

# *Santa Cruz Naturopathic Medical Center*



Hello-

Welcome to the Santa Cruz Naturopathic Medical Center! You can read more about us and our center at [www.scnmc.com](http://www.scnmc.com).

Attached are forms to complete before your appointment. Please bring these completed forms with you at the time of your appointment, and also bring any medications, herbs, and/or supplements you are currently taking. Please also bring copies of any recent laboratory test results. If you have had labs but do not have the results, we will have you sign a release of record and we can obtain those for you.

Your new patient exam lasts an hour and a half, and includes an extensive intake and treatment plan. The cost is \$200. You may also receive supplements on your first visit (i.e. vitamins, herbs, homeopathics, etc.) for an additional charge. Payment is due in full at the time of the visit. If you have insurance, we will submit a superbill to your insurance on your behalf requesting reimbursement for the office visit. You may or may not receive partial reimbursement, depending on your insurance provider and your particular plan.

Our clinic is located at 736 Chestnut Street in Santa Cruz, CA 95060. If you need further directions, or if you have any questions, please don't hesitate to call.

We look forward to seeing you at your appointment and partnering with you in your health.

**Please note:**

**If you need to cancel your appointment, we require a 48 hour notice for a new patient exam. You will be charged a \$100 cancellation fee for a missed appointment or cancelling with less than 48 hour notice.**

All the best,

Sarah Hellman  
Office Manager

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

*736 Chestnut Street, Santa Cruz, CA 95060*  
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[www.scnmc.com](http://www.scnmc.com)

# Santa Cruz Naturopathic Medical Center



## BIOGRAPHICAL INFORMATION FORM – ADOLESCENT

Date: \_\_\_\_\_

### Personal History:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_ M \_\_ F

Address: \_\_\_\_\_  
Street and Number City State Zip

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Race: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Parents Name: \_\_\_\_\_

Parents Phone: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

### List Yes (Y), No (N), or Past (P) regarding the use of the following:

Antacids: Y N P      Steroids: Y N P      Smoking: Y N P      Packs per day / Number of years \_\_\_\_\_

Analgesics: Y N P      Laxatives: Y N P      Coffee: Y N P      Cups per day if Yes / Past: \_\_\_\_\_

Soda: Y N P      Ounces per day if Yes / Past: \_\_\_\_\_

Alcohol: Y N P      How often & how much if Yes / Past: \_\_\_\_\_

Any Alcohol Addiction: Y N P      Any Alcohol Treatment: Y N P

Recreational Drugs: Y N P      Any Drug Addictions: Y N P      Any Drug Treatment: Y N P

### Exercise

How often do you exercise? \_\_\_\_\_

What type of exercise? \_\_\_\_\_ For How Long? \_\_\_\_\_

Hobbies: \_\_\_\_\_

How did you hear about our center, or who referred you? \_\_\_\_\_

What do you expect from this visit? \_\_\_\_\_

Are you willing to make lifestyle and diet changes? \_\_\_\_\_

Please indicate any allergies to medications or food:

\_\_\_\_\_

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**Health Concerns:**

List in order of importance your primary health concerns:

How long have these problems persisted?

1) \_\_\_\_\_

\_\_\_\_\_

2) \_\_\_\_\_

\_\_\_\_\_

3) \_\_\_\_\_

\_\_\_\_\_

4) \_\_\_\_\_

\_\_\_\_\_

Under what conditions do your problems usually get worse?

Under what conditions do they improve?

1) \_\_\_\_\_

\_\_\_\_\_

2) \_\_\_\_\_

\_\_\_\_\_

3) \_\_\_\_\_

\_\_\_\_\_

4) \_\_\_\_\_

\_\_\_\_\_

**Medical History:**

Your primary physician:

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

List any major illnesses, hospitalizations and/or operations you have had (include year).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was your most recent physical exam? \_\_\_\_\_

When was your most recent blood work and by what doctor? \_\_\_\_\_

**For Women -----** Date of last Pap Smear \_\_\_\_\_

Date of last Mammogram \_\_\_\_\_

Any family history of breast cancer? \_\_\_\_\_ If yes, whom? \_\_\_\_\_

**Sleep**

How many hours per night? \_\_\_\_\_ If you wake, what is the reason? \_\_\_\_\_

Nightmares: Y N P      Wake Refreshed: Y N P      Must nap during the day: Y N P

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**Diet**

Have you gained or lost over ten pounds in the past year? Yes \_\_\_\_ No \_\_\_\_ Gained \_\_\_\_ Lost \_\_\_\_

If yes, was the gain/loss on purpose? Yes \_\_\_\_ No \_\_\_\_

**Medications**

What medications are you currently taking?

Medications	Dosage	For What	How Long

List any supplements and dosages you are currently taking:


**Counseling History**

Are you currently receiving counseling? Yes \_\_\_\_ No \_\_\_\_

If yes, please briefly described: \_\_\_\_\_

Have you received counseling in the past? Yes \_\_\_\_ No \_\_\_\_

If yes, please briefly describe: \_\_\_\_\_

Please list what are the major stresses in your life:

\_\_\_\_\_

**Family History**

	Father	Mother	Siblings	Grandparents	Spouse	Children
<b>Age If Living:</b>	_____	_____	_____	_____	_____	_____
<b>Age when Died:</b>	_____	_____	_____	_____	_____	_____
<b>Cause of Death</b>	_____	_____	_____	_____	_____	_____

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**Family History Cont.**

	Father	Mother	Siblings	Grandparents	Spouse	Children
<b>High Blood Pressure:</b>	Y N	Y N	Y N	Y N	Y N	Y N
<b>Heart Attack/Stroke:</b>	Y N	Y N	Y N	Y N	Y N	Y N
<b>Heart Disease:</b>	Y N	Y N	Y N	Y N	Y N	Y N
<b>Asthma/Allergies:</b>	Y N	Y N	Y N	Y N	Y N	Y N
<b>Mental Illness:</b>	Y N	Y N	Y N	Y N	Y N	Y N
<b>Auto-Immune Dz:</b>	Y N	Y N	Y N	Y N	Y N	Y N
<b>Diabetes:</b>	Y N	Y N	Y N	Y N	Y N	Y N
<b>Osteoporosis:</b>	Y N	Y N	Y N	Y N	Y N	Y N
<b>Cancer</b>	Y N	Y N	Y N	Y N	Y N	Y N

**Thoughts and Behaviors**

Please check how often the following thoughts occur to you:

- |                                |          |           |              |               |
|--------------------------------|----------|-----------|--------------|---------------|
| 1) Life is hopeless.           | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 2) I am lonely.                | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 3) No one cares about me.      | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 4) I am a failure.             | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 5) People don't like me.       | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 6) I want to die.              | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 7) I want to hurt someone.     | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 8) I am so stupid.             | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 9) I am going crazy.           | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 10) I can't concentrate.       | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 11) I am so depressed.         | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 12) God is disappointed in me. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 13) I can't be forgiven.       | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 14) Why am I so different?     | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 15) I can't do anything right. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 16) People hear my thoughts.   | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 17) I have no emotions.        | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 18) I hear voices in my head.  | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 19) I am out of control.       | Never___ | Rarely___ | Sometimes___ | Frequently___ |

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**Symptoms**

Circle the behaviors and symptoms that occur to you more often than you would like them to:

- |                   |                 |                     |                       |                     |
|-------------------|-----------------|---------------------|-----------------------|---------------------|
| aggression        | fatigue         | sexual difficulties | alcohol dependence    | hallucinations      |
| sick often        | anger           | antisocial behavior | anxiety               | avoiding people     |
| chest pain        | depression      | disorientation      | distractibility       | worrying            |
| drug dependence   | eating disorder | mood elevated       | heart palpitations    | high blood pressure |
| hopelessness      | impulsivity     | irritability        | judgment errors       | loneliness          |
| memory impairment | mood shifts     | panic attacks       | phobias/fears         | recurring thoughts  |
| sleeping problems | dizziness       | suicidal thoughts   | thoughts disorganized | trembling           |

Other (specify): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any other information you feel is important to share:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Santa Cruz Naturopathic Medical Center

736 Chestnut Street  
Santa Cruz, CA 95060

### Informed Consent Form

I, (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed Naturopathic Doctor.

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act,<sup>1</sup> which may include but are not limited to nutritional counseling, western herbs, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections, and IV therapy.

I have had the opportunity to discuss with the Naturopathic Doctor 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. It is extremely important that you 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 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, please seek treatment immediately from a trauma center or call 9-1-1.

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.

**PATIENT NAME, (printed)** \_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(or Patient Representative)

**Indicate relationship if signing on behalf of patient** \_\_\_\_\_

I agree to provide a 24 hour notice of cancellation for all follow-up appointments. \$100 will be charged for new patient exams if cancellations are made with less than a 48 hour notice.

Initial:

\_\_\_\_\_