No | Lower abdominal pain, bloating or distress |
| Yes | No | Diarrhea |
| Yes | No | Constipation (ever skip a day?) |
| Yes | No | Gas or belching, gurgling or uncomfortable digestion |
| Yes | No | Burning or pain with urination, or if a male, with ejaculation |
| Yes | No | Any history of sexually transmitted disease, please list: |
| Yes | No | Past or current exposure to unusual chemicals or pesticides |
| Yes | No | Headaches, if so please list how often and how severe: |
| Yes | No | Past or current history of physical, emotional or sexual abuse |
| Yes | No | Do you usually feel relatively emotionally positive? |

Women:

Are you pregnant?

What is the due date?

Are you menstruating?

Do you keep track of your cycles each month?

How many days between periods, and how many days do you bleed?

Do you have painful cramps, heavy flow, or difficult periods? Please describe.

Do you experience symptoms of PMS? Please describe.

Eating, Exercise and Sleep:

Yes No Do you ever skip meals?

Yes No Do you feel good about your eating habits?

Yes No Are you vegetarian? If so, please list what you avoid:

Yes No Is your weight a major concern in your life?

How often do you exercise and for how long?

What do you like to do?

What have you done in the past?

What would you like to try?

Do you sleep well? Do you wake up feeling refreshed in the morning?

How many hours of sleep per night?

Please list how often you consume these foods per week:

Sugar:

Candy:

Artificial sweeteners:

Soft Drinks:

Juice:

Ice cream:

Coffee

Pastries, donuts, cookies, cake:

Packaged/processed foods:

Fast food:

Alcohol, list type and quantity

Water: How many glasses per day?

Is it filtered, bottled, or from the tap?

Do you smoke/chew tobacco?

How often?

Please list all the supplements you take and how often:

Please list all prescription and over the counter medications you take and how often:

Family History

Please indicate ailments that have affected your relatives. List their current ages, or age at death. Please let me know if you were adopted.

Mother:

Father:

Brothers:

Sisters:

Grandmother:

Grandmother:

Grandfather:

Grandfather:

Any other family members with serious ailments:

Dr. Evie Katahdin, N.D., L.Ac.
Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with Naturopathic and/or Chinese Medicine by Evie Katahdin, ND, LAc. I understand that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Naturopathic Medicine: I understand that I may be treated with nutritional therapies, botanical medicine, homeopathy, lifestyle counseling and/or physical medicine under the care of Dr. Katahdin.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Dr. Katahdin as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

SIGN BELOW ONLY IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

X _____
Patient's Signature Date

X _____
Explained by me and signed in my presence Date