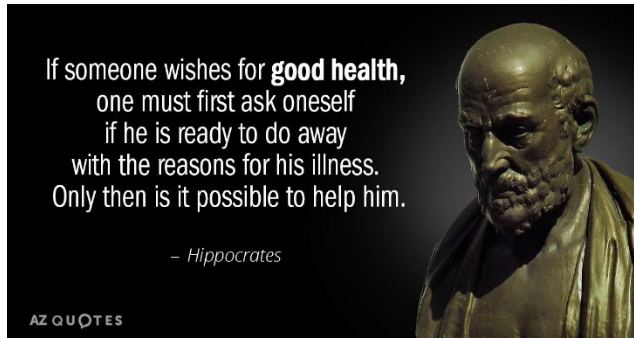
GLOW HEALTH NATUROPATHIC WELLNESS NEW CLIENT AND CONSENT FORM



WE WELCOME YOU!

A visit to a Traditional Naturopath may be different from any other health care practitioner visit you have had. We not only want to know about what initially brought you into our office, but we want to know as much as we can about you. Many challenges today are not caused by a single, specific event, but often are a compilation of many factors that have shaped your health over the years, such as diet, stress, environment, pathogens, toxic loads, exercise, beliefs, and sleep to name a few. We take all of this into consideration in working with you to help you achieve optimal health.

If you are running a fever or in case of a contagious illness, please call as soon as possible to reschedule.

If you are currently taking **any medication and/or supplements,** please bring them with to your initial visit so we know exactly what you are taking.

If you have any **current lab test results (within the last 6 months)**. If you do not have any copies, we are happy to have you fill out a records release and get those at a later date.

Please **arrive 10-15 minutes before your visit** so we can get your paperwork ready.

FEE SCHEDULE POLICY

Payment is due the time of services. Please initial

______I understand **I am responsible for payment in full at the time/day of session**. If you do not have the means to pay the day of the session, the session with be rescheduled with a 25.00$ reschedule fee that must be paid before the next appointment.

_______I understand **time is valuable and out of respect for staff and other clients,** I am aware that **I am responsible for arriving on time.**

______I understand there will be a fee of 50.00$ for missed appointments that are not due to emergencies or are not cancelled 24 hours in advance. This charge will be applied to your account and must be paid before your next appointment.

Your first appointment is 60-90 minutes but can run over.
______ I understand the Initial Consultation $295.00. This includes any extended written/emailed consultation materials/handouts.

______ I understand the Follow up Consultation $85.00/per 30min. This includes any extended written/emailed consultation materials/handouts.

______I understand Blood Lab Work Review Consultation $85.00/per 30min. This includes any extended written/emailed consultation materials/handouts.

Please note: A few quick questions pertaining to your consultation under 5min can be addressed via phone/text/email. Anything beyond this, we ask you to respectfully schedule a Naturopathy Consultation.

If you intend to pay by credit card, please provide your credit card details and sign below. I

____ authorize Anastiscia Lang, Naturopath, BCTN, Glow Health to charge my credit card for sessions, fees, any outstanding feed as mentioned above if necessary, including outstanding cancellation fees. Invoice/statements will appear as Glow Health.

Name on credit card:

Mastercard Visa Other: ________________________________

Number:

Expiration Date: 3-digit code:

Signature: Signature of Parent/Guardian:

I intend to make payment via (circle one) Zelle Venmo Cash Check

I understand that:

A Traditional Naturopath specializes in wellness. That is to say, teaching clients how applying natural lifestyle approaches can act to facilitate the body's own natural healing and health building potential. The traditional naturopath does not undertake to "diagnose" or "treat diseases," "or cure," but rather recognizes that the majority of sub-health conditions are cumulative effects, and that the underlying cause of what we call "disease" (or, "dis-ease") are factors which cause biological imbalances leading to a weakening of the bodies' natural defenses and subsequent breakdown in health.

The practice of Traditional Naturopathy is recognized as a common occupation at the Federal level (U.S. Congress 1928, 1929, 1930 and 30 Federal Court rulings between 1958 and 1978) and as such it is a profession protected under the 14th and 9th Amendments of the U.S. Constitution. Several states have also made this stipulation either by statute or in the Courts. Anastiscia Lang is a California Borad Certified Naturopath with the California Naturopathic Certification Board as well as a sitting board member.

I understand that:

A Traditional Naturopath uses natural approaches to health with evidence-based techniques for health concerns and detoxification. Instead of focusing on just one aspect of the person, or taking a one size fits all methodology, holistic wellness evaluates the complete health history, emotional state, lifestyle habits, environment, beliefs, and current diet habits of an individual to determine the root cause of his or her health concerns.

INFORMED CONSENT FOR CONSULATATION AND WELLNESS CARE

I hereby request Holistic Nutrition and or Traditional Naturopathic therapies, including nutritional consultations, and other procedures including various modes of holistic nutrition and traditional naturopathy and diagnostic procedures including laboratory testing, on me (or the client named below, for whom I am legally responsible) by Naturopath Anastiscia Lang, BCTN, Traditional Naturopath.

I do not expect the Naturopath/Nutritionist to be able to anticipate and explain all the risks and complications and I wish to consult with the Naturopath to exercise judgment during the course of the session which they feel at the time, based upon the facts then known, is in my best interest.

Some of the potential risks and benefits could include but are not limited to: allergic reactions and other side effects to suggested herbs and supplements; aggravation of pre-existing symptoms discomfort, pain, detox reactions like nausea, light headedness headaches, fatigue etc., inconvenience of lifestyle changes.
If you experience any symptoms let us know immediately.

Potential benefits include but are not limited to restoration of health and wellness and the body's maximal functional capacity without the use of drugs or surgery; relief of pain

and symptoms of health issues, assistance in injury and health issue recovery; and prevention of health challenges or progression.
I agree that I am accepting or rejecting this care of my own free will and choice. I understand that, as with any optimal wellness plan, there is no guarantee that this provides complete resolution to any or all the conditions I may have. I also understand that it is inherent in the practice of Traditional Naturopathy/ Holistic Nutrition **that the client is ultimately responsible for the choices made, whether to follow the advice and guidance or not.** **"There is nothing the Naturopath can do that will overcome what the client will not".**

I am not an agent of any private, local, county, state or federal agency attempting to gather information without stating my intentions.

I have read and/or have had read to me, the above consent. With this knowledge, I voluntarily consent to Traditional Naturopathic consultations/ Holistic Nutrition consultations, realizing that no guarantees have been given to me by Glow Health Wellness/ Lake Tahoe Wellness Center or any of its personnel, regarding improvement of my condition. I intend this consent form to cover the entire course of my wellness plan for my present condition and for any future conditions for which I seek guidance.

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless required by law.

Signature:

Print Name:

Date:

Right to Receive Confidential Communications.
Information Confidentiality
You have the right to request that we use a certain method to communicate with you or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
All your medical records are confidential and if you would like your information shared with another health care professional or family member you must put that request in writing.

Other Permitted or Required Disclosures • As Required by Law. We must disclose protected health information about you when required to do so by law. • Public Health Activities. We may disclose your protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability. • Victims of Abuse, Neglect or Domestic Violence. We may disclose your protected health information to government agencies about abuse, neglect or domestic violence. • Health **Oversight Activities**. We may disclose protected health information to government oversight agencies (e.g. state insurance departments) for activities authorized by law. • Judicial and Administrative Proceedings. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process. • Law Enforcement. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime. • Coroners or Funeral Directors. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. • Research. Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been

taken to protect your privacy. • To Avert a Serious Threat to Health or Safety. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. • Special Government Functions. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities. • Workers' Compensation. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

FEE SHEDULE

Payment is required at the time of service.

Traditional Naturopathy Consultation $295.00.
Traditional Naturopathy Follow up/ Blood and Lab Work Review $85.00/30min.

All returned checks will be assessed as a $35.00 charge in addition to the payment fees covered by that check.

Cancellation Policy

Please give a minimum of 24hrs cancellation notice out of courtesy for staff and other clients. Anything less that this or missed appointments without 24hrs notice are subject to a $50.00charge.

Confidential Client Information

Please fill in all portions of this form printing clearly and legibly to ensure accuracy.

Today's Date:

Client name: ____

Age: _______ Birthdate____/____/___ SS#______________________

Mailing Address: ___________________________________ City: _____________
State: ____ Zip: _________

Physical Address: __________________________________ City: _____________
State: ____ Zip: _________ Home phone: ___________________ Work phone:
___________________ Cell phone: __________________

Marital Status: _______________________

Occupation: _____________________Employer: ____________________ Referred by:
____

Work Address: ____________________________________ City: ______________
State _______ Zip ______

Name and phone# of nearest relative not living with you:
____

Name of spouse (or parent for minor child): ________________________________
SS# ______________________

Emergency Contact person and email/ phone
number:____

CASE HISTORY

What brings you to the office today?

How do you hope your life will change as a result of working holistically?

What are the most significant changes you have made to improve your health?

What gives you joy in life?

What would make life more joyful for you?

Health Concerns: What are your major health problems/concerns?

Date of onset/Description/all information you feel helpful

1.

2.

3.

4.

5.

6.

7.

8.

____Are your problems getting progressively worse? Yes___ No___

Are your problems interfering with your: Work___ Daily routine___ Sleep___ All___ Other

If your condition involves pain, please characterize type: Ache___ Sharp___ Radiating___ Constant___ Intermittent___ Please rate the amount of pain you are generally experiencing (circle one): Minor 1 2 3 4 5 6 7 8 9 10 Severe Previous

Treatment for Health Problems:

Name of Doctor/hospital Address

Date first seen: ___________________ Date last seen:____________________________________

What tests were done, including x-rays, blood work, MRI, CT?

Pertinent test results?

Condition or Diagnosis?

How was the condition treated?

Health Maintenance Update

Please indicate approximate dates and results of last:

Physical examination____
Spinal examination____Dental examination____Dental X-ray____Cholesterol profile____Other blood tests (such as PSA) List here. Or copies.

Chest X-ray____Spinal X-ray____
Bone Density (DEXA) Scan____
Mammogram or

Thermogram____ Eye exam____Colonoscopy or flexible sigmoidoscopy____Other:

Please list medications/supplements/foods/environmental allergies/chemical allergies/toxic exposures/ or intolerances and the reactions you have experienced to them:

Pets:

Animal Allergies/ Reactions:

Surgical History: Please chronologically indicate all major and minor surgeries you have undergone and their approximate dates:

Any medical implant devices:

Any issues:

Were you breastfed or bottle-fed? If breastfed, please indicate duration: _____________________ Was your home life during childhood and adolescence loving and supportive, or were there significant stresses?

Please check if you had any of the following childhood illnesses: Frequent ear infections___ Ear tubes ____ Colic___ Eczema___ Recurrent colds___ Bronchitis___ Pneumonia___ Meningitis___ Other___ Were you on frequent or prolonged antibiotic therapy? Other:

Did you receive standard immunizations? or any recent immunizations or Covid immunizations? What were they/ and dates?

Did you experience any adverse reactions to immunizations? What?

Conditions: Fever____Chills____ Feel cold____Feel hot____Sinus issues____ Throat issues____ Coughing issues_____ Flu ___ Appendicitis ___Allergies ___Alcohol/drug addiction ___Anemia ___Arthritis – rheumatoid or osteo ___Asthma ___ Auto-immune disease ___Cancer ___Chronic Fatigue Syndrome ___Headaches/Migraines___Chicken Pox ___ Chronic Infection ___ Circulatory problems ___ Colitis ___ Dental Problems ___ Depression ___Diabetes ___ Eating disorder ___ Eczema ___Excessive dental tartar ___Epilepsy ___Eye, ear, nose throat problems ___ Environmental Sensitivities ___ Fibromyalgia ___ Food Intolerance ___ Gastric Reflux ___ Glaucoma ___ Gout ___ Gall Bladder issues__Heart attack ___ Heart disease ___ High blood pressure ___ Low blood pressure___High cholesterol ___ Inflammatory Bowel Disease ___ Irritable Bowel Syndrome ___ Kidney or bladder disease ___ Learning disabilities ___ Liver or gallbladder disease (gallstones) ___Mental Illness ___Migraine Headaches ___ Neurological problems (Parkinson's, MS etc.) ___ Periodontal disease ___ Psoriasis ___ Sinus Problems ___ Stroke ___ Thyroid trouble ___ Obesity ___ Osteoporosis/Osteopenia ___ Pleurisy ___ Pneumonia ___ Sexually transmitted disease ___ Seasonal Affective Disorder ___ Skin problems/Rashes ___ Tuberculosis ___ Ulcer ___ Urinary tract infection ___Varicose Veins____Thyroid issues/disease____ Emotional issues____Joint problems_____Tremors____Dizzy_____Please list past or present exposure to harmful

chemicals: (this includes solvents, paints, varnishes, heavy metals, industrial waste, pesticides, herbicides, molds etc.):

Other Information to add regarding Conditions:

new home remodeling -carpeted or re-painted your house or installed a new deck or other flooring or any other work on your house? If so, what and when?

Use of chemical home products?

Do you have mercury amalgam fillings? ___________ How many? ______________ How long? _______________ Do you eat fish regularly? __________ What type: Do you eat organic produce? ___________ If not, why not?

Do you eat organic/free range meats? ___________________ If not, why not?

Family Health History

Please review the conditions listed below. Indicate those that are current health problems of a family member by writing the letter C under his/her column. Use a letter P to indicate a past problem. Spaces that do not apply should be left blank.

Condition Father Age ____ Mother Age ____ Spouse Age ___ Brother/s Ages _______ Sister/s Ages _____ Children Ages _____

Alcoholism/Addiction Alzheimer's Disease Allergies/hay fever Arthritis Asthma Cancer (indicate type) Depression Diabetes Digestive problems Heart disease High blood pressure Insomnia Kidney problems Liver disease Mental health problems Migraine Osteoporosis Other (indicate) Other (indicate) If any of the above family members are deceased, please list their age at death and cause:

Other major conditions that run in your family:

Lifestyle Habits Please check major stresses:

Job___ New retirement___ New baby___ Change of marital status___ Health problems___ Family stress___ Financial concerns___ Abusive relationship___Other:

Please describe your occupation:

Please describe the quality of major relationships in your life:

Please indicate job satisfaction: Excellent___ Good___ Fair___ Poor___

Sleep: sleeping pills:_________ Time arise:______ Time retire:_____
Naps:________________ Difficulty falling asleep? ______ Staying asleep? ________
Quality of sleep: Well-rested___ Tired upon awakening___ Awaken during night___
Sleep in total darkness_____ Sleep with some light in room______ Is your sleep disturbed at the same time each night? ____ If yes, what time? _____ Frequency of vacations:_____/year Travel frequency:
____
__ Is your present sex life satisfactory: Yes___ No___ If not, why not?
____ Have you experienced physical, emotional, sexual, or verbal abuse? Yes___ No___

Exercise: Type____
Frequency________________________________ How do you relax or relieve stress?
Exercise: Type____
Frequency________________________________ How do you relax or relieve stress?

Diet History

Coffee yes/no ________ Type: Decaf ____ Regular _____ Organic ______
(amount/day):____
___ Tea yes/no ______ Type: Regular_____ Decaf Black ______ Green _____ Herbal ______ (amount/day):
____
Soda pop yes/no ______ Type:
____

(amount/day):____ __________ Liquor: None___ Type and amount per day and week:______________________________________ Present or former history of alcohol overuse? Yes___ No___ Tobacco: None___Chew or smoke and amount per day:______________________________________ Number of years using tobacco:___________Date(s) quit:____________________________________

Current or Former history of recreational drug use? No___ Yes___ Please specify type and history.

Typical breakfast: ____Typical lunch: ____Typical dinner: ____ Typical snacks: ____ How many meals/snacks per typical day? ____ Frequency of dining out:___________ Frequency of eating fast food: __________________________ Quantity of water consumed/day:__________ Is your water filtered? Yes___ No___ Foods you avoid:

____ Foods you crave:

Foods you dislike:

____ History of eating disorder? Yes___ No___ Your weight today?

Digestive Function: Describe any food intolerances you have:

Bowel movement frequency: ____ Do you usually have to strain to have a bowel movement? Yes___ No___

Do you ever have blood with bowel movements? Yes___ No___

Are your stools ever black or tarry or bloody? Yes___ No__

Describe stool type and color:

What type of diet do you currently follow?

Last time you received antibiotics: ____

Please use this space to tell us about anything you feel it is important for us to know about you, your health, your condition, your goals that may not have been covered in the previous pages.

PLEASE LIST ALL CURRENT PRESCRIPTION MEDICATIONS AND DOSAGES BELOW:

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

7) ____

PLEASE LIST ALL CURRENT OVER THE COUNTER MEDICATIONS AND DOSAGES (ie: aspirin, allergy medications, stomach medications etc)

1) ____

2) ____

3) ____

4) ____

PLEASE LIST ALL CURRENT NUTRITIONAL, HERBAL OR HOMEOPATHIC SUPPLEMENTS AND DOSAGES (ie: vitamins, anti-oxidants, hormone balancers) Include brand name. Use the back of the page if additional room is needed.

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

7) ____

8) ____

Women Only

Gynecologic History	**Yes**	**No**	**Details**
Age your period began:			**Abnormal Pap smear? Date:**
Menopause			If yes, date of last period:
Perimenopause			If yes, describe symptoms:
Ovaries removed (one/both)			If yes, when:
Uterus removed			If yes, when:
DES – did your mother take it during pregnancy?			
Are you still menstruating?			**If yes, complete the section below; if no, skip that section**

Menstruation	**Yes**	**No**		**Yes**	**No**
Regular periods			Bleeding between periods		

Irregular menses Symptoms:			Spotting		
Cramps / # of days: Mild___ moderate___ severe____			Midcycle spotting		
PMS / # of days: Symptoms:			Spotting instead of period		
Oral contraceptives (past/present)			Weight gain (how many lbs)		
Periods every _____days (length of cycle) Duration: _____ days (flow days) Flow: heavy__ medium___ light___					
Date your last 6 periods began: _____ ______ ______ ______ ______ _____					

Pelvic Exam	
Date of last pelvic exam:	Performed by:
Date of last PAP smear:	Result:
Recurrent vaginal yeast infections Yes____ No ____	Are you sexually active: Yes____ No ______

Breast Health	**Yes**	**No**		**Yes**	**No**
Breast pain			Fibrocystic breast disease		
Breast lumps			Do you perform monthly breast exam on yourself?		
History of abnormal mammogram			Currently breastfeeding		
Nipple discharge			Breast implants / Type:		
Date of last mammogram: **Results:** **Location of diagnostic center:**					

Pregnancy	**Yes**	**No**		**Yes**	**No**
Currently pregnant			Planning pregnancy (If yes, when:)		
Desire pregnancy			Pregnancy complications (If yes, describe)		
Prior pregnancies: #___ Births #___ C-Sections #__ Miscarriages #___ Abortions #____					

Female Hormone Imbalance Rating

Please rate the severity of the symptom(s) or condition **if it's present** by rating it on a **Wellness Gauge Scale 0 to 10**
when 0 = symptom is not present ☺ and 10 = symptom is severe ☹

	Abdominal pain		Fibroids		Mood swings
	Allergies		Fluid retention		Night sweats
	Anger easily		Food cravings/binge eating		Ovarian cyst(s)
	Back pain		Heavy menstrual bleeding		PMS
	Bloating		Vaginal dryness		Rheumatoid arthritis
	Chronic stress		Hot flashes		Skin problems
	Depression		Insomnia		Spotting
	Disinterest in sex/low sex drive		Irregular menstrual cycle		Subfertility
	Endometriosis		Irritable or anxious		Other:
	Fatigue		Meat eater (rate frequency)		
	Fibrocystic breast disease		Menstrual migraines		
				TOTAL SCORE:	

Past or Present Condition (0 = none, 10 = yes)

	Ovarian Cancer		Infertility (never able to conceive)
	Uterine Cancer		Loss of height/ bone loss
	Cervical Cancer		Miscarriage
	Breast Cancer		Premature menopause (<45 yrs old)
	Estrogen/Progesterone sensitive Cancer		Pain with intercourse
			TOTAL SCORE:
			GRAND TOTAL SCORE:

OTHER INFO:			

	Estrogen/Progesterone sensitive Cancer		Pain with intercourse
			TOTAL SCORE:
			GRAND TOTAL SCORE:

	Yes	**No**		**Yes**	**No**
Breast lump			DES – did your mother take it during pregnancy?		
Lump in testicle			Date of last genital exam:		
Penis discharge			Date of last prostate exam:		
Sore on the penis			Date of last PSA test: Result:		
Erection difficulties					

Men Only

	Yes	**No**		**Yes**	**No**
Breast lump			DES – did your mother take it during pregnancy?		
Lump in testicle			Date of last genital exam:		
Penis discharge			Date of last prostate exam:		
Sore on the penis			Date of last PSA test: Result:		
Erection difficulties					

Male Hormone Imbalance Rating

Please rate the severity of the symptom(s) or condition **when it's present** by rating it on a **Wellness Gauge Scale 0 to 10,**
when 0= symptom is not present ☺, 10= symptom is severe ☹

	Abdominal pain		Thinning armpit, head, pubic hair		Urine flow dribbling at the end
	Joint pain/Stiffness		Skin problems/dryness		Blood in urine
	Anger easily		Excessive sweating (day or night)		Urinary incontinence
	Back pain		Mood swings		Pain with urination
	Rheumatoid arthritis		Lack interest in leisure/social activities		Pain with ejaculation
	Chronic stress		Low stamina		Bloody ejaculation
	Depression		Difficulty obtaining erection		Pain with intercourse
	Disinterest in sex/low sex drive		Difficulty maintaining erection		Unable to conceive (subfertility)
	Erectile dysfunction		Pain with erection		Mass in genital organs
	Fatigue		Lack of nocturnal erections		Heavy drinking (past/ present)
	Insomnia		Lack of morning erections		Frequent urination
	Irritable or anxious		Urine flow slow to start		Other:
	Food cravings/binge eating		Weak urine stream		
	Breast enlargement		Unable to void bladder completely		
				TOTAL SCORE:	

Past or Present Condition (0 = none, 10 = yes)

	History of mumps infection		Infertility (never able to conceive)
	History of mass in genitalia		Loss of height/bone loss
	History of testicular/scrotal surgery		Cancer: (list type)
	Developmental issues w/sex organs		Other:
	Family history of prostate cancer		**TOTAL SCORE:**
			GRAND TOTAL SCORE:

Other added information:

Other therapies currently doing:

Other added information:

Date:

Time:

Signature: