4525 S Lakeshore Dr Ste 101, Tempe, AZ 85282
info@drlauralambert.com P: 602-688-4325 F: 602-680-5778

Date: _____

Name: _____Age:_____Date of Birth:_____Gender: M F

Address:_____

City_____ State_____ Zip Code_____

Home Phone: _____ Work Phone: _____

Cell Phone:_____ At which numbers is it ok to leave a message?_____

Email Address:_____

Marital Status: ___Single ___Married ___Partnership ___Separated ___Divorced ___Widowed

If married, years married to present spouse: _____

Live with:___ Spouse___Partner ___Parents ___Children ___Friends ___Alone ___Roommate

Occupation:_____ Hours per week:_____ Do you like your job?

Emergency Contact:_____

Relationship:_____ Phone:_____

Are you currently receiving healthcare? Y N

If yes, where and from whom?

If no, when and where did you last receive medical or health care?

What was the reason?

What do you expect from this visit?

Are you willing to make lifestyle and diet changes?

How did you hear about our clinic?

Health Concerns:

What are your most important health concerns? How long have these problems persisted? Please list in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

General

Height: _____ Weight _____lbs. Weight one year ago_____ lbs.

Maximum Weight_____lbs. When?_____

List Yes (Y), No (N), or Past (P) regarding the use of the following:

Antacids: Y N P Steroids: Y N P Smoking: Y N P Packs per day / Number of years_____

Analgesics: Y N P Laxatives: Y N P Coffee: Y N P Cups per day if Yes / Past:_____

Soda: Y N P Ounces per day if Yes / Past:_____

Alcohol: Y N P How often & how much if Yes / Past:_____

Any Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P

Recreational Drugs: Y N P Any Drug Addictions: Y N P Any Drug Treatment: Y N P

Do you follow a special diet? _____

Exercise

How often do you exercise?_____ For How Long?_____

What type of exercise?_____

Sleep

How many hours per night? _____ If you wake, what is the reason?_____

Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P

Allergies

Drugs (please specify reaction):_____
Foods: _____
Environmental sensitivities: _____

Hospitalization and Surgery

List any major illnesses, hospitalizations and/or operations you have had (include year):

_____

_____

X-rays and Special Studies

X-rays, CAT scans, or other imaging you have had:

Electrocardiogram	Y	N	Electroencephalogram	Y	N
Bone Density Scan	Y	N	Mammogram	Y	N

Medications

What medications are you currently taking?

Medications	**Dosage**	**For What**	**How Long**

List any supplements you are currently taking, and why you are taking them:

<u>Family Health History</u>

Do you have blood relatives with any of the following major medical conditions: ***high blood pressure, heart attacks, strokes, asthma/allergies, mental illness, autoimmune disease, diabetes, osteoporosis, cancer, etc.*** Please list relationship, age if living and/or cause of death.

Personal History

For all of the following sections:

Y = a condition you have now **N** = never had **P** = a condition you had previously

Childhood Illnesses					
Scarlet Fever	Y N P	Diphtheria	Y N P	Rheumatic Fever	Y N P
Mumps	Y N P	Measles	Y N P	German Measles	Y N P
Immunizations					
Polio	Y N	Pertussis	Y N	Flu	Y N
Tetanus	Y N	Diphtheria	Y N	Chicken Pox	Y N
Measles/Mumps/Rubella	Y N	Hep B	Y N	H. Influnzae (HIB)	Y N
Musculoskeletal					
Joint pain or stiffness	Y N P	Broken bones	Y N P	Weakness	Y N P
Muscle spasms/cramps	Y N P	Arthritis	Y N P	Sciatica	Y N P
Blood/Peripheral Vasc.					
Easy bleeding/bruising	Y N P	Varicose veins	Y N P	Cold hands/feet	Y N P
Deep leg pain	Y N P	Anemia	Y N P	Clotting disorders	Y N P
Mental/Emotional					
Treated for emotional problems	Y N P	Considered/ Attempted Suicide	Y N P	Anxiety or Nervousness	Y N P
Mood swings	Y N P	Depression	Y N P	Memory problems	Y N P
Poor concentration	Y N P	Tension	Y N P	History of Abuse	Y N
Endocrine					
Hypothyroid	Y N P	Diabetes	Y N P	Heat/Cold intoler.	Y N P
Hyperthyroid	Y N P	Excessive thirst	Y N P	Weight loss/gain	Y N P
Hypoglycemia	Y N P	Fatigue	Y N P	Seasonal Depression	Y N P
Immune					
Chronic swollen glands	Y N P	Chronic Infections	Y N P	Slow wound healing	Y N P
Neurologic					
Seizures	Y N P	Paralysis	Y N P	Loss of balance	Y N P
Numbness or Tingling	Y N P	Loss of memory	Y N P	Dizziness	Y N P
Skin					
Rashes	Y N P	Acne, Boils	Y N P	Lumps	Y N P
Itching	Y N P	Color Change	Y N P	Perpetual hair loss	
Head					
Headaches	Y N P	Migraines	Y N P	Head Injury	Y N P
Jaw/TMJ problems	Y N P				

Eyes					
Spots in Eyes	Y N P	Cataracts	Y N P	Impaired vision	Y N P
Glasses or contacts	Y N P	Blurriness	Y N P	Eye pain/strain	Y N P
Color blindness	Y N P	Tearing or dryness	Y N P	Double vision	Y N P
Ears					
Impaired hearing	Y N P	Ringing	Y N P	Frequent earaches	Y N P
Nose and Sinuses					
Frequent colds	Y N P	Nose bleeds	Y N P	Stuffiness	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	Dental cavities	Y N P	Teeth grinding	Y N P
Sore tongue/lips	Y N P	Gum problems	Y N P	Hoarseness	Y N P
Neck					
Lumps	Y N P	Swollen glands	Y N P	Goiter	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
Short of breath lying down	Y N P	Pneumonia	Y N P	Emphysema	Y N P
Shortness of breath	Y N P	Pain on breathing	Y N P	Tuberculosis	Y N P
Cardiovascular					
Heart disease	Y N P	Chest pain	Y N P	Murmurs	Y N P
High/Low blood pressure	Y N P	Blood clots	Y N P	Fainting	Y N P
Palpitations/fluttering	Y N P	Phlebitis	Y N P	Swelling in ankles	Y N P
Gastrointestinal					
Trouble swallowing	Y N P	Heartburn	Y N P	Change in thirst	Y N P
Change in appetite	Y N P	Nausea	Y N P	Vomiting	Y N P
Vomiting blood	Y N P	Blood in stool	Y N P	Pain or cramps	Y N P
Belching or passing gas	Y N P	Constipation	Y N P	Diarrhea	Y N P
Gallbladder disease	Y N P	Black stools	Y N P	Ulcer	Y N P
Jaundice (yellow skin)	Y N P	Liver disease	Y N P	Hemorrhoids	Y N P
Frequency of bowel movements:					
Urinary & Reproductive					
Pain on urination	Y N P	Incr. frequency	Y N P	Incontinence	Y N P
Frequency at night	Y N P	Frequent infections	Y N P	Kidney stones	Y N P
Condyloma (genit. warts)	Y N P	Chlamydia	Y N P	Gonorrhea	Y N P
Herpes	Y N P	Syphilis	Y N P	HPV	Y N P
Are you sexually active?	Y N	Sexual orientation?		Using birth control? If so, list type:	

Male Reproduction					
Testicular masses	Y N P	Hernias	Y N P	Prostate disease	Y N P
Testicular pain	Y N P	Discharge	Y N P	Impotence	Y N P
Premature ejaculation	Y N P				
Female Reprod./Breast					
Age of first menses		Are cycles regular?	Y N	Length of cycle	
Age of last menses		Duration of menses		Clotting	Y N P
Bleeding between cycles	Y N P	Painful menses	Y N P	Discharge	Y N P
Heavy or excessive flow	Y N P	Ovarian cysts	Y N P	PMS	Y N P
Pain during intercourse	Y N P				
Number of pregnancies		# of Live births		# of miscarriages	
Number of abortions		Abnormal PAP	Y N P	Breast self-exams?	Y N P
Breast pain/tenderness	Y N P	Breast lumps	Y N P	Nipple discharge	Y N P

Sexual Abuse:

Do you have a history of rape, sexual trauma, or incest? If so, when did you have this/these experiences?

_____

_____

Did you seek counseling for this?_____ Have you resolved the emotions around it?

_____

Please feel free to share any personal insights on how your condition affects you, why you think it might be happening, or any other information about your health you would like to add:

_____

_____

_____

On a scale of 1-10, 10 being the strongest commitment, how strongly are you committed to making the necessary changes to achieve your health goals?

1 2 3 4 5 6 7 8 9 10

Welcome! I'm happy to serve you. If you have any questions, please ask!

Consent for Treatment

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 Arizona licensed Naturopathic Doctor. I understand that the methods of treatment are permitted under the Naturopathic Licensure in the state of Arizona, which may include but are not limited to nutritional counseling, acupuncture, botanical medicine, homeopathy, nutritional supplements, oral chelation, hydrotherapy, naturopathic manipulation, intramuscular injections, and IV therapy.

I have had 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 outcomes of these practices by a Naturopathic Doctor 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 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 if I experience any 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. In any event, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.

I understand that it is my right to refuse recommendations and seek out an alternative medical opinion elsewhere without negative consequences on my health care as provided by Dr. Lambert Rampe.

I have read, or have had read to me, the above information and consent. I have also had 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 (18 years or older)	Date
_____	_____
Parent, Guardian, Responsible Party	Date

I agree to provide a 24 hour notice of cancellation for all follow-up appointments. $50 will be charged for if cancellations are made with less than a 24 hour notice. Initial: _____

I agree to accept email from Dr. Lambert as an acceptable form of communication in regards to my healthcare. Email address: _____. Initial: _____

HIPAA and "Privacy Rule"

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information in protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment and health care operations.

Dr. Laura Lambert Rampe respects the privacy of your personal medical records. She will do all we can to secure and protect that privacy. In some cases, she will be asked to submit sections of your medical chart to your health insurance plan (if applicable) or to another practitioner (with a "Release of Records" form signed by you.) If at any point you do not want us to share your personal health information, please submit to us a written request. If we need to request your records from another practitioner, we will ask you to sign a "Release of Records" form before doing so.

Please speak with us or with a HIPAA Compliance Officer if you need more information.

I have read and understand the above statement regarding the "privacy rule".

Signature of Patient: Date:

Print Name: