Dr. Mary Clement / Uptown Natural Medicine
8308 Warren Drive NW
Gig Harbor, WA 98335
253 265-8388

CONFIDENTIAL CLIENT INFORMATION

Name____**Date**______________

Parent/Guardian (if under 18 years old)____

Age _____ **Sex**___________ **Date of Birth**______/______/______

Address____

Home Phone_________________________**Work Phone**_____________________________

Mobile Phone______________________________ **Marital Status** **S** **M** **W** **D**

Circle all phones where we may leave a message. **Home** **Work** **Mobile** **None**

Email address:____

Occupation______________________**Employer**___________________________________

Emergency Contact___________________**Phone Number**___________________________

Referred by______________________**Primary Care Physician**_______________________

____

Please initial the following:

______***I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Dr. Clement will provide a superbill for me at my request to submit to my insurance company for reimbursement.***

_____ ***I understand that Dr. Clement does not bill insurance companies for weight loss management, including hCG.***

_____ ***I agree to pay for all services rendered at the time of service unless covered by insurances listed above.***

______ ***Fee: $240 per hour***

______***Phone calls, email time over 5 mins are billed at the same rate of $240/hr.***

______***A cancellation fee of $75.00 will be charged for no shows or cancellations within 24 hours notice.***

CLIENT SIGNATURE____**DATE**_________

MAIN REASON FOR THIS VISIT:

INFORMED CONSENT FOR TREATMENT

I,____________________________, hereby authorize Dr. Mary Clement to perform any of all of the following specific procedures as they deem necessary to facilitate diagnosis and treatment. I understand that each procedure including the risks and benefits <u>will be discussed with me at the time of treatment.</u>

hCG Diet Protocol; including injections, sublingual hCG, diet recommendations, supplemtation
Homeopathic Medicine: including pellets, liquids, sprays, tinctures.
Physical Medicine: including assessment, laser treatment, electro-stimulation, energetic adjustments.
Lifestyle Counseling: including recommendations for diet, exercise, smoking cessation, stress reduction.
Energetic Medicine: including NET, NAET, EFT, PSE, HR, Cranio-sacral, Polarity, Energetic Balancing.
Prescription Medications: including medicines within the scope of practice of naturopathic medicine.
Clinical Nutrition: including nutritional supplementation and intramuscular injection.
Botanical Medicine: including tinctures, teas, capsules, tablets, crèmes, or suppositories.
Common diagnostic procedures: Consultation in office or by phone, physical examination, including laboratory tests which may include finger stick, urine test, blood work, stool analysis, saliva test, hair analysis, referral for ECG, diagnostic imaging including x-ray, ultrasound, CT and MRI.

I recognize the potential risks and benefits of the procedures as described below.

Potential Risks: allergic reaction to prescribed herbs, supplements and medications; side effects of natural or prescription medications; aggravation of pre-existing conditions; inconvenience of lifestyle changes, bruising or pain from veni-puncture or IM injection, or procedures; temporary increased discomfort from the cold laser treatment,alpha-stim, or electro-block treatment.

Potential Benefits: restoration of mental and physical health, relief of pain and increase of mobility; improvement in sleep quality and energy during the day; prevention of disease or improvement of its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or are suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy. Pregnant women must be under the primary care of a midwife or obstetric physician. Supportive treatments in this office may include selected herbs deemed safe for pregnancy, homeopathy, vitamins, as deemed necessary by Dr. Clement.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Clement or any personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

____________________________ ____
Date Signature of Client

____
Signature of Client Representative or Guardian

____
Witness, Dr. Mary Clement

____
Date

ACKNOWLEDGEMENT OF PRIVACY POLICY

My signature confirms that I have read the information below and have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I understand that this information can and will be used to:

- Provide and coordinate all treatment among a number of health care providers who may be involved in my treatment directly or indirectly.
- Obtain payment form third party payers for my health care services.
- Conduct normal health care procedures.

I have been informed of my right to receive a copy of Dr. Clement's Notice of Privacy Practices and to obtain written acknowledgement, if possible, that I have received it. The notice outlines the types of uses and disclosures that may occur involving my protected health information, describes my rights and explains how I may exercise those rights. I understand that Dr. Clement has the right to change the Notice of Privacy Practices and I may contact this office for a current copy.

I understand that I may request in writing that Dr. Clement restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that Dr. Clement is not required to agree to my requested restrictions, but if she does disagree than she is bound to abide by such restrictions.

____date_____________________
Client's Signature

____
Guardian's/ Representative's Signature

____
Relationship to Client

If you would like more information on HIPAA, go to:
ttp://www.hhs.gov/ocr/privacysummary.pdf

I ________________________________give my permission for Dr. Mary Clement to discuss my case with the following persons:

____relationship____________________

____relationship____________________

____relationship____________________

____relationship____________________

Signed___________________________________ Date__________________________

Name______________________________________ **Date**____________________________

I am taking the following prescription medication

____________________________dosage_________taken for___________________________

____________________________dosage_________taken for___________________________

____________________________dosage_________taken for___________________________

____________________________dosage_________taken for___________________________

____________________________dosage_________taken for___________________________

____________________________dosage_________taken for___________________________

List your nutritional supplements.____

____

____

____

Current Health Concerns:

____

____

____

Surgical History with Surgical dates.

:____

____

____

Allergies to Drugs/Medications :____

FoodAllergies/Sensitivities:____

____

Female Only: Are you pregnant or trying to get pregnant? Yes No: Last Menstrual Period______

Please circle:

Personal History Past and/or Present:

stroke high blood pressure low blood pressure heart disease heart block irregular heart beat
cancer hyperthyroid hypothyroid adrenal disorders insomnia low blood sugar diabetes
gallstones or gallbladder disease liver disease kidney stones or kidney disease alcoholism
Parkinson's Disease dementia/Alzheimer's eating disorder obesity depression anxiety other

Family History Past and/or Present

stroke high blood pressure low blood pressure heart disease heart block irregular heart beat
cancer hyperthyroid hypothyroid adrenal disorders insomnia low blood sugar diabetes
gallstones or gallbladder disease liver disease kidney stones or kidney disease alcoholism
Parkinson's Disease dementia/Alzheimer's eating disorder obesity depression anxiety other

Name____ **Date**_________________________

Physical Activity: Adults.
1) Do you do at least 20 minutes of aerobic exercise 2 or more times a week? ____Yes ____No
2) Do you do resistive (e.g. weights) exercises at least 2 or more times a week? ____Yes ____No
3) Do your job and/or daily responsibilities keep you physically active? ____Yes ____No
4) Do you consider yourself reasonably fit for your age? ____Yes ____No

Sleep:
1) Do you usually get at least 6 hours of uninterrupted sleep per night? ____Yes ____No
2) Do you sleep without significant kicking or jerking? ____Yes ____No
3) Do you sleep without significant snoring or airway obstruction? ____Yes ____No
4) Do you feel rested in the morning upon awakening? ____Yes ____No
5) Do you have to take supplements, OTC or prescription drugs to sleep? ____Yes ____No

Nutrition and Oral Intake Behaviors:
1) Do you consume at least 3 servings of fruits and vegetables per day? ____Yes ____No
2) Do you drink at least 4 (8oz) glasses of water per day? ____Yes ____No
3) Do you regularly eat junk foods/ fast food? ____Yes ____No
4) Do you eat simple carbohydrates (pastas, breads, sugars)? ____Yes ____No
5) Do you regularly eat fatty foods (fries, burgers, butter, cheese)? ____Yes ____No
6) Do you drink alcoholic beverages daily? ____Yes ____No
7) Do you smoke cigarettes/ cigars/ chew? ____Yes ____No
8) Do you drink two or more servings of caffeinated beverages per day? ____Yes ____No
9) Do you use recreational drugs (marijuana, cocaine…)?____Yes ____No

Environmental Exposures:
1) Do you usually avoid drinking unfiltered well or tap water? ____Yes ____No
2) Do you have mercury amalgam fillings? ____Yes ____No
3) Are your home and work place free of excessive toxin exposure? ____Yes ____No
If no, please explain:____
4) Do you microwave and store food in plastic containers? ____Yes ____No

Psychoscocial/Emotional:
1) Do you consider your job/ school and home environment pleasing? ____Yes ____No
2) Has your life been free of emotional/psychological trauma? ____Yes ____No
3) Are you comfortable pushing yourself beyond your comfort zone? ____Yes ____No
4) Do you have hobbies or activities to pass the time? ____Yes ____No
5) Do you generally feel happy most of the time? ____Yes ____No
6) Do you generally feel calm most of the time? ____Yes ____No
7) Do you have a strong sense of self confidence? ____Yes ____No
8) Do you enjoy getting out of the house and being active? ____Yes ____No

Allergy Symptom Questionnaire

Please rate your symptoms:
0 – Never have the symptom
1 – Occasionally have the symptom
2 -- Frequently have the symptom
Circle if the symptom is severe

HEAD
______ Headaches
______ Faintness
______ Dizziness
______ Insomnia

DIGESTIVE TRACT
______ Nausea/vomiting
______ Diarrhea
______ Constipation
______ Bloating
______ Belching/passing gas
______ Heartburn
______ Intestinal/stomach pain

JOINTS/MUSCLE
______ Weakness
______ Joint pain
______ Arthritis
______ Muscle pain
______ Stiffness in joints

EYES
______ Watery or itchy eyes
______ Swollen, red eyelids
______ Bags or dark circles
______ Blurred, tunnel vision

EARS
______ Itchy ears
______ Earaches, ear infections
______ Drainage from ear
______ Ringing in ears
______ Hearing loss

NOSE
______ Stuffy nose
______ Sinus problems
______ Hay fever
______ Sneezing attacks
______ Excessive mucus

WEIGHT
______ Underweight
______ Food cravings
______ Water retention
______ Compulsive eating
______ Binge eating/drinking
______ Excessive weight

SKIN
______ Acne
______ Hives, rashes, dry skin
______ Hair loss
______ Flushing, hot flashes
______ Excessive sweating

MOUTH/THROAT
______ Chronic cough
______ Frequent throat
______ Sore throat, hoarseness
______ Swollen gums, lips
______ Canker/cold sores

ACTIVITY/ENERGY
______ Restlessness
______ Fatigue/sluggishness
______ Apathy/lethargy
______ Hyperactivity

HEART
______ Rapid heartbeat
______ Chest pain
______ Irregular heartbeat

LUNGS
______ Asthma/bronchitis
______ Shortness of breath
______ Difficulty breathing
______ Chest congestion

MIND
______ Poor memory
______ Confusion
______ Poor concentration
______ Stuttering or stammering
______ Slurred speech
______ Difficulty making decisions

EMOTIONS
______ Anxiety, fear
______ Anger, irritability
______ Depression
______ Mood swings

OTHER
______ Frequent/urgent urination
______ Genital itch, discharge
______ Frequent illness

Please note:

As we have many chemically sensitive clients,
we are a fragrance-free office.
Please refrain from wearing any scented
hand lotions, perfumes, colognes or hairsprays,
clothes dried with dryer sheets or fabric softeners
in our office.

We sincerely appreciate
your understanding and cooperation
with our fragrance-free, chemical-free policy.

When you come into the lobby for your appointment,
please be seated and I will be with you shortly.

Kind regards,
Dr. Mary Clement