Dr. Joanne Feaster, NMD
Patient Informed Consent Form

A Naturopathic Medical Doctor uses natural therapies and medication for the purpose of treatment and prevention of illness and disease.
A case history will be taken, and physical examinations, including the testing of blood and urine may be necessary. Other complaint oriented physical examinations/testing may be necessary. Naturopathic treatment includes acupuncture, hydrotherapy, far infrared sauna, homeopathy, massage, manipulation, nutritional intervention, botanical prescription, medication, parenteral therapy (IV, IM, intradermal, subcutaneous), chelation, minor surgery and physical therapy.

Informing your doctor of any disease process which you are suffering from and any medications/over the counter drugs which you are currently taking or have taken is very important. Please advise your doctor immediately: if you are pregnant, suspect you are pregnant or if you are breast-feeding.
As a patient, you will receive information about your diagnosis and/or treatment, alternative courses of action, the material costs, expected benefits, risks, side effects, and in each case the consequences of not having the diagnosis and/or treatment and alternative courses of action acted upon.

There are some health risks associated with treatment by naturopathic medicine. These may include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs or medications, including IV therapeutics
- Pain, bruising or injury from venipuncture or acupuncture or parental therapy or minor surgery
- Possibility of accidental death as a result of intravenous therapy or chelation
- Fainting, or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa, localized reddening of the skin or bruising from cupping
- Muscular pain, strains and sprains, disc injuries from manipulation
- The potential for stroke is a concern with neck (cervical) manipulation

I understand;

- 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 law requires it or I give my written consent. I realize that in rare instances courts may subpoena my medical records, which means that my records will have to be released.
- The physician will have to report me in the following instances: when I am in imminent danger of harming myself or others, when there is reasonable suspicion that I am neglecting and/or emotionally, physically, or sexually abusing a minor.
- I may access my medical records at any time, and can request a copy, by doing so in advance and by paying the appropriate fee.
- The clinic does not guarantee treatment results. I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I voluntarily consent to diagnostic and therapeutic procedures mentioned above.
- The clinic is not responsible or liable for any referrals to other doctors, lawyers or laboratories.
- I am responsible for payment of services rendered if not covered by my insurance policy and any fees incurred during the collection of this payment.

I recognize that this consent form covers the entire course of my treatment.
With this consent, I have the knowledge that I have the right to refuse treatment, or discontinue treatment at any time, for any reason, should I choose to do so.
I have read this statement and agree to work within its guidelines, including the limits of confidentiality.

Please PRINT Patient Name:_____

Signature of PATIENT or Guardian:_____Date:_____

Patient Information Form

Name:_____ SSN:_____-____-_____

Insurance Provider:_____ Policy #:_____

Date of Birth:_____ Age:_____

Birthplace:_____

Home address_____
(street)

_____
(city/town) (state) (zip code)

Phone:_____
(home) (work) (other)

May we leave messages at your home phone number relating to your appointments?

_____ Emergency contact & phone #:_____

Email address:_____ _____

Current
Medications:_____

_____

Past Medications (include date and duration):_____

_____

_____

Current Supplements:_____

_____

Past Supplements (please include date and duration):_____

Please list all surgeries and hospitalizations (date and duration):_____

_____

_____

_____

Major Illnesses/Diseases:_____

_____

_____

Family History:
Please list family member(s) with any of the following illnesses:

Cancer:_____
Heart disease:_____
High blood pressure: _____
High cholesterol: _____
Diabetes:_____
Obesity:_____
Depression:_____
Dementia: _____
Mental illness:_____
Congenital (mental/physical):_____
Autoimmune disease/disorder: _____

List Other Doctors/Family Physicians/Specialists:_____

_____

_____

_____

Pharmacy: _____

Allergies: _____

Patient Review of Systems Form

Y = a condition you have NOW
P = a condition you had in the PAST
N = a condition you NEVER had

Responses and Comments:

1. GENERAL				
Weight				
Weight 1 year ago				
Maximum weight				
When?				
Height				
Fatigue/Weakness	Y	P	N	
Fever/Chills	Y	P	N	

2. SKIN				
Rashes	Y	P	N	
Eczema, hives	Y	P	N	
Acne, boils	Y	P	N	
Itching	Y	P	N	
Color change	Y	P	N	
Lumps	Y	P	N	
Night sweats	Y	P	N	
Dryness/Moistness	Y	P	N	
Temperature	Y	P	N	
Nail changes	Y	P	N	
Change in Mole	Y	P	N	
Skin Cancer	Y	P	N	

3. HEAD				
Headache	Y	P	N	
Head injury	Y	P	N	
Dizziness	Y	P	N	

4. EYES				
Impaired vision	Y	P	N	
Glasses/Contacts	Y	P	N	
Eye pain	Y	P	N	
Tearing or dryness	Y	P	N	
Double vision	Y	P	N	

Glaucoma	Y	P	N	
Cataracts	Y	P	N	
Blurring	Y	P	N	
Bothered by sun	Y	P	N	
Itching	Y	P	N	
Redness	Y	P	N	
Discharge	Y	P	N	
Blind spot	Y	P	N	

5. EARS				
Impaired hearing	Y	P	N	
Earache	Y	P	N	
Dizziness	Y	P	N	
Discharge	Y	P	N	
Infections	Y	P	N	

6. NOSE and SINUSES				
Frequent colds	Y	P	N	
Nose bleeds	Y	P	N	
Stuffiness	Y	P	N	
Hay fever	Y	P	N	
Sinus problems	Y	P	N	

7. MOUTH and THROAT				
Frequent sore throat	Y	P	N	
Sore tongue/mouth	Y	P	N	
Gum problems	Y	P	N	
Hoarseness	Y	P	N	
Dental cavities	Y	P	N	
Loss of taste	Y	P	N	

8. NECK				
Lumps	Y	P	N	
Swollen glands	Y	P	N	
Goiter	Y	P	N	
Pain or stiffness	Y	P	N	
Decreased range of motion	Y	P	N	

9. RESPIRATORY				
Cough	Y	P	N	

Sputum	Y	P	N	
Spitting up blood	Y	P	N	
Wheezing	Y	P	N	
Asthma	Y	P	N	
Bronchitis	Y	P	N	
Pneumonia	Y	P	N	
Pleurisy	Y	P	N	
Emphysema	Y	P	N	
Difficulty breathing	Y	P	N	
Pain on breathing	Y	P	N	
Shortness of breath	Y	P	N	
Shortness of breath at night	Y	P	N	
Shortness of breath lying down	Y	P	N	
Tuberculosis	Y	P	N	
Tuberculin Test	Y	P	N	
Last Chest Xray?				

10. CARDIOVASCULAR				
Heart disease	Y	P	N	
Angina	Y	P	N	
High blood pressure	Y	P	N	
Low blood pressure	Y	P	N	
Dizziness upon standing or bending over	Y	P	N	
Murmurs	Y	P	N	
Rheumatic fever	Y	P	N	
Chest pain	Y	P	N	
Swelling in ankles	Y	P	N	
Palpitations, fluttering	Y	P	N	
Cyanosis	Y	P	N	
Past ECG	Y	P	N	
Other heart tests?				

11. BREASTS				
Do you do self exams?	Y	P	N	
Lumps	Y	P	N	
Pain or tenderness	Y	P	N	
Nipple discharge	Y	P	N	

12. GASTROINTESTINAL

Trouble swallowing	Y	P	N	
Heartburn	Y	P	N	
Change in thirst	Y	P	N	
Change in appetite	Y	P	N	
Nausea	Y	P	N	
Vomiting	Y	P	N	
Vomiting blood	Y	P	N	
Bowel movements - How Often?				
Is this a change?	Y		N	
Blood in stool	Y	P	N	
Belching or passing gas	Y	P	N	
Jaundice (yellow skin)	Y	P	N	
Liver disease	Y	P	N	
Gall bladder disease	Y	P	N	
Ulcer	Y	P	N	
Indigestion	Y	P	N	
Diarrhea	Y	P	N	
Rectal bleeding	Y	P	N	
Hemorrhoids	Y	P	N	
Black, tarry stool	Y	P	N	
Abdominal pain	Y	P	N	
Food allergy	Y	P	N	
Hernias	Y	P	N	

13. URINARY				
Pain on urination	Y	P	N	
Increased frequency	Y	P	N	
Frequency at night	Y	P	N	
Inability to hold urine	Y	P	N	
Frequent infections	Y	P	N	
Kidney stones	Y	P	N	
Blood in urine	Y	P	N	
Urgency	Y	P	N	
Hesitancy	Y	P	N	

14. MALE REPRODUCTIVE				
Hernias	Y	P	N	
Testicular masses	Y	P	N	
Testicular pain	Y	P	N	

Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Veneral disease	Y	P	N	
Discharge or sores	Y	P	N	
15. FEMALE REPRODUCTIVE				
Age menses began?				
Age menopause began?				
Symptoms related to menopause?				
Menses - average number of days?				
Length of cycle?				
Bleeding between periods	Y	P	N	
Are cycles regular	Y	P	N	
Pain during intercourse	Y	P	N	
Painful menses	Y	P	N	
Excessive menstrual flow	Y	P	N	
PMS	Y	P	N	
Birth control?	Y	P	N	
What type/brand?				
Number of pregnancies?				
Number of live births?				
Number of miscarriages?				
Number of abortions?				
Difficulty conceiving	Y	P	N	
Are you sexually active	Y	P	N	
Sexual difficulties	Y	P	N	
Venereal disease	Y	P	N	
Last menstrual period?				
Vaginal discharge	Y	P	N	
Vaginal itching	Y	P	N	
Last PAP - date?				

16. MUSCULOSKELETAL				
Joint pain or stiffness	Y	P	N	
Arthritis	Y	P	N	
Broken bones	Y	P	N	
Muscle spasms or cramps	Y	P	N	
Weakness	Y	P	N	
Joint swelling	Y	P	N	
Backache	Y	P	N	

17. PERIPHERAL VASCULAR				
Deep leg pain	Y	P	N	
Cold hands/feet	Y	P	N	
Varicose veins	Y	P	N	
Thrombophlebitis	Y	P	N	
Leg cramps	Y	P	N	
Extremity numbness	Y	P	N	
Extremity coldness	Y	P	N	
Extremity swelling	Y	P	N	
Extremity ulcers	Y	P	N	

18. NEUROLOGIC				
Fainting	Y	P	N	
Seizures/Convulsions	Y	P	N	
Paralysis	Y	P	N	
Muscle weakness	Y	P	N	
Numbness or tingling	Y	P	N	
Loss of memory	Y	P	N	
Involuntary movement	Y	P	N	
Loss of balance	Y	P	N	
Speech problems	Y	P	N	

19. ENDOCRINE				
Heat or cold intolerance	Y	P	N	
Thyroid trouble	Y	P	N	
Excessive thirst	Y	P	N	
Excessive hunger	Y	P	N	
Excessive urination	Y	P	N	
Excessive sweating	Y	P	N	
Diabetes	Y	P	N	
Hypoglycemia	Y	P	N	
Hormone therapy	Y	P	N	

20. BLOOD/LYMPHATIC				
Anemia	Y	P	N	
Easy bleeding or bruising	Y	P	N	
Past transfusions	Y	P	N	
Lymph node swelling	Y	P	N	

21. ALLERGIC HISTORY				
Drug sensitivity	Y	P	N	
Reaction to vaccine	Y	P	N	
Allergies? Please list				

22. EMOTIONAL				
Depression	Y	P	N	
Mood swings	Y	P	N	
Anxiety or nervousness	Y	P	N	
Tension	Y	P	N	
Phobias	Y	P	N	
Alcohol/Drug abuse	Y	P	N	
Insomnia	Y	P	N	

23. HOBBIES/HABITS			
Please answer yes (Y) or no (N)			
Do you eat three meals daily?	Y	N	
Do you consume water daily?	Y	N	
How many cups per day?			
Do you awake rested?	Y	N	
Do you sleep well?	Y	N	
Do you average 6-8 hours sleep?	Y	N	
Do you enjoy your work?	Y	N	
Do you watch television?	Y	N	
How many hours/day?			
What are your main interests and hobbies?			
Do you read?	Y	N	
Do you exercise?	Y	N	
Forms of exercise?			
How many times/week?			
Do you take vacations?	Y	N	
History of cigarette smoking? When? How much?	Y	N	
Do you use recreational drugs? What? How often?	Y	N	
How often do you consume alcoholic beverages?			