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CenterAlternativeMedicine.com
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Client Intake Form

Date:_____

Name: _____ Email address:_____

Address: _____ City: _____

State: _____ Zip: _____

Mobile Phone: _____ Secondary Phone: _____

Permissible to leave message on? (Circle): Mobile / Secondary / Both

Place of Employment: _____ Position: _____

Date of Birth: _____ Age: _____

Person to Contact in Case of Emergency

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____ City: _____

State: _____ Zip: _____

How were you referred to the center? _____

What are your *most important* **health concerns**? Please list in order of importance, so that the health problems you want to address first are listed first.

1._____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

Medications: (List all prescription and non-prescription drugs, dosages and length of time you have been taking these medications):

_____

_____

_____

Supplements: (List all vitamins, minerals, herbs, etc. List amounts of each):

_____

_____

_____

When was your last physical exam? _____

Do you experience acute or chronic stress Y N If yes, please describe:

_____

_____

Exercise: Please describe what type, duration, and how often you exercise:

_____

_____

Energy: On a scale of "1 to 10", "1" being the absolute lowest energy, while"10" being the absolute best energy, rate your general energy level: _____

Do you have energy fluctuations throughout the day? Y N

Are you currently using or have used tobacco? Y N If yes, how much? _____

Have you used tobacco in the past? Y N If yes, then for how long and how much?

_____

Do you get enough sleep? Y N How many hours/night? _____

Do you have trouble falling asleep? Y N Do you awaken well rested? Y N

Do you get more than two colds a year? Y N

When you get a "cold" does it take longer than 1 week for it to resolve? Y N

Dental History:

Do you have any root canals? Y N If yes, how many and what year were they done?

_____

How many silver tooth fillings do you have? _____

Are they relatively new or have they been there for many years? _____

Please list other practitioners of "natural medicine" that you have used

(e.g. acupuncture, chiropractic, homeopaths, etc.) :

_____

_____

Food Record:

Please list the foods that you typically eat for each meal. Make sure to include foods that are not eaten frequently. Please underline the foods that are eaten more frequently. For example, if you eat cereal almost every day for breakfast, but only have eggs once a week, then underline the cereal and make sure to include the eggs on the list.

Breakfast:_____
_____
_____

Lunch:_____
_____
_____

Dinner:_____
_____
_____

Snack:_____
_____

Dessert:_____
_____

For each food class, please indicate how often you eat it. Write down whatever is most appropriate, be it once a day, 4 times a week, 3 times a day, etc…

Meat (beef, chicken, steak, turkey, ham, pork, luncheon meats, burgers): _____

Dairy (milk, cheese, yogurt, ice cream): _____ Eggs: _____

Bread: _____ Beans: _____ Fruit: _____

Fish (including tuna): _____ Salads: _____ Vegetables: _____

Nuts and seeds (including peanut butter): _____ Rice: _____

Sweets (cookies, candy, cake, ice cream, etc.): _____ Cereal: _____

Pasta: _____ Tofu: _____ Sugar Supplement_____

For the liquids, please list how many 8 ounce cups per day or week.

Water: _____ Juice: _____ Milk: _____

Coffee (regular or decaf): _____ Tea: _____ Energy Drinks _____

Alcohol: _____ Soda: _____ Other: _____

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Informed Consent Form

I, _____, a mature adult of sound mind, come to

the Center for Alternative Medicine, LLC and its associates for holistic health counseling.

I understand that although Guy DeAngelis, N.D., Ph.D. is a Doctor of Naturopathy, the state of Ohio does not recognize Naturopathic Doctors as physicians, therefore, Guy DeAngelis, N.D., Ph.D. cannot diagnose or treat any health condition.

I understand that the herbs, nutritional supplements and homeopathic remedies discussed in this office are neither a treatment for my condition nor replacement for medication. I understand that in all circumstances I should continue to consult with my regular physician in regard to all medical concerns that I may have.

Accordingly, I sign this Informed Consent, to express that it is my own decision without undue persuasion to see Guy DeAngelis, N.D., Ph.D. for naturopathic counseling. I hold no party responsible for my own actions.

I hereby release Guy DeAngelis, N.D., Ph.D., and Center for Alternative Medicine, LLC and its associates from liability for any results that may occur to me thereafter.

In an effort to best serve clients, please give at least 24 hour's notice when canceling an appointment. Missed appointments and appointments not cancelled with 48 hours advanced notice are billed at the full rate for the session scheduled.

Finally, I understand that Guy DeAngelis, N.D., Ph.D. does not accept insurance and that I am responsible for payment in full upon services rendered. The fee for the initial office consultation is $110 and follow up visits are charged at an individual therapy rate of services rendered.

Print Name: _____

Signature: _____

Date & Time: _____