Welcome to the
Wang Center for Naturopathic Health

your optimal health solution

Wang Center for
Naturopathic Health, P.C.

We value you, your health, and your health goals.

① Please take time to fill out this 13-page New Patient Packet.

② Please EMAIL, FAX, MAIL, or DROP OFF your New Patient Packet **at least 2-3 days before your appointment date**. This will allow Dr. Wang to go over your health history and learn more about you before your appointment.

③ Please feel free to include any relevant lab and/or imagining reports with your New Patient Packet.

④ Please bring the physical PAPER copy of your **New Patient Packet and lab and/or imagining reports** with you to your appointment.

⑤ Please bring **ALL medications and supplements** you are currently taking to your appointment.

Thank you for considering us for your healthcare needs.

EMAIL: info@wanghealthcenter.com // FAX: (855) 802-6293 // 1730 Huntington Dr. Suite 204 South Pasadena

PATIENT REGISTRATION

GENERAL INFORMATION			**Date:**
Name			
Referred by			
Date of Birth		Age:	Sex: ☐ M ☐ F
Phone Numbers	*Home:*	*Cell:*	*Fax:*
	Which phone number would you prefer we call first? ☐ Home ☐ Cell		
Address			
E-mail Address			

Do you authorize the Wang Center of Naturopathic Health staff to communicate with you about your treatment and appointment scheduling at the contact information listed above? ☐ YES ☐ NO (initials)_____

Emergency Contact	*Name:*	*Relationship to Patient:*
	Phone:	
Financially Responsible Party (if other than patient)	*Name:*	*Relationship to Patient:*
	Address:	
	Phone:	*E-mail:*
Primary Health Provider	*Name:*	
	Address:	
	Phone:	*Fax:*

If you would like to authorize Dr. Wang to exchange your health information with your current physician or other health practitioner, please complete a HIPPA Authorization for the Release of Information form.

If you would like to authorize Dr. Wang to exchange your health information with a member of your family or other individual(s), please complete a HIPPA Authorization for Disclosure and Exchange of Information.

I ACKNOWLEDGE THAT ALL OF THE ABOVE INFORMATION IS ACCURATE AND CORRECT.

I ALSO UNDERSTAND THAT TO AVOID A $75 CANCELLATION FEE, I MUST CANCEL 24 HOURS PRIOR TO THE TIME OF MY APPOINTMENT.

Signature: *Date:*

Wang Center for Naturopathic Health

www.wanghealthcenter.com | (626) 808-4365

Under current California legislation, naturopathic services are NOT required to be covered through insurance. Dr. Wang's services are out-of-pocket.

RATES

- **New Patient Appointment**: (90-min): $275
  - If over 90-min, overtime: $35 per 15-min
- **Follow-up Appointment:** $35 per 15-min
- **Blood Draw Fee**: $20
- **Lab Fees:** NOT included in service. Prices vary depending on lab test.
  - Some lab tests MAY be covered through insurance.
- **IV Therapy**: Prices vary depending on treatment.
- **Craniosacral Therapy**: $85 per treatment

****Form of payment accepted:**
- All major credit cards, including HSA debit cards or similar (please ask)
- Cash (change will be given back as credit for next sales transaction)
- Check

I ALSO UNDERSTAND THAT TO AVOID **A $75 CANCELLATION FEE**, I MUST CANCEL 24 HOURS PRIOR TO THE TIME OF MY APPOINTMENT.

Signature: Date

Wang Center for Naturopathic Health

www.wanghealthcenter.com | (626) 808-4365

Cancellation/Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients whom are pain needing immediate care.

Cancellation of an Appointment

In order to be respectful of other patients' needs, please be courteous and email us at **info@WangHealthCenter.com** or call **(626) 808-4365** promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. Any appointment(s) not cancelled 24 hours in advance is subject to a **$75 cancellation fee**.

I understand this policy and authorize Wang Center for Naturopathic Health, P.C. to assess cancellation and no-show fees according to the above outlined policy to the credit card listed below.

_____

Signature - Signed by Patient (or responsible financial party)

_____ _____

Printed Name Date

Credit Card Information:

____ MasterCard ____ Visa ____ Discover ____ Amex

Name appear on the Credit Card: _____

Number: _____ CVV code: _____

Expiration: _____/_____

YOUR HEALTH CONCERNS	Patient Name:	Date of Birth: / /

What are your top three (3) health concerns?

①	
②	
③	

When was the last time you felt well?

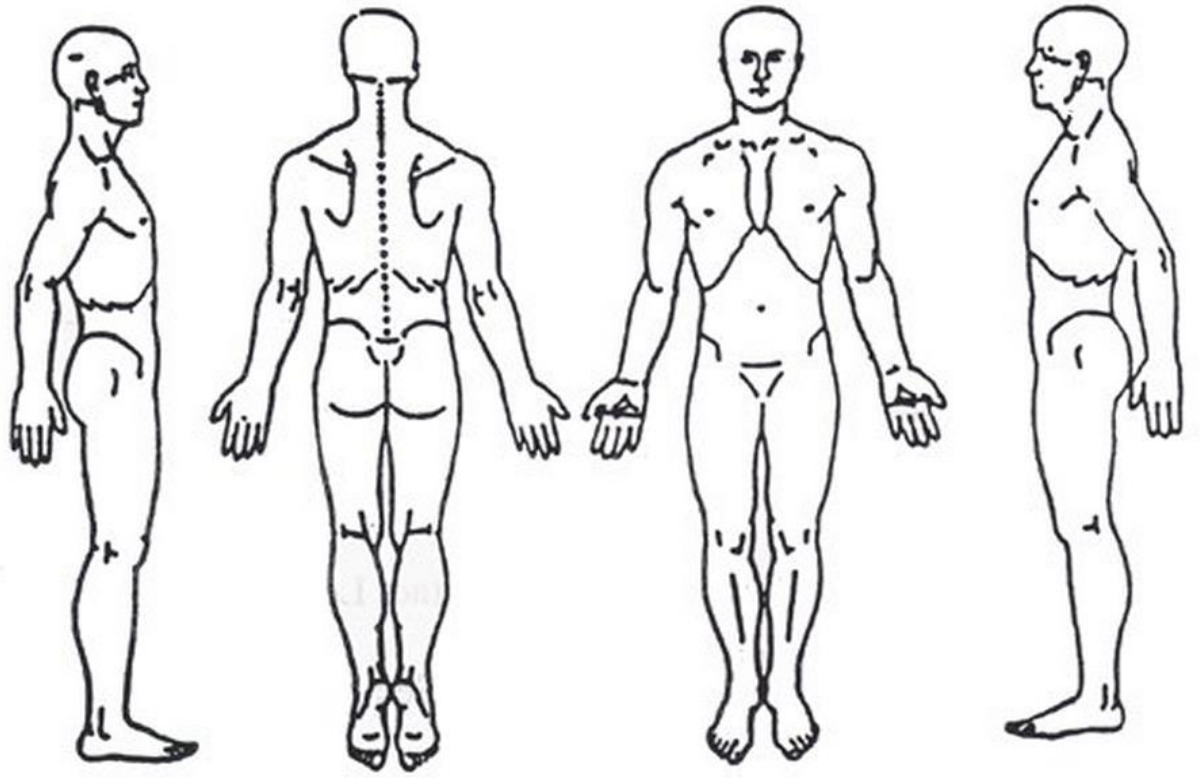
Did something trigger your change in health? When?

What makes you feel better?

What makes you feel worse?

Please note any past or current injuries (include date):

Please indicate areas of pain or distress:



RIGHT SIDE BACK FRONT LEFT SIDE

MEDICAL HISTORY	**Patient Name:**
ABO Blood Type: *(circle one)* O A B AB	**Have you ever had a blood transfusion?** *(circle one)* Yes No Unsure

Height:	**Weight:**	**Waist Circumference:**

MEDICATIONS

Please list all prescribed and over-the-counter medications you are taking.

Name/Dose:	*Reason:*
Name/Dose:	*Reason:*
Name/Dose:	*Reason:*
Name/Dose:	*Reason:*

If you need more space to list your current prescribed medications, please list on a separate page.

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.) Motrin, Aspirin? ☐ Y ☐ N

Have you had prolonged or regular use of Tylenol? ☐ Y ☐ N

Have you had prolonged or regular use of acid-blocking drugs (Prilosec, Tagamet, Zantac, etc.)? ☐ Y ☐ N

Frequent antibiotics >3 times per year? ☐ Y ☐ N Long-term antibiotics? ☐ Y ☐ N

SUPPLEMENTS

Please list all **nutritional supplements** you currently take daily. Please include **brand names** and **dosage amounts** as well as any **herbs/botanical** products.

Name/Dose:	*Name/Dose:*
Name/Dose:	*Name/Dose:*
Name/Dose:	*Name/Dose:*
Name/Dose:	*Name/Dose:*

If you need more space to list your current nutritional supplements, please list on a separate page.

ALLERGIES

Please list all FOOD allergies & symptoms you experience:

Please list all NON-food allergies & symptoms you experience:

MEDICAL HISTORY (continued) | **Patient Name:**

Please check all health conditions that your doctor has diagnosed and provide the date of onset.

GASTROINTESTINAL

- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Gastric or Peptic Ulcer Disease
- ☐ GERD (reflux/heartburn)
- ☐ Celiac Disease
- ☐ Hepatitis C or Liver Disease
- ☐ Other Digestive:

INFLAMMATORY – AUTOIMMUNE

- ☐ Chronic Fatigue Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Lupus SLE
- ☐ Poor Immune Function *(frequent infections)*
- ☐ Severe Infectious Disease
- ☐ Herpes-Genital
- ☐ Multiple Chemical Sensitivities
- ☐ Gout
- ☐ Other:

CARDIOVASCULAR

- ☐ Heart Disease (heart attack)
- ☐ Stroke
- ☐ Elevated Cholesterol
- ☐ Irregular heart rate – Pacemaker
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse/heart murmur
- ☐ Other Heart & Vascular:

METABOLIC – ENDOCRINE

- ☐ Diabetes ☐ Type 1 or ☐ Type 2
- ☐ Metabolic Syndrome (insulin resistance)
- ☐ Hypoglycemia
- ☐ Hypothyroidism (low thyroid)
- ☐ Hyperthyroidism (overactive thyroid)
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Genetic Disorder:
- ☐ Other:

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Sinusitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Other:

MUSCULOSKELETAL & PAIN

- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Migraines
- ☐ Other:

NEUROLOGICAL & MOOD

- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Other:

CANCER

- ☐ Cancer *(please describe type and treatment)*

OTHER

- ☐ Kidney stones
- ☐ Anemia
- ☐ Eczema
- ☐ Urinary (UTIs)
- ☐ Psoriasis
- ☐ Frequent Yeast
- ☐ Acne

Please list any other diseases or health conditions.

Your Birth ☐ Natural/vaginal ☐ C-Section

Were you breastfed as an infant (if known)? ☐ Y ☐ N

SURGERIES & HOSPITALIZATIONS

Patient Name:

Please list any surgeries or hospitalizations (include dates and your ages if known).

FAMILY HEALTH HISTORY

Please note any family history of the following diseases: *heart disease, cancer, stroke, high blood pressure, overweight/obese, diabetes, lung disease, kidney disease, cancer, mental illness, and/or addiction.*

Family Member:		*Health Condition:*	
Family Member:		*Health Condition:*	
Family Member:		*Health Condition:*	
Family Member:		*Health Condition:*	
Genetic Disorders Known:			

DENTAL HISTORY

Do you have any: ☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis ☐ Chewing problems

Do you visit a dentist regularly (twice per year)? ☐ Y ☐ N

Have you ever had an infection in your jawbone? ☐ Y ☐ N

TMJ: ☐ grinding teeth ☐ jaw clicking ☐ braces? If yes, what age ____ ☐ surgery ☐ jaw pain

Do you have any of the following? Please label.

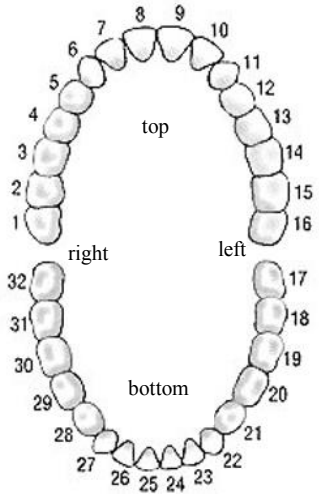
☐ Silver amalgam fillings

☐ Root Canals

☐ Bridges

☐ Crowns

☐ Missing Teeth



LIFESTYLE INFORMATION	**Patient Name:**

Do you engage in moderate physical activity at least 3 days a week, for a minimum of 20 minutes duration?

(brisk walking, jogging, hiking, cardio exercise classes, cycling, stair-climbing, etc.) ☐ Y ☐ N

ACTIVITY	TYPE / INTENSITY *(low-moderate-high)*	# DAYS / WEEK	DURATION *(minutes)*
Stretching/Yoga			
Cardio/Aerobics			
Strength Training			
Sports			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High

Note any reasons that limit your physical activity.

Do you smoke? ☐ Y ☐ N	How many years?	Packs per day?
2nd hand smoke exposure? ☐ Y ☐ N	How often are you exposed?	
Excess stress in your life? ☐ Y ☐ N	Do you have difficulty handling stress? ☐ Y ☐ N	

Daily Stressors: *Rate on a scale of 1 (low) to 10 (high)*

☐ Family____ ☐ Finances____ ☐ Health____ ☐ Social____ ☐ Work____ ☐ Other:____

Do you feel your life has meaning and purpose? ☐ Y ☐ N ☐ unsure	Do you think stress is presently affecting the quality of your life? ☐ Y ☐ N
Average number of hours you sleep per night **during the weekdays**?	Average number of hours you sleep per night **on the weekends**?

Any trouble falling asleep? ☐ Y ☐ N	Any trouble staying asleep? ☐ Y ☐ N	Do you feel rested upon waking? ☐ Y ☐ N

How often do you wake up during the night? What time in general?

What are your reason(s) for waking up during the night?

How long before you fall back asleep?

How would you rate the overall quality of your sleep? *low quality* 1 2 3 4 5 *high quality*

ENVIRONMENTAL INFORMATION

Patient Name:

Are you exposed regularly to any of the following? *(check all that apply)*

☐ Cigarette smoke	☐ Heavy metals	☐ Pesticides
☐ Auto exhaust/fumes	☐ Teflon Cookware	☐ Fertilizers
☐ Dry-cleaned clothes	☐ Aluminum Cookware	☐ Pet dander
☐ Nail polish/hair dyes	☐ Paint fumes	☐ Chemicals
☐ Perfumes	☐ Mold	☐ Other:

Do you use any recreational drugs? If so, please note type and frequency.

NUTRITION HISTORY

Have you ever had a nutrition consultation? ☐ Y ☐ N

Have you made any changes in your eating habits because of your health? ☐ Y ☐ N

If so, please describe.

Do you currently follow a special diet or nutritional program? *Check all that apply*.

☐ Low fat	☐ Low Carb	☐ High protein	☐ Low sodium
☐ No Gluten	☐ Vegetarian	☐ Vegan	☐ Diabetic
☐ No Dairy	☐ No Wheat	☐ Weight Loss	☐ Other:

How often do you weigh yourself?

Have you had any recent history of ☐ weight loss or ☐ weight gain? Please describe.

How many meals per day do you eat? How many snacks per day?

Do you avoid any particular foods? Please describe.

If you could only eat a few foods a week, what would they be?

Number of times you eat out per week?	☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ more than 5 per week

Describe your eating habit. Check all that applies.

☐ Fast eater	☐ Family member have different tastes
☐ Erratic eating patterns	☐ Love to Eat
☐ Eating too much	☐ Eat because I have to
☐ Late night eating	☐ Have a negative relationship to food
☐ Dislike healthy food	☐ Struggle with eating issues
☐ Time constraints	☐ Emotional eater (stress, bored, etc.)
☐ Travel frequently	☐ Confused about food/nutrition
☐ Do not plan meals or menus	☐ Frequently eat fast foods
☐ Rely on convenience items	☐ Poor snack choices

NUTRITION HISTORY (continued)	**Patient Name:**
What are the top three dietary changes do you think would make the most difference in your overall health?	① ② ③

Do you drink alcohol? ☐ Y ☐ N # drinks/week? Beverage of choice?

Do you drink coffee or other caffeinated beverages? ☐ Y ☐ N # drinks/day?

Do you use artificial sweeteners? ☐ Y ☐ N Which ones?

Do you feel like belching or are you bloated after eating? ☐ Y ☐ N

Do you have (or had) any eating disorders? ☐ Y ☐ N

Please describe.

CURRENT EATING HABITS

Mark the meals you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks

Where do you obtain your food from: ☐ home prepared from whole foods ____% ☐ organic ____%

☐ home prepared convenience foods ____% ☐ eat out ____%

Mark <u>how many times</u> you eat or drink the following items **PER WEEK**:

___ Soda (regular)
___ Soda (diet)
___ Alcohol
___ Hot tea
___ Cold tea
___ Coffee (regular)
___ Coffee (decaf.)
___ Sugar in coffee
___ Coffee drinks
___ Sweetened drinks
___ Sparkling water
___ Purified water
___ Tap water
___ Fruit juice
___ Lemonade
___ Milk (cow)
___ Milk (goat)
___ Soy Milk
___ Rice Milk
___ Nut Milk
___ Herbal teas
___ Yogurt (plain)
___ Yogurt (sweet)

___ Fast food
___ Ice cream
___ Pudding
___ Refined sugars
___ Tuna fish
___ Swordfish
___ Sushi/sashimi
___ Salmon/other fish
___ Lunch meats
___ Bacon
___ Hot dogs
___ Whole eggs
___ Red meat
___ Poultry
___ Tofu
___ Tempeh/Miso
___ Legumes (beans, lentils)
___ Vegetarian foods
___ Green Salads
___ Potatoes
___ Yams & Sweet Potatoes

___ Raw vegetables
What kind?

___ Cooked vegetables
What kind?

___ Popcorn
___ Cereals
___ Oatmeal
___ Bagels/pretzels
___ White bread
___ Sprouted Bread
___ Wheat Bread
___ Crackers
___ Pasta
___ Brown rice
___ White rice
___ Corn tortillas
___ Flour tortillas
___ Potato Chips
___ Tortilla Chips
___ Pizza

___ Prepared meals (ex: Lean cuisine)
___ Microwave meals & soups
___ Restaurant meals ("healthy")
___ Restaurant meals ("unhealthy")
___ Airplane meals

Sweets & Sweeteners:
___ Equal/Nutrasweet (aspartame)
___ Splenda (sucralose)
___ Saccharin
___ Stevia/Xylitol
___ Dried fruit
___ Canned fruit
___ Fresh Fruit
___ Jelly/jam
___ Candy
___ Chocolate (milk)
___ Chocolate (dark)

FATS AND OILS	**Patient Name:**	
Please indicate how many times **PER WEEK** you eat the following fats/oils.		
OMEGA 9 *stabilizer* ~50% of daily fat calories Oleic Fatty Acid	___ Almond Oil ___ Almonds/Cashews ___ Almond butter ___ Avocados ___ Peanuts ___ Peanut butter (natural/soft)	___ Olives ___ Olive Oil ___ Sesame Seeds/Tahini ___ Hummus (tahini oil) ___ Macadamia Nuts ___ Pine Nuts
OMEGA 6 *controllers* *Essential Fatty Acid Family* *~30% of daily fat calories* LA → GLA → DGLA → AA	___ Eggs (whole), organic (AA) ___ Meats (commercial) (AA) ___ Meats (grass-fed, org) (AA) ___ Brazil nuts (raw) ___ Pecan (raw) ___ Hazelnuts/Filberts (raw) ___ Hemp Seeds	___ Evening Primrose (GLA) ___ Black Currant Oil (GLA) ___ Borage Oil (GLA) ___ Hemp Oil ___ Grapeseed Oil ___ Sunflower Seeds (raw) ___ Pumpkin seeds (raw)
OMEGA 3 *fluidity/communicators* *Essential Fatty Acid Family* *~10% of daily fat calories* ALA → EPA → DHA	___ Fish Oil capsule: ↑DHA ___ Fish Oil capsule: ↑EPA ___ Fish (salmon/fin-fish) ___ Fish (shellfish) ___ Flax seeds/meal	___ Flax Oil ___ UDO's DHA Oil ___ Algae ___ Greens Powder w/algae ___ Chia seeds
BENEFICIAL SATURATED *structure* *~10% of daily fat calories* Short-chain & Medium-chain Triglycerides	___ Coconut Oil ___ Butter, organic ___ Ghee (clarified butter) ___ Dairy, raw & organic	___ Meats, grass-fed ___ Wild game ___ Poultry, organic ___ Eggs, whole organic
DAMAGED FATS/OILS *promotes stress to cells & tissues* *<5% (should completely avoid)* Trans Fats, Acrylamides, Odd-Chain Fatty Acids, VLCFA/damaged	___ Margarine ___ Reg. vegetable oils (corn, sunflower, canola) ___ Mayonnaise (commercial) ___ Hydrogenated Oil (as an ingredient) ___ "Imitation" cheeses ___ Tempura	___ Doughnuts (fried) ___ Deep-fried foods ___ Chips fried in oil ___ Reg. Salad dressing ___ Peanut Butter (ex: JIF) ___ Roasted nuts/seeds

MOTIVATION ASSESSMENT	**Patient Name:**
In order to improve your health, **how willing are you to**:	*most willing* ---------- *least willing*
Significantly modify your diet	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Take several nutritional supplements each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Keep a record of everything you eat each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Modify your lifestyle (work demands, sleep habits, exercise, etc)	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Practice a relaxation technique	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Engage in regular exercise/physical activity	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Have periodic lab tests to assess your progress	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Thank you for completing your new patient health information. We understand that it takes a considerable amount of time to complete this form and appreciate your patience.
This valuable information will help guide Dr. Wang in better understanding <u>you</u> as she creates your individualized health plan.

INFORMED CONSENT TO NATUROPATHIC MEDICAL CARE

I, (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the California licensed naturopathic doctor named at the end of this notice and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the below named doctor, whether signatories to this form or not.

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act,[1] which may include but are not limited to nutritional counseling, herbal medicine, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections, and intravenous (IV) therapy.

I have had the opportunity to discuss with the naturopathic doctor named below the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. I understand that it is extremely important that I follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I understand that some herbs and supplements may be inappropriate during pregnancy and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, I will seek treatment immediately from a trauma center or call 9-1-1.

(Initials) _____ I have informed the doctor of any known allergies to drugs or other substances, or of any past reactions to anesthetics. I have informed the doctor of all current medications and supplements.

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

Signature: _____ **Date:** _____

Print Name: _____

Name of Patient if other than self: _____

Dr. Shinshan Wang, ND
1730 Huntington Dr. Suite 204
South Pasadena, CA 91030

NOTICE OF PRIVACY PRACTICES

The privacy of your medical information, as described in the Health Insurance Portability and Accountability Act of 1996, is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements.

We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other health care providers to assist them in treating you. We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: _____ **Date:** _____

Print Name: _____

Name of Patient if other than self: _____

Dr. Shinshan Wang, ND
1730 Huntington Dr. Suite 204
South Pasadena, CA 91030