IV THERAPY & INJECTION HISTORY
DR.PRESTON, ND

***** Please be sure to read and sign the last two pages of this form *****

Name____ **Date**___________________

Address______________________________________ **Date of birth**__________________

City__________ **State** _______ **Zip.**_____________ **Phone (H)(**_____**)**_______________

e-Mail address______________________________ **Phone (W)(**_____**)**_______________

As these are not considered "secure" communication devices:
Is it acceptable for us to contact you via e-mail? **Yes / No**
Is it acceptable for us to leave messages on a voice mail / answering machine for you? **Yes / No**

Occupation____

Employers name: ____

How were you referred to us? ____

If under 18, Parent or Guardian name(s): ____

Name and phone number of someone we may contact in an emergency______________________________

CONSENT TO TREAT

I understand that the treatment provided is determined by the professional discretion of my naturopathic doctor. Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children or those with multiple medications. It is very important that you inform Dr. Preston immediately of any disease process that you are suffering from or if you are taking any medications. If you are pregnant or you are breast-feeding please inform me as well. It is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements because they may be toxic when taken in large doses. I will immediately notify the doctor if I become aware that I am pregnant.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to temporary aggravation of pre-existing symptoms, allergic reactions to herbs or supplements, bruising and bleeding from injection/IV therapies.

I will immediately inform the doctor if I experience any gastrointestinal upset, allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur.

I have read, or have had read to me, the above information and I consent to receiving naturopathic medical care from the above mentioned naturopathic doctor 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. Signing below means I consent to treatment

CYNTHIA**PRESTON**
NATUROPATHIC DOCTOR

PATIENT INITIALS _______Date_______

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Gender: Male Female Marital status: ____

Current height: __________ Weight: ___________ Last physical examination:______________

Are all vaccines current?____________ Have elected to decline vaccination______________

Last chest X-Ray:________________________ Last blood tests:_________________________

Last eye examination:______________________ Last dental visit:________________________

***If adult*, when was your last:**

Pneumonia vaccine: _______________ Tetanus booster:_______________ Flu vaccine: ____________

Any other diagnostic tests in the past 3 years, if so what and when:_______________________

____

____

*****If child*, last well child visit:____**

*****If male*, last prostate exam / PSA evaluation:____**

*****If female*, last Pap test:__________, physical exam: __________, breast exam:____________**

Last mammogram:_______________________. Do you do self breast exams ? Yes / No

__________________________ ______________________________ _____________________

__________________________ ______________________________ _____________________

__________________________ ______________________________ _____________________

__________________________ ______________________________ _____________________

Please list any past surgeries / hospitalizations: (include approximate date)

____ ____

____ ____

____ ____

CYNTHIA**PRESTON**
NATUROPATHIC DOCTOR

Do you have a family history of any of the following diseases: (Check those that apply)

	Brother/Sister	Mother	Maternal GM	Maternal GF	Father	Paternal GM	Paternal GF
Diabetes							
Cancer							
Heart Disease							
Stroke							
Other							

When was your last medical care: ____

Who did you see at that time: ____

Who is your primary care medical provider: ___________________________________

Please list *ALL your known ALLERGIES*; Drug, Food, Insect, Animal, etc.:

____

____

The following pages are for health history information: Please fill out all areas that apply to you and your case. If you are in for URGENT / ACUTE CARE, these can be filled in later. Turn to the last page and read / sign it.

I have questions about:

Diet **Exercise** **Vaccinations** **My current medications**

Prevention of____

Please add comments as needed to clarify the symptoms listed, leave blank any which do not apply.

Rate the following as : 1 = three or four times yearly, _ 2 = monthly, _ 3 = once a week, _ 4 = Daily

HEAD:

1 2 3 4 Headaches
1 2 3 4 Dry Scalp
1 2 3 4 Acne
1 2 3 4 Dizzy

____

____

EYE / EAR / NOSE / THROAT:

1 2 3 4 Vision blurry
1 2 3 4 Dry eyes
1 2 3 4 Dark circles under eyes
1 2 3 4 Earwax builds up
1 2 3 4 Earaches
1 2 3 4 Hearing loss
1 2 3 4 Ringing in ears
1 2 3 4 Sinus pain / infection
1 2 3 4 Nose / sinuses dry
1 2 3 4 Nose runs
1 2 3 4 Seasonal allergies
1 2 3 4 Voice hoarse
1 2 3 4 Sore throat
1 2 3 4 Postnasal drip
1 2 3 4 Nose bleeds

CHEST:

1 2 3 4 Heart pounds
1 2 3 4 Heart "flutter"
1 2 3 4 Shortness of breath
1 2 3 4 Asthma (Triggered by ______________________)
1 2 3 4 Chest pains
1 2 3 4 Wheezing
1 2 3 4 Coughing

Diagnosed heart / cardiovascular disease: _______________

____

____

GASTROINTESTINAL:

1 2 3 4 Heartburn
1 2 3 4 Stomach aches
1 2 3 4 Gas / Bloating
1 2 3 4 Fatty meals bother
1 2 3 4 Constipation
1 2 3 4 Diarrhea
1 2 3 4 Blood or Mucus in stools
1 2 3 4 Vomiting
1 2 3 4 Hemorrhoids

Bowel movements:

___ Daily, ___ Other

1 2 3 4 Increased appetite
1 2 3 4 Decreased appetite

URINARY TRACT:

1 2 3 4 Bladder infections
1 2 3 4 Kidney infections
1 2 3 4 Burning with urination
1 2 3 4 Frequent urination
1 2 3 4 Blood in urine
1 2 3 4 Urinary incontinence (**Constant** **Occasional**)

____

MUSCULO-SKELETAL:

1 2 3 4 Joint pains
1 2 3 4 Back pain **Upper** **Lower** **All**
1 2 3 4 Neck pain
1 2 3 4 Muscle aches
1 2 3 4 Bruising **Easy** **Only with trauma**
1 2 3 4 Sprains Locations:____________________
1 2 3 4 Joint stiffness
1 2 3 4 Arthritis

Diagnosed with Fibromyalgia **YES** **NO** **When**_____

NEURO-ENDOCRINE:

1 2 3 4 Panic / Anxiety attacks

1 2 3 4 Irritability

1 2 3 4 Feel bad when not eating regularly

1 2 3 4 Weight gain

1 2 3 4 Weight loss

1 2 3 4 Mood swings

1 2 3 4 Snack often

1 2 3 4 Increased thirst

1 2 3 4 Insomnia

1 2 3 4 Feel restless at bedtime

1 2 3 4 Wake up easily at night

My stress level weekly averages: **1-2-3-4-5-6-7-8-9-10**

(1 is low – 10 is high)

ENERGY

1 2 3 4 Sleep soundly

1 2 3 4 Wake rested

1 2 3 4 Feel energetic in the morning

1 2 3 4 Heart races

1 2 3 4 Easy fatigue

1 2 3 4 Feel down / depressed

1 2 3 4 Poor memory

1 2 3 4 Slow starter

1 2 3 4 Afternoon tiredness

1 2 3 4 Tired all day

1 2 3 4 Tired, no matter how much I sleep

Do you smoke **Yes No**
How many drinks with alcohol do you have weekly: _______

Circle things you eat MORE than 3 times a week:

TUNA OTHER FISH RAW VEGETABLES

CHEESE WHEAT PRODUCTS SOY PRODUCTS

RAW NUTS/SEEDS POULTRY RED MEAT

MALE ONLY: Circle what applies to you.

Frequent urination (Specify**: Day Night**)

Incomplete urination

Discharge from urethra

Trouble initiating urination

Hernias (Specify: **Current Past**)

Decrease in sex drive

Erectile difficulty

Rectal burning / itch

FEMALE ONLY: Circle what applies to you.

PMS symptoms_________________________________

Duration: **1 - 2 - 3 – ALL : Week(s) before period**

Menses painful Heavy flow Light flow

Menses change (duration, regularity, flow, pain)

Avg. cycle length **22-25 days**, **26-30 days**, **other**_____

Date last period started: ___________________________

Menopause Began: ______________________________

CYNTHIAPRESTON
NATUROPATHIC DOCTOR

Financial Policies Statement ~ Cynthia Preston, ND

Please read and sign this form

1. Health insurance is a contract between you and the insurance carrier. We require payment for services when rendered, unless one of the following is applicable: It is a **Workers Compensation** claim

   It is a claim being handled by an attorney, and we have a signed lien

2. Co-Payments (and or co-insurance amounts) are due on the date of service

3. If a collection service becomes necessary for payment of the account, you agree to pay all collection fees in addition to any balances due.

4. A late fee of 1.5% per month may be added to delinquent balances.

5. **Medicare: Medicare does NOT cover services or supplies provided in this office.**

6. If the doctor must do any physical exam outside of vitals, this will be considered a full initial visit and payment of $275 will be required. This is up to the doctors discretion for your safety and care as IVs are an invasive procedure and you must be well enough and have the correction substances used. IV Consults are ONLY a short visit for patients to qualify and make sure you are healthy enough for an IV. You may be required to come back if more intensive medical evaluation is required.

7. **Release of information:** *By signing this, I give this office permission to release information required by law or insurance regulation to insurance agencies involved in my case. This **does not** give permission for any other release of information by this office, which has not been authorized by me.*

8. Some Lab testing and other services (such as IV therapy) may not be covered by your insurance. It is your responsibility to verify coverage for such services, or alert our office if there are questions regarding a specific service. Once such services are rendered or ordered they become your financial responsibility.

I have read, understand, and agree to the above policies:

_______________________________________ ____________________

Signature (Parent / Guardian, if under 18 years old) Date