LAKESIDE
Natural Medicine

CONSENT FOR TREATMENT

I, _____, hereby request and consent to examination and treatment with Naturopathic Medicine with Dr. Sarah Axtell.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Sarah Axtell:

- 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 procedures
- potential consequences if treatment or advice is not followed and/ or nothing is done

I recognize that Dr. Axtell is a licensed naturopathic doctor in the state of Oregon, and that she has been trained as a primary care physician. I am aware that in the state of Wisconsin, there is no licensure regulating the practice of naturopathic medicine, therefore clinical diagnosis may not be made.

I confirm that I have read and fully understand the above prior to my signing.

_____ _____
Signature of Patient (Parent/Guardian if patient is a minor) Date

4433 N. Oakland Ave, Shorewood, WI 53211 Ph: 414-939-8748 Fax: 414-939-8748

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Dear New Patient,

Welcome to Lakeside Natural Medicine. We look forward to providing for your health care needs. Please read and initial the following statements:

_____ Payment for all services and medicinary items is due in full at the time of visit. We accept cash, credit card, and checks. We do not bill insurance directly, but you are more than welcome to submit the receipt for reimbursement. Some insurance companies cover naturopathic medicine, while others do not.

_____ Lakeside Natural Medicine is not responsible for any lab expenses. Insurance may not cover your lab work. Prior to getting your blood drawn, we recommend that you call your insurance company to inquire about in-network lab locations, as well as an estimated expense for the labs ordered.

_____ Due to time constraints, you will be charged for scheduled and unscheduled phone consultations that exceed 10 minutes. Uncharged phone calls are for matters concerning clarification of treatment plans and past medical issues. Any new medical concerns will be scheduled as follow-up appointments. Your physician will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment.

_____ Please give your physician 24 hours advance notice of cancellations. If you cancel within 24 hours of your appointment, you will be charged a fee of $50.

_____ Unless a specific payment plan has been agreed upon and put into writing, we reserve the right to charge interest on any outstanding balance on the account. After 2 months, a 5% compounded interest will accrue, and after 6 months, an 8% compounded interest will accrue.

I have read and understand the above-stated policies of Lakeside Natural Medicine and will comply with them in all respects.

Patient Name (Please print. Include parent/guardian if patient is a minor.)

_____ _____

Patient signature (Parent/guardian signature if patient is a minor) Date

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LAKESIDE
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Email Consent

Email offers us an easy and convenient way to communicate between office visits. In order for me to serve you best, I ask that you follow the below guidelines for email communication.

Conditions for email communication:

- Emails are great for asking general questions that do not require detailed discussion and for clarification of previous recommendations.
- Emails are not meant to replace in-person or phone appointments, nor are they meant to discuss new health concerns or receive new treatment recommendations.
- Although I do check my email regularly, I cannot guarantee that I will be able to answer your email right away nor can I guarantee that I will receive it. Call the office if the matter is urgent or if you do not hear back from me within a reasonable amount of time.
- Confidentiality is not guaranteed with emails! It is like sending a postcard in the mail.
- Email is never appropriate for emergency situations. Please call the office or your local emergency department.
- Emails may be added to your patient chart.

Finally, either one of us can revoke permission to use the email system at any time.

- □ **YES**, I would like the option to correspond via email. I agree to and understand the terms of email communication as detailed above.
- □ **NO,** I do not want to correspond via email.

Name: _____

E-mail Address: _____

Signature: _____ Date: _____

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YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

___Please do not phone me at home. Use this alternate phone number: _____
___Please do not phone me at work. Use this alternate phone number: _____
___Please do not leave messages on my answering machine.
___Please do not contact me by email.
___Please send mail, including my bills, to this alternate address:_____
_____
___Other request (please describe):_____

_____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____
Patient Signature (Parent/guardian signature if minor) Date

LAKESIDE Natural Medicine

ADULT HEALTH HISTORY INTAKE

Name: _____

Address:_____

_____

Phone: _____ _____ _____
Home Work Cell

Email:_____

Date of Birth _____ Gender: Male _____ Female_____

Emergency Contact: _____

_____(Phone)

_____(Relationship)

Occupation:_____ Hours worked per week:_____

Marital Status: Married_____ Partnership_____ Separated_____ Divorced_____ Widowed_____ Single_____

Live with: Spouse_____ Partner_____ Parents_____ Children_____Alone_____ Friends_____
Other_____

How did you hear about our clinic?_____

Do you have Medicare or Medicaid? Yes_____ No_____

Are you currently receiving health care? Yes_____ No_____

If yes, where and from whom?_____

If no, when, where, and why did you last receive health care?_____

_____

What are your primary health concerns in order of importance?
1._____
2._____
3._____
4._____
5._____

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CONTEXT OF CARE REVIEW

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 responses to the following questions will help me understand your needs and how to help you reach your health goals. 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?

What do you know about our approach?

2) What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

3) 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, with 10 being 100% committed)
0% 0 1 2 3 4 5 6 7 8 9 10 100%

4) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

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

6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

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FAMILY HISTORY

Please check where applicable:

	Father	Mother	Brother(s)	Sister(s)	Child(ren)	Grandparent	Spouse
Age if living							
Cancer							
Diabetes							
Heart Disease							
Heart Murmur							
High Blood Pressure							
Stroke							
Epilepsy							
Mental Illness							
Asthma							
Hayfever, Hives							
Autoimmune Disease							
Kidney Disease							
Liver Disease							
Gallbladder Disease							
Ulcer							
Glaucoma							
Cataracts							
Anemia							
Goiter							
Arthritis							
Tuberculosis							
Age/Cause of Death							

PERSONAL HISTORY

Allergies

Please list anything you are sensitive or allergic to:
Foods:

Medications:

Environment:

Hospitalizations and Surgery

What hospitalizations and surgeries have you had? When?

Major Traumas

Please list any major traumas you have experienced:

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Childhood Illnesses

Have you had:

Scarlet Fever	Yes	No	Polio	Yes	No
Chicken Pox	Yes	No	Mumps	Yes	No
Measles	Yes	No	German Measles	Yes	No
Small Pox	Yes	No	Whooping cough	Yes	No
Allergies	Yes	No	Rashes	Yes	No
Asthma	Yes	No	Chronic ear infections	Yes	No

Childhood Immunizations

Have you had:

Polio	Yes	No	Pertussis	Yes	No
Tetanus	Yes	No	Diphtheria	Yes	No
Measles	Yes	No	Chicken Pox	Yes	No
Mumps	Yes	No	Small Pox	Yes	No
Rubella	Yes	No	Meningiococcus	Yes	No
Influenza (HiB)	Yes	No	Tuberculosis	Yes	No
Have you ever had a bad reaction to a vaccine?	Yes	No	If yes, what and when?		

Medications

List prescription and over the counter medications you currently take:

List vitamins, minerals, and any other supplements you currently take:

Screening Tests (please indicate most recent date where applicable)

General physical _____ Screening bloodwork _____

Eye exam _____ Dental cleaning/exam _____

Bone scan/DEXA_____ (women 65+) Mammogram _____(women 40+)

Prostate exam/PSA _____(men 50+) Colonoscopy _____(women/men 50+)

Gyn & breast exam/PAP smear _____ (women 18+)

REVIEW OF SYSTEMS

General

Height:_____

Weight now:_____ Weight 1 year ago:_____

Highest adult weight:_____ When?_____Lowest adult weight:_____ When?_____

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Yes= condition you have now; No=a condition you've never had; Past= condition you've had in the past

Head

Headaches	Yes	No	Past	Head Injury	Yes	No	Past
Migraines	Yes	No	Past	Hair loss	Yes	No	Past
Other:							

Eyes

Poor vision	Yes	No	Past	Cataracts	Yes	No	Past
Glasses or contacts	Yes	No	Past	Glaucoma	Yes	No	Past
Tearing/dryness	Yes	No	Past	Eye infections	Yes	No	Past
Eye pain	Yes	No	Past	Blurriness	Yes	No	Past
Other:							

Ears

Poor hearing	Yes	No	Past	Ringing/noises	Yes	No	Past
Excess wax	Yes	No	Past	Chronic infections	Yes	No	Past
Other:							

Nose and Sinuses

Frequent colds	Yes	No	Past	Nose bleeds	Yes	No	Past
Congestion	Yes	No	Past	Sneezing often	Yes	No	Past
Sinus infections	Yes	No	Past	Runny nose	Yes	No	Past
Hay fever	Yes	No	Past	Loss of smell	Yes	No	Past
Other:							

Mouth and Throat

Dentures	Yes	No	Past	Frequent sore throat	Yes	No	Past
Cavities	Yes	No	Past	Gum problems	Yes	No	Past
Sore lips/tongue	Yes	No	Past	Teeth grinding	Yes	No	Past
Jaw/TMJ pain	Yes	No	Past	Difficulty swallowing	Yes	No	Past
Hoarseness	Yes	No	Past	Cold/canker sores	Yes	No	Past
Other:							

Neck

Lumps	Yes	No	Past	Swollen glands	Yes	No	Past
Goiter	Yes	No	Past	Pain or stiffness	Yes	No	Past
Other:							

Respiratory

Asthma	Yes	No	Past	Tuberculosis	Yes	No	Past
Wheezing	Yes	No	Past	Persistent cough	Yes	No	Past
Bronchitis	Yes	No	Past	Cough up mucus	Yes	No	Past
Pneumonia	Yes	No	Past	Cough up blood	Yes	No	Past
Other:				Difficult breathing on exertion	Yes	No	Past

Cardiovascular

Heart disease	Yes	No	Past	High blood pressure	Yes	No	Past
Murmurs	Yes	No	Past	Low blood pressure	Yes	No	Past
Palpitations	Yes	No	Past	Ankle/leg swelling	Yes	No	Past
Fainting	Yes	No	Past	Other:			

Blood/Peripheral Vascular

Anemia	Yes	No	Past	Deep leg pain	Yes	No	Past
Leukemia	Yes	No	Past	Cold hands/feet	Yes	No	Past
Vein inflammation	Yes	No	Past	Easy bleeding or bruising	Yes	No	Past
Blood clots	Yes	No	Past	Varicose veins	Yes	No	Past
Other:							

Gastrointestinal

Heartburn	Yes	No	Past	Frequent nausea	Yes	No	Past
Change in thirst	Yes	No	Past	Frequent vomiting	Yes	No	Past
Change in appetite	Yes	No	Past	Vomiting blood	Yes	No	Past
Ulcers	Yes	No	Past	Blood in stool	Yes	No	Past
Hemorrhoids	Yes	No	Past	Undigested food in stool	Yes	No	Past
Gallbladder disease	Yes	No	Past	Belching/passing gas excessively	Yes	No	Past
Liver disease	Yes	No	Past	Pain/cramping in abdomen	Yes	No	Past
Diarrhea	Yes	No	Past	Frequency of bowel movements:			
Constipation	Yes	No	Past	Is this a recent change?	Yes	No	
Other:							

Urinary

Bladder infections	Yes	No	Past	Frequency in day	Yes	No	Past
Kidney infections	Yes	No	Past	Frequency at night	Yes	No	Past
Incontinence	Yes	No	Past	Painful urination	Yes	No	Past
Stones	Yes	No	Past	Difficult urination	Yes	No	Past
Other:							

Immune

Frequent infections	Yes	No	Past	Chronic fatigue	Yes	No	Past
Slow wound healing	Yes	No	Past	Chronically swollen glands	Yes	No	Past
Other:							

Skin

Rashes	Yes	No	Past	Lumps	Yes	No	Past
Hives	Yes	No	Past	Color change	Yes	No	Past
Itching	Yes	No	Past	Warts	Yes	No	Past
Eczema	Yes	No	Past	Acne	Yes	No	Past
Psoriasis	Yes	No	Past	Shingles/Herpes	Yes	No	Past
Other:							

Musculoskeletal

Weakness	Yes	No	Past	Spasm or cramps	Yes	No	Past
Tremors	Yes	No	Past	Broken bones	Yes	No	Past
Joint pain or stiffness	Yes	No	Past	Joint swelling	Yes	No	Past
Where:				Where:			

Other:

Neurologic

Seizures	Yes	No	Past	Memory loss	Yes	No	Past
Sciatica	Yes	No	Past	Numbness or tingling	Yes	No	Past
Paralysis	Yes	No	Past	Vertigo/dizziness	Yes	No	Past
Autism	Yes	No	Past	ADD/ADHD	Yes	No	Past
Other:							

Endocrine

Diabetes	Yes	No	Past	Hypothyroid	Yes	No	Past
Fatigue	Yes	No	Past	Hyperthyroid	Yes	No	Past
Night sweats	Yes	No	Past	Excess thirst	Yes	No	Past
Seasonal depression	Yes	No	Past	Excess hunger	Yes	No	Past
Crave salt	Yes	No	Past	Heat/Cold intolerance	Yes	No	Past
Dark circles under eyes	Yes	No	Past	Symptoms when miss meals	Yes	No	Past
Other:							

Female Reproductive

Age menses began:				Age menses ended:			
# Days of flow:				# Days between periods:			
# Pregnancies				Regular cycles	Yes	No	Past
# Live births				Bleeding between periods	Yes	No	Past
# Miscarriages				Painful periods	Yes	No	Past
# Abortions				PMS	Yes	No	Past
Difficulty conceiving	Yes	No	Past	Excessive flow	Yes	No	Past
Vaginal discharge	Yes	No	Past	Menopausal symptoms	Yes	No	Past
Vaginal infections	Yes	No	Past	Painful intercourse	Yes	No	Past
Pelvic infections	Yes	No	Past	Sexual difficulties	Yes	No	Past
Vaginal dryness	Yes	No	Past	Sexually transmitted disease	Yes	No	Past
Breast pain or tenderness	Yes	No	Past	Sexually active	Yes	No	Past
Breast lumps	Yes	No	Past	Sexual orientation	Heterosexual	Homosexual	Bisexual
Nipple discharge	Yes	No	Past	Type of birth control:			
Last PAP/GYN exam				Abnormal PAP	Yes	No	Past

Level of sexual desire	0	1	2	3	4	5	6	7	8	9	10
Other:											

Male Reproductive

Hernias	Yes	No	Past	Enlarged prostate	Yes	No	Past
Testicular pain	Yes	No	Past	Sexually transmitted disease	Yes	No	Past

Testicular masses	Yes	No	Past	Sexually active	Yes	No	Past
Discharges or sores	Yes	No	Past	Sexual orientation	Heterosexual	Homosexual	Bisexual
Infertility	Yes	No	Past	Sexual difficulties	Yes	No	Past

Level of sexual desire	0	1	2	3	4	5	6	7	8	9	10
Other:											

Mental/Emotional

Mood swings	Yes	No	Past	Tension/difficulty relaxing	Yes	No	Past
Depression	Yes	No	Past	Considered/attempted suicide	Yes	No	Past
Anxiety	Yes	No	Past	Poor concentration	Yes	No	Past
Memory problems	Yes	No	Past	Obsessive or Compulsive	Yes	No	Past
Panic attacks	Yes	No	Past	Easy/frequent crying	Yes	No	Past
Other:							

HEALTH HABITS

Hobbies:_____

Exercise (what kind, how often):_____

_____

Sleep: # hours/night_____ Sleep well?_____ Wake rested?_____

Stress level: High_____ Moderate_____ Low_____

Major stressors:_____

Do you have a religious or spiritual practice? Yes_____ No_____

Do you use:

	Yes	No	Past	Amount	Frequency
Alcohol					
Tobacco					
Caffeine					
Other recreational drugs					
Type of recreational drug:					

Have you ever been treated for:

alcoholism: Yes_____ No_____
drug dependence: Yes_____ No_____
eating disorder: Yes_____ No_____

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Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

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