

trillium
NATURAL MEDICINE
naturopathic medicine & acupuncture

3043 West Liberty Ave.
Pittsburgh, PA 15216
412.571.9355

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

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? _____

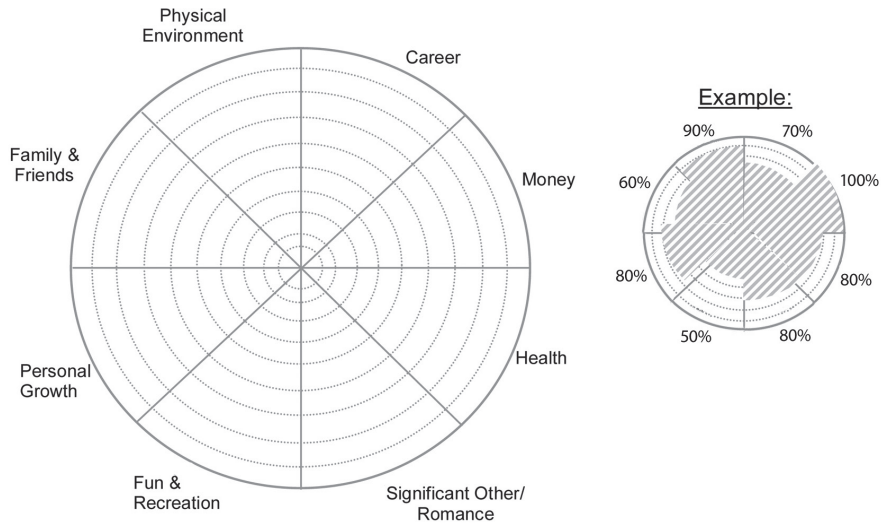
6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

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. _____

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

If yes, what? _____

Have you tested positive for Hepatitis B, HIV or other blood borne illnesses? Yes No

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 environmental or chemicals? _____

Current Medications

Do you take or use?

- | | | |
|---|--|--|
| Antacids <input type="checkbox"/> Yes <input type="checkbox"/> No | Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No | Appetite suppressants <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone <input type="checkbox"/> Yes <input type="checkbox"/> No | Laxatives <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain relievers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No | Tranquilizers <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid medication <input type="checkbox"/> Yes <input type="checkbox"/> 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

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

Review of Systems

Mental / Emotional

- | | | | |
|--------------------------------------|--|-------------------------------|--|
| Treated for emotional problems?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Depression? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Mood Swings? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Anxiety or nervousness? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Considered/Attempted suicide? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Tension? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Poor concentration? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Memory problems? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

Immune

- | | | | |
|-----------------------------------|--|----------------------------------|--|
| Reactions to immunizations?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Reactions to vaccinations? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Chronic Fatigue Syndrome? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Chronic infections? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Chronically swollen glands? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Slow wound healing? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

Endocrine

- | | | | |
|----------------------------|--|---------------------------------|--|
| Hypothyroid? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Heat or cold intolerance? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Hypoglycemia? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Diabetes? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Excessive thirst? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Excessive hunger? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Fatigue? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Seasonal depression? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Neurologic | | | |
| Seizures? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Paralysis? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Muscle weakness?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Numbness or tingling? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Loss of memory? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Easily stressed?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Vertigo or dizziness?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Loss of balance? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

Skin

- | | | | |
|--------------------|--|---------------------------|--|
| Rashes?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Eczema, Hives? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Acne, Boils? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Itching? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Color Change?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Perpetual Hair Loss?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Lumps?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Night Sweats? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

Head

- | | | | |
|-----------------|--|------------------------|--|
| Headaches?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Head Injury? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Migraines?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Jaw/TMJ problems | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

Eyes

- | | | | |
|------------------------|--|----------------------------|--|
| Spots in Eyes?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Cataracts?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Impaired vision? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Glasses or contacts? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Blurriness? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Eye pain/strain?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Color blindness? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Tearing or dryness?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Double Vision?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Glaucoma? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

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

Ears

- Impaired hearing? Y N P Ringing? Y N P
Earaches? Y N P Dizziness?..... Y N P

Nose and Sinuses

- Frequent colds?..... Y N P Nose Bleeds?..... Y N P
Stiffness?..... Y N P Hayfever?..... Y N P
Sinus problems? Y N P Loss of smell? Y N P

Mouth and Throat

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

Neck

- Lumps?..... Y N P Swollen glands? Y N P
Goiter? Y N P Pain or stiffness?..... Y N P

Respiratory

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

Cardiovascular

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

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

Gastrointestinal

- | | | | |
|------------------------------|--|-----------------------------------|--|
| Trouble swallowing?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Heartburn? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Change in thirst?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Abdominal pain or cramps?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Change in appetite? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Belching or passing gas? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Nausea/vomiting..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Constipation? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Ulcer?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Diarrhea? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Jaundice (yellow skin)?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Bowel Movements: How often? _____ | |
| Gall Bladder disease? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Is this a change? _____ | |
| Liver Disease? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Black stools?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Hemorrhoids?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Blood in stool? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

Urinary

- | | | | |
|-------------------------------|--|-------------------------------|--|
| Pain on urination?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Increased frequency? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Frequency at night?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Inability to hold urine?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Frequent infections?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Kidney stones?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Musculoskeletal | | | |
| Joint pain or stiffness?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Arthritis? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Broken bones? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Weakness? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Muscle spasms or cramps?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Sciatica? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

Blood / Peripheral Vascular

- | | | | |
|---------------------------------|--|------------------------|--|
| Easy bleeding or bruising?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Anemia? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Deep leg pain?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Cold hands/feet? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Varicose veins? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Thrombophlebitis?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

Male Reproduction

- | | | | |
|-------------------------------|--|---------------------------|--|
| Hernias? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Testicular masses? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Testicular pain?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Prostate disease? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Venereal disease?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Discharge or sores? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Are you sexually active?..... | <input type="checkbox"/> Y <input type="checkbox"/> N | Chlamydia?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Impotence?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Gonorrhea? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Premature ejaculation? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Condyloma? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Birth control? Type? _____ | | Herpes?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| | | Syphilis?..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

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

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? _____

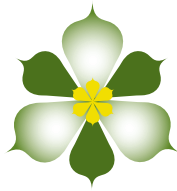
Endometriosis?..... Y N P
Ovarian cysts?..... Y N P
Uterine fibroids..... Y N P
Difficulty conceiving?..... Y N P
Cervical Dysplasia?..... Y N P
Sexual difficulties?..... Y N P
Gonorrhea?..... Y N P
Herpes?..... Y N P
Are you sexually active?..... Y N P
Do you do breast self exams?..... Y N P
Breast 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.*



trillium
 NATURAL MEDICINE
 naturopathic medicine & acupuncture

3043 West Liberty Ave.
 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.
Initials 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.

_____ You will be charged a Missed Appointment Fee for the full amount of the visit for any missed appointments or late cancellations (less than 48 hours notice).
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

_____ Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Your naturopathic doctor or acupuncturist 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.
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).

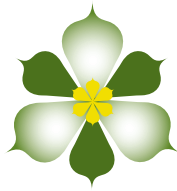
Your Naturopathic doctor or Acupuncturist may prescribe natural medicine, which may be purchased either at Trillium Natural Medicine or elsewhere. Most insurance companies do not cover the medicinary items that we prescribe and dispense.

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
naturopathic medicine & acupuncture

3043 West Liberty Ave.
Pittsburgh, PA 15216
412.571.9355

***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 to be 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. 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 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 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)
- 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)
- 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 devices including heat lamps
- 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 of these conditions.

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

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

_____ I understand that Dr. Maureen D. Tighe, ND, L.Ac, MSOM is not an MD, psychologist or psychiatrist. She is not
Initials licensed in Pennsylvania to diagnose disease or prescribe pharmaceutical drugs. She can make nutritional, herbal, homeopathic and lifestyle recommendations and can diagnose and treat Chinese medicine patterns of disharmony.

I do not expect Dr. Maureen D. Tighe, ND, L.Ac, MSOM 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. Maureen D. Tighe, ND, L.Ac, MSOM 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