Trillium Natural Medicine, LLC

naturopathic medicine & acupuncture

3043 West Liberty Ave.
Pittsburgh, PA 15216
412-571-9355

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # (home): _____ (work): _____

E-mail address: _____

Age: _____ Date of Birth: _____ Gender: ❑ Female ❑ Male

Education: _____

❑ Married ❑Separated ❑ Divorced ❑ Widowed ❑ Single ❑ Partnership

Live with: ❑ Spouse ❑ Partner ❑ Parents ❑ Children ❑ Friends ❑ Alone

Occupation: _____ Hours per week: _____ ❑ Retired

Employer: _____

(Work address): _____

How did you hear about Trillium Natural Medicine? _____

Has any other family member already been a patient at Trillium Natural Medicine? _____

Next of Kin or other to reach in an emergency: _____

Relationship: _____ Phone: _____

Address: _____

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 go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1a. Why did you choose to come to Trillium Natural Medicine? _____

_____

_____

1b. What do you know about our approach? _____

_____

_____

2a. What **three** expectations do you have from **this visit**? _____

_____

_____

2b. What **long term** expectations do you have of me personally as your Naturopathic doctor and/or Acupuncturist?

_____

_____

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%

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

_____

_____

4b. 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?

_____

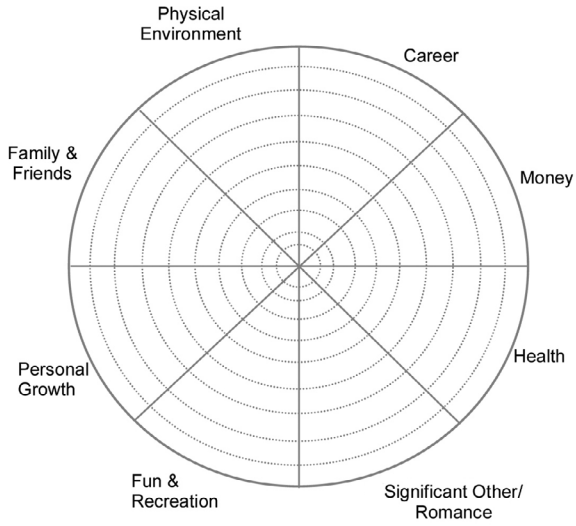
_____

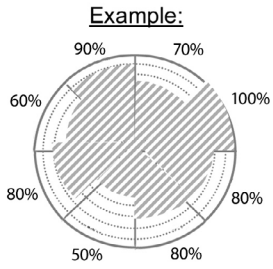
Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.





Are you currently receiving healthcare? ❑ Yes ❑ No

If yes, where and from whom: _____

_____

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

_____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Do you have any known contagious diseases at this time? ❑ Yes ❑ No

If yes, what? _____

Family History

Do you have a family history of any of the following (please check)?

❑ Asthma/Hayfever/Hives ❑ Alzheimer's ❑ Cancer ❑ Diabetes
❑ Epilepsy Arthritis ❑ Heart Disease ❑ High Blood Pressure ❑ Glaucoma
❑ Kidney Disease ❑ Mental Illness ❑ Stroke Anemia ❑ Tuberculosis

Any other relevant family history? _____

_____

What is your heritage (for identifying risk factors for disease) _____

Childhood Illnesses

Please check whether you had any of these as a child:

❑ Diphtheria ❑ Measles ❑ Mumps
❑ German measles ❑ Rheumatic fever ❑ Scarlet fever

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

Allergies

Are you hypersensitive or allergic to. . .

Any drugs? _____

Any foods? _____

Any environmentals or chemicals? _____

Current Medications

Do you take or use?

Antacids ❑ Yes ❑ No Antibiotics ❑ Yes ❑ No Appetite suppressants ❑ Yes ❑ No
Cortisone ❑ Yes ❑ No Laxatives ❑ Yes ❑ No Pain relievers ❑ Yes ❑ No
Sleeping pills ❑ Yes ❑ No Tranquilizers ❑ Yes ❑ No Thyroid medication ❑ Yes ❑ No

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

General

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum Weight : _____ When: _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

For the Following, Please Check the Appropriate Response Based on the Key Below:

Y=a condition you have now **N**=Never had **P**=Significant problem in the past

Habits

Main interests and hobbies? _____

Do you exercise? ❑ Y ❑ N

If yes, what kind? _____ How often? _____

Average 6-8 hrs. sleep? ❑ Y ❑ N

Sleep well? ❑ Y ❑ N

Awaken rested? ❑ Y ❑ N

Have a supportive relationship? ❑ Y ❑ N

Have a history of abuse? ❑ Y ❑ N

Any major traumas? ❑ Y ❑ N ❑ P

Use recreational drugs? ❑ Y ❑ N ❑ P

Been treated for drug dependence? ❑ Y ❑ N ❑ P

Use alcoholic beverages? ❑ Y ❑ N ❑ P

Treated for alcoholism? ❑ Y ❑ N ❑ P

Do you use tobacco? ❑ Y ❑ N ❑ P

Smoked previously? ❑ Y ❑ N ❑ P

How many years? _____

How many packs per day? _____

Enjoy your work? ❑ Y ❑ N

Take vacations? ❑ Y ❑ N

Spend time outside? ❑ Y ❑ N

Watch television? ❑ Y ❑ N

How many hours? _____

Read? ❑ Y ❑ N

How many hours? _____

Do you have a religious /spiritual practice? ❑ Y ❑ N

Do you eat 3 meals a day? ❑ Y ❑ N

Do you go on diets often? ❑ Y ❑ N

Do you eat out often? ❑ Y ❑ N

Do you drink coffee? ❑ Y ❑ N ❑ P

Drink black/green tea? ❑ Y ❑ N ❑ P

Do you drink cola/other sodas? ❑ Y ❑ N ❑ P

Do you eat refined sugar? ❑ Y ❑ N ❑ P

Do you add salt? ❑ Y ❑ N ❑ P

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Review of Systems

Mental / Emotional

Treated for emotional problems? ❑ Y ❑ N ❑ P
Mood Swings? ❑ Y ❑ N ❑ P
Considered/Attempted suicide? ❑ Y ❑ N ❑ P
Poor concentration? ❑ Y ❑ N ❑ P
Depression? ❑ Y ❑ N ❑ P
Anxiety or nervousness? ❑ Y ❑ N ❑ P
Tension? ❑ Y ❑ N ❑ P
Memory problems? ❑ Y ❑ N ❑ P

Immune

Reactions to immunizations? ❑ Y ❑ N ❑ P
Chronic Fatigue Syndrome? ❑ Y ❑ N ❑ P
Chronically swollen glands? ❑ Y ❑ N ❑ P
Reactions to vaccinations? ❑ Y ❑ N ❑ P
Chronic infections? ❑ Y ❑ N ❑ P
Slow wound healing? ❑ Y ❑ N ❑ P

Endocrine

Hypothyroid? ❑ Y ❑ N ❑ P
Hypoglycemia? ❑ Y ❑ N ❑ P
Excessive thirst? ❑ Y ❑ N ❑ P
Fatigue? ❑ Y ❑ N ❑ P
Heat or cold intolerance? ❑ Y ❑ N ❑ P
Diabetes? ❑ Y ❑ N ❑ P
Excessive hunger? ❑ Y ❑ N ❑ P
Seasonal depression? ❑ Y ❑ N ❑ P

Neurologic

Seizures? ❑ Y ❑ N ❑ P
Muscle weakness? ❑ Y ❑ N ❑ P
Loss of memory? ❑ Y ❑ N ❑ P
Vertigo or dizziness? ❑ Y ❑ N ❑ P
Paralysis? ❑ Y ❑ N ❑ P
Numbness or tingling? ❑ Y ❑ N ❑ P
Easily stressed? ❑ Y ❑ N ❑ P
Loss of balance? ❑ Y ❑ N ❑ P

Skin

Rashes? ❑ Y ❑ N ❑ P
Acne, Boils? ❑ Y ❑ N ❑ P
Color Change? ❑ Y ❑ N ❑ P
Lumps? ❑ Y ❑ N ❑ P
Eczema, Hives? ❑ Y ❑ N ❑ P
Itching? ❑ Y ❑ N ❑ P
Perpetual Hair Loss? ❑ Y ❑ N ❑ P
Night Sweats? ❑ Y ❑ N ❑ P

Head

Headaches? ❑ Y ❑ N ❑ P
Migraines? ❑ Y ❑ N ❑ P
Head Injury? ❑ Y ❑ N ❑ P
Jaw/TMJ problems ❑ Y ❑ N ❑ P

Eyes

Spots in Eyes? ❑ Y ❑ N ❑ P
Impaired vision? ❑ Y ❑ N ❑ P
Blurriness? ❑ Y ❑ N ❑ P
Color blindness? ❑ Y ❑ N ❑ P
Double Vision? ❑ Y ❑ N ❑ P
Cataracts? ❑ Y ❑ N ❑ P
Glasses or contacts? ❑ Y ❑ N ❑ P
Eye pain/strain? ❑ Y ❑ N ❑ P
Tearing or dryness? ❑ Y ❑ N ❑ P
Glaucoma? ❑ Y ❑ N ❑ P

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Ears

Impaired hearing? ❑ Y ❑ N ❑ P
Earaches? ❑ Y ❑ N ❑ P
Ringing? ❑ Y ❑ N ❑ P
Dizziness? ❑ Y ❑ N ❑ P

Nose and Sinuses

Frequent colds? ❑ Y ❑ N ❑ P
Stuffiness? ❑ Y ❑ N ❑ P
Sinus problems? ❑ Y ❑ N ❑ P
Nose Bleeds? ❑ Y ❑ N ❑ P
Hayfever? ❑ Y ❑ N ❑ P
Loss of smell? ❑ Y ❑ N ❑ P

Mouth and Throat

Frequent sore throat? ❑ Y ❑ N ❑ P
Teeth grinding? ❑ Y ❑ N ❑ P
Gum problems? ❑ Y ❑ N ❑ P
Dental cavities? ❑ Y ❑ N ❑ P
Copious saliva? ❑ Y ❑ N ❑ P
Sore tongue/lips? ❑ Y ❑ N ❑ P
Hoarseness? ❑ Y ❑ N ❑ P
Jaw clicks? ❑ Y ❑ N ❑ P

Neck

Lumps? ❑ Y ❑ N ❑ P
Goiter? ❑ Y ❑ N ❑ P
Swollen glands? ❑ Y ❑ N ❑ P
Pain or stiffness? ❑ Y ❑ N ❑ P

Respiratory

Cough? ❑ Y ❑ N ❑ P
Spitting up blood? ❑ Y ❑ N ❑ P
Asthma? ❑ Y ❑ N ❑ P
Pneumonia? ❑ Y ❑ N ❑ P
Emphysema? ❑ Y ❑ N ❑ P
Pain on breathing? ❑ Y ❑ N ❑ P
Shortness of breath at night? ❑ Y ❑ N ❑ P
Tuberculosis? ❑ Y ❑ N ❑ P
Sputum? ❑ Y ❑ N ❑ P
Wheezing ❑ Y ❑ N ❑ P
Bronchitis? ❑ Y ❑ N ❑ P
Pleurisy? ❑ Y ❑ N ❑ P
Difficulty breathing? ❑ Y ❑ N ❑ P
Shortness of breath? ❑ Y ❑ N ❑ P
. . .lying down? ❑ Y ❑ N ❑ P

Cardiovascular

Heart disease? ❑ Y ❑ N ❑ P
High/Low Blood Pressure? ❑ Y ❑ N ❑ P
Blood clots? ❑ Y ❑ N ❑ P
Phlebitis? ❑ Y ❑ N ❑ P
Rheumatic Fever? ❑ Y ❑ N ❑ P
Swelling in ankles? ❑ Y ❑ N ❑ P
Angina? ❑ Y ❑ N ❑ P
Murmurs? ❑ Y ❑ N ❑ P
Fainting? ❑ Y ❑ N ❑ P
Palpitations/Fluttering? ❑ Y ❑ N ❑ P
Chest pain? ❑ Y ❑ N ❑ P

For the Following, Please Check the Appropriate Response Based on the Key Below:

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Gastrointestinal

Trouble swallowing?..... ❑ Y ❑ N ❑ P
Change in thirst?..... ❑ Y ❑ N ❑ P
Change in appetite? ..... ❑ Y ❑ N ❑ P
Nausea/vomiting..... ❑ Y ❑ N ❑ P
Ulcer?..... ❑ Y ❑ N ❑ P
Jaundice (yellow skin)?..... ❑ Y ❑ N ❑ P
Gall Bladder disease?..... ❑ Y ❑ N ❑ P
Liver Disease?..... ❑ Y ❑ N ❑ P
Hemorrhoids?..... ❑ Y ❑ N ❑ P

Heartburn?..... ❑ Y ❑ N ❑ P
Abdominal pain or cramps?..... ❑ Y ❑ N ❑ P
Belching or passing gas? ..... ❑ Y ❑ N ❑ P
Constipation? ..... ❑ Y ❑ N ❑ P
Diarrhea? ..... ❑ Y ❑ N ❑ P
Bowel Movements: How often?_____
Is this a change? _____
Black stools?..... ❑ Y ❑ N ❑ P
Blood in stool? ..... ❑ Y ❑ N ❑ P

Urinary

Pain on urination?..... ❑ Y ❑ N ❑ P
Frequency at night?..... ❑ Y ❑ N ❑ P
Frequent infections?..... ❑ Y ❑ N ❑ P

Increased frequency? ..... ❑ Y ❑ N ❑ P
Inability to hold urine?..... ❑ Y ❑ N ❑ P
Kidney stones?..... ❑ Y ❑ N ❑ P

Musculoskeletal

Joint pain or stiffness?..... ❑ Y ❑ N ❑ P
Broken bones? ..... ❑ Y ❑ N ❑ P
Muscle spasms or cramps?..... ❑ Y ❑ N ❑ P

Arthritis? ..... ❑ Y ❑ N ❑ P
Weakness?..... ❑ Y ❑ N ❑ P
Sciatica? ..... ❑ Y ❑ N ❑ P

Blood / Peripheral Vascular

Easy bleeding or bruising?..... ❑ Y ❑ N ❑ P
Deep leg pain?..... ❑ Y ❑ N ❑ P
Varicose veins? ..... ❑ Y ❑ N ❑ P

Anemia?..... ❑ Y ❑ N ❑ P
Cold hands/feet? ..... ❑ Y ❑ N ❑ P
Thrombophlebitis?..... ❑ Y ❑ N ❑ P

Male Reproduction

Hernias? ..... ❑ Y ❑ N ❑ P
Testicular pain?..... ❑ Y ❑ N ❑ P
Venereal disease?..... ❑ Y ❑ N ❑ P
Are you sexually active?..... ❑ Y ❑ N

Impotence?..... ❑ Y ❑ N ❑ P
Premature ejaculation? ..... ❑ Y ❑ N ❑ P
Birth control? Type? _____

Testicular masses? ..... ❑ Y ❑ N ❑ P
Prostate disease? ..... ❑ Y ❑ N ❑ P
Discharge or sores? ..... ❑ Y ❑ N ❑ P
Chlamydia?..... ❑ Y ❑ N ❑ P
Gonorrhea? ..... ❑ Y ❑ N ❑ P
Condyloma? ..... ❑ Y ❑ N ❑ P
Herpes?..... ❑ Y ❑ N ❑ P
Syphilis?..... ❑ Y ❑ N ❑ P

For the Following, Please Check the Appropriate Response Based on the Key Below:

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Female Reproduction/Breasts

Age of first menses? _____

Age of last menses? (if menopausal) _____

Length of cycle? _____ days

Duration of menses? _____ days

Painful menses?..... ❑ Y ❑ N ❑ P

Heavy or excessive flow?..... ❑ Y ❑ N ❑ P

PMS?..... ❑ Y ❑ N ❑ P

If yes, what are your symptoms? _____

_____

_____

Endometriosis?..... ❑ Y ❑ N ❑ P

Ovarian cysts?..... ❑ Y ❑ N ❑ P

Uterine fibroids ..... ❑ Y ❑ N ❑ P

Difficulty conceiving? ..... ❑ Y ❑ N ❑ P

Cervical Dysplasia?..... ❑ Y ❑ N ❑ P

Sexual difficulties?..... ❑ Y ❑ N ❑ P

Gonorrhea?..... ❑ Y ❑ N ❑ P

Herpes?..... ❑ Y ❑ N ❑ P

Are you sexually active?..... ❑ Y ❑ N ❑ P

Do you do breast self exams?..... ❑ Y ❑ N ❑ P

Breast pain/tenderness?..... ❑ Y ❑ N ❑ P

Date of last annual exam/ PAP _____

Are cycles regular? ..... ❑ Y ❑ N

Bleeding between cycles? ..... ❑ Y ❑ N ❑ P

Pain during intercourse? ..... ❑ Y ❑ N ❑ P

Clotting?..... ❑ Y ❑ N ❑ P

Discharge?..... ❑ Y ❑ N ❑ P

Birth control?..... ❑ Y ❑ N ❑ P

What type?_____

Number of pregnancies: _____

Number of live births:_____

Number of miscarriages:_____

Number of abortions: _____

Number of IUIs or IVFs: _____

Menopausal symptoms? ..... ❑ Y ❑ N ❑ P

Abnormal PAP?..... ❑ Y ❑ N ❑ P

Chlamydia?..... ❑ Y ❑ N ❑ P

Condyloma? ..... ❑ Y ❑ N ❑ P

Syphilis?..... ❑ Y ❑ N ❑ P

Breast lumps?..... ❑ Y ❑ N ❑ P

Nipple discharge?..... ❑ Y ❑ N ❑ P

Is there anything else you would like to add or comment on?

_____

_____

_____

_____

_____

_____

_____

Thank you for your time and effort.
We look forward to providing you with the best possible care.

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naturopathic medicine & acupuncture

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Pittsburgh, PA 15216
412-571-9355

Dear New Patient,

Welcome to our clinic. We look forward to providing for your health needs and encourage your questions and participation in all aspects of your health care.

_____ Payment for all services and dispensary items is due at the time of the visit.
Initials

_____ We are not providers on insurance plans, therefore you may be required to bill your own insurance. We will provide you with all the necessary information for you to send your claim for reimbursement. You have the primary relationship with your insurance company and are responsible for the entire amount that is owed.
Initials

_____ Out of courtesy for our wait list patients, please call the office to **cancel your appointment at least 24 hours in advance**. This allows us to provide care to our patients that need our services as soon as possible. If you fail to comply, you will be responsible for your office visit payment in full.
Initials

_____ I give permission for the staff at Trillium Natural Medicine to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.
Initials

_____ I have read Trillium Natural Medicine's Privacy Practices (found on website or in office).
Initials

As the patient, you are responsible for the total charges incurred for each visit. We accept MasterCard, VISA, Debit cards, checks, and cash. There will be a charge of $20.00 for every returned check(s). We do arrange payment plans.

You recognize, understand and agree that your health care provider is a sole practitioner and is not a partner or otherwise affiliated with any other health care provider who may be providing similar services at Trillium Natural Medicine. You further recognize, understand and agree that your health care provider is solely responsible for and shall provide all professional services to you, and you are relying solely on your practitioner's skill for the professional services rendered at Trillium Natural Medicine.

Your Naturopathic doctor or Acupuncturist may prescribe natural medicine, which may be purchased either at Trillium Natural Medicine or elsewhere. Most insurance companies do not cover the medicinary items that we prescribe and dispense.

I have read and understand the above-stated policies and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

_____
Print your name (parent name if minor & patient name)

_____
Your Signature (parent signature if minor) Date

Trillium Natural Medicine, LLC
naturopathic medicine & acupuncture

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Informed Consent and Request for Naturopathic Medical Care, Acupuncture & Classical Chinese Medicine Treatment

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Maureen D. Tighe, N.D., L.Ac., M.S.O.M. and/or Yasmin Fakih, L.Ac. having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with Naturopathic Medicine, Classical Chinese Medicine (CCM) by Dr. Maureen D. Tighe, ND, L.Ac, MSOM, Yasmin Fakih and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called *allied health care provider*. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Maureen D. Tighe, ND, L.Ac, MSOM, Yasmin Fakih, L.Ac. and/ or with the *allied health care provider* providing backup:

1. My suspected diagnosis(es) or condition(s)
2. The nature, purpose, goals and potential benefits of the proposed care
3. The inherent risks, complications, potential hazards or side effects of treatment or procedure
4. The probability or likelihood of success
5. Reasonable available alternatives to the proposed treatment procedure
6. Potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Trigger point injection therapy with vitamin substances
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)

The scope of practice of acupuncture is outlined below. I understand that Classical Chinese medicine and Acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Use of electrical, mechanical and magnetic devices
- Moxa (indirect burning of herbal material in the form of a loosely compacted herb or stick

- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Gua sha (rubbing on an area of the body with a blunt or round instrument)
- Dietary advice (based on traditional Chinese medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials)

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies; allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor- stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer: For your safety it is vital to alert your provider, Dr. Maureen D. Tighe, ND, L.Ac, MSOM or Yasmin Fakih, L.Ac., of these conditions.

_____ I understand that Dr. Maureen D. Tighe, ND, L.Ac, MSOM and Yasmin Fakih, L.Ac. are not licensed to prescribe any controlled substances.
Initials

_____ I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.
Initials

_____ I understand that Dr. Maureen D. Tighe, ND, L.Ac, MSOM and Yasmin Fakih, L.Ac. are not psychologists or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies.
Initials

I do not expect Dr. Maureen D. Tighe, ND, L.Ac, MSOM, Yasmin Fakih, L.Ac. and/or any *allied health care provider* to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Tighe and Yasmin Fakih, L.Ac. explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

Printed Name of Patient	Signature of Patient
Printed Name of Guardian	Signature of Guardian
Date Signed	Print Provider's Name