Brad West, N.D. Inc
244 Oak Meadow Dr. Los Gatos, CA 95032
(831) 332-0143 and (408) 359-7804

INFORMATION FOR HEALTH RECORD

DATE _____ EMAIL _____

PATIENT'S FULL NAME _____
(FIRST) (MIDDLE) (LAST)

BIRTHDATE _____ PLACE_____ _____ AGE _____

ADDRESS _____
(STREET) (CITY) (ZIP)

HOME PHONE # _____WORK/CELL PHONE #_____

OCCUPATION/EMPLOYER _____ _Location_____

Marital Status: M S W SPOUSE'S NAME_____# of Children/Ages:_____
(OR PARENT IF PATIENT IS A MINOR)

IN CASE OF EMERGENCY _____
(NAME) (Relationship) (PHONE)

DRIVERS LICENSE # _____(for checks) Credit Card #_____Exp____
Sec code____ (HIPAA protected)
PERSON RESPONSIBLE FOR PAYMENT _____($50 charge for missed appointments without 48 hours notice)

RELATIONSHIP TO PATIENT _____

WHO RECOMMENDED US TO YOU? _____

INSURANCE _____
(we are a low cost "cash practice", meaning we do not bill insurance but provide a Superbill for your own submission and files. A paper check is the preferred payment form, thank you.)

PAYMENT IN FULL IS EXPECTED AT THE TIME OF THE OFFICE VISIT.
If this is not possible, please let us know prior to the visit so that arrangements may be discussed.

REASON FOR VISIT:

SIGNATURE _____

Brad West, N.D. Inc.
244 Oak Meadow Drive
Los Gatos, CA 95032

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 and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not. I have the right to request a copy of the NOTICE OF PRIVACY PRACTICES**,** which discusses my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

I have had or will have 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 risk of poor outcomes of these practices by the doctor, though rare, are inherently feasible and 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 herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. 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 (by phone) if I experience any severe 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. 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 or will have 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)_____Date:_____

PATIENT SIGNATURE _____(or Patient Representative)
Indicate relationship if signing on behalf of patient _____

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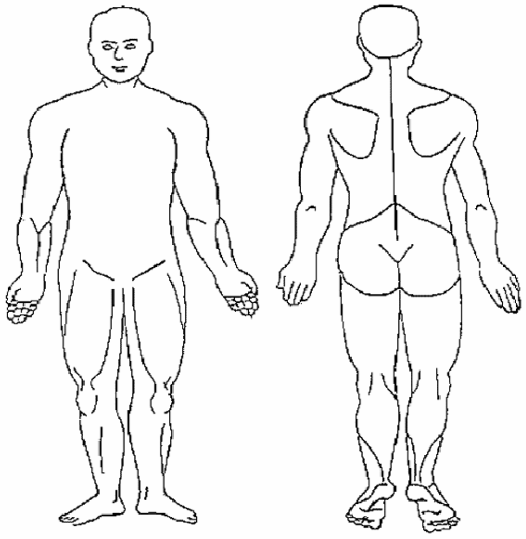
PATIENT PROFILE

Last Name: _____ First Name: _____

Height_____ Weight now_____ Ideal_____ At age 20____ Blood Type___

A note to our patients: Please complete this *two-sided* questionnaire as thoroughly as possible. This is a confidential record of your medical information and will not be released, except under the guidelines of the Notices of Privacy Practices.

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	When did it start? How? Why?	Indicate painful or distressed areas:
1.		
2.		
3.		
4.		
5.		

What goals do you have for your visit at the clinic today? _____

_____

Have you ever consulted a Naturopathic Doctor or other alternative medicine provider before?_____

_____

Do you have any questions about our clinic or the care that you've chosen today? _____

_____

Please list prescription medications that you are currently taking, with dosages:

1._____ 2._____ 3._____ 4.

_____ 5._____ 6._____ List

vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. see Dr Brad's Supplement Schedule if possible and list there. 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

Do you have any allergies (medications, topicals, foods, etc.) that are severe or life threatening: **YES** **NO**
If yes, please describe: _____

_____

Personal Habits:
Please circle the following substances that you have used more than once in the past month:

Tobacco (Smoke / Chew) **Coffee/ Black tea / Cola**

Alcohol **Recreational drugs**

Do you follow any particular diet regimens or restrictions? If yes, please describe in detail:_____

_____

_____

Do you exercise regularly? **Yes** **No** What type?_____

How long?_____How often? _____

Rank your level on a scale of 1-10 for most weeks: (10 is best except for stress which 10 is highest)

Stress_____ Sleep_____ Energy_____

Mood_____ Appetite_____

_____

When are you hungry?_____ Cravings?_____When do you eat?
(list times for most days (meals and snacks):_____

Daily normal bowel movements?_____How many per day or week?_____Complaints or issues?_____

_____

Serious Injuries/Chronic Illnesses: _____

_____

Date of last physical/annual exam _____ Date of last blood tests: _____

Doctors name:_____

Personal and Family History:
Please check the "Self" box next to each condition that applies to you and please list closest family members who have each of the following conditions. Please note whether condition applied in the past (P) or is currently applicable (C).

	Self	P/C	Relation	P/C		Self	P/C	Relation	P/C
Alcohol/Drug Addiction					Headaches				
Allergies					Heart Disease				
Anemia					Hepatitis				
Arthritis					High Blood Pressure				
Asthma					Kidney Disease				
Cancer					Mental Illness				
Depression					STDs				
Diabetes					Stroke				
Eczema					Tuberculosis				
Epilepsy					Other:				

Past Medical History:

Mark an **X** in the box next to any of the following that you have now or ever had. To the right of the disease write the approximate time(s) of occurrence, using your age(s), date(s), or approximate time period such as, "in high school". Since many of these "diseases" are really broad categories, please write to the right of the disease any other comments that might be helpful to us such as the type, cause or exact diagnosis if known.

- ☐ Anemia
- ☐ Blood Clot Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Alcoholism
- ☐ Osteoporosis
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Neurologic Disease
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Asthma
- ☐ Pneumonia
- ☐ Stomach or Duodenal Ulcer
- ☐ Eating Disorder
- ☐ Pancreatitis
- ☐ Lyme Disease
- ☐ Liver Disease
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Kidney Infection
- ☐ Bladder Infection
- ☐ Uterine Fibroid
- ☐ Ovarian Cyst
- ☐ Physical Handicap _____
- ☐ Congenital Disease
- ☐ Hernia (location) _____
- ☐ Mold Exposure
- ☐ Other _____

Note: Surgeries, Infections, and Reproductive problems are covered in other sections

Infectious Diseases

Mark an X in the box and note approximate date of infection if beyond normal childhood timing.

☐ Mononucleosis	☐ Polio
☐ Chicken Pox	☐ Measles
☐ German Measles	☐ Mumps
☐ Scarlet Fever	☐ Malaria
☐ Tuberculosis	☐ Hepatitis A
☐ Rheumatic Fever	☐ Hepatitis B
☐ Other _____	☐ Hepatitis C

If you think you night have AIDS, or desire an AIDS test simply discuss it with us confidentially.

Hospitalizations: Describe reasons and dates for past hospitalizations and surgeries; list fractures and other major injuries. Do not include normal vaginal deliveries. _____

_____

_____

☐ If you need more room mark an X in the box and use back and bottom of this form.

Allergies to Medications:

_____

_____

Other Allergies: (i.e. foods, dust, cats)

_____

_____

_____

Menses (woman only):

Please try to describe the frequency of your menstrual cycle.
Example "every 28 to 32 days"
Approx. date of Menopause: _____
Or if still menstruating, please describe your menstrual flow: Number of heavy days_____
Light days_____ Total days _____
Do you feel it is excessively heavy_____
Unusually light_____
How would you rate your menstrual cramps?
None Moderate Severe Variable (circle range)

_____

_____

_____

_____

_____

(Print and fill out one page below, corresponding to sex and if over age 13)

Health Check – Women's Symptom Review

Please review the symptom check list below and indicate any symptoms you are experiencing

Symptom	none	mild	moderate	severe	
Hot Flashes					Low Estrogen
Night Sweats					
Vaginal Dryness					
Incontinence					
Bleeding Changes					Estrogen Dominance
Uterine Fibroids					
Water Retention					
Tender Breasts					
Fibrocystic Breasts					
Increased Forgetfulness					
Foggy Thinking					
Tearful					
Depressed					
Mood Swings					
Stress					Adrenal
Morning Fatigue					
Difficulty Sleeping					
Decreased Stamina					
Anxious					
Irritable					
Nervous					
Fibromyalgia					
Allergies					
Headaches					
Sugar Cravings					
Dizzy Spells					
Cold Body Temperature					Thyroid
Goiter					
Hoarseness					
Hair Dry or Brittle					
Nails Breaking or Brittle					
Constipation					
Slow Pulse Rate					
Rapid Heartbeat					
Heart Palpitations					
Infertility Problems					
Acne					Metabolic Syndrome High Androgens
Increased Facial/Body Hair					
Scalp Hair Loss					
Weight Gain – Hips					
Weight Gain – Waist					
High Cholesterol					
Elevated Triglycerides					
Decreased Libido					Low Androgens/ Other
Decreased Muscle Size					
Thinning Skin					
Ringing in Ears					
Rapid Aging					
Aches and Pains					
Bone Loss					

Health Check – Men's Symptom Review

Please review the symptom check list below and indicate any symptoms you are experiencing

Symptom	none	mild	moderate	severe	
Decreased Urine Flow					Estrogen Dominance
Increased Urinary Urge					
Prostate Problems					
Weight Gain – Chest / Hips					
Weight Gain – Waist					
Decreased Libido					Metabolic Syndrome/ Low Androgens
Decreased Erections					
Ringing in Ears					
High Cholesterol					
Elevated Triglycerides					
Hot Flashes					
Night Sweats					
Decreased Mental Sharpness					
Increased Forgetfulness					
Decreased Muscle Size					
Decreased Flexibility					
Sore Muscles					
Increased Joint Pain					
Bone Loss					
Rapid Aging					
Thinning Skin					
Decreased Stamina					
Burned Out Feeling					Adrenals
Stress					
Morning Fatigue					
Evening Fatigue					
Difficulty Sleeping					
Apathy					
Depressed					
Mental Fatigue					
Anxious					
Irritable					
Nervous					
Headaches					
Sugar Cravings					
Dizzy Spells					
Cold Body Temperature					Thyroid/ Other
Goiter					
Hoarseness					
Hair Dry or Brittle					
Constipation					
Slow Pulse Rate					
Rapid Heartbeat					
Heart Palpitations					
Infertility problems					
Allergies					