LEWIS HEALING INSTITUTE Dr. Lisa Lewis, ND, LAc

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Confidential Patient Profile

Name:____ Date of First Visit:______________
(Last) (First) (MI)

Address:____
(number, street, apt number, city, state, zip/postal code)

Phone: h____________ w _____________ c _____________ Email: ________________________

Birthdate: ___/___/______ Birthplace: _________________ Age:_______ Gender(Sex): M F

Social Security # _______ - _____-________ Occupation: _______________________________

Employer's Name and Address: ____
____

Name of Emergency Contact: __________________________ Relationship to self:______________
Address: ____

Phone: h ______________ w______________ c______________ Email: _____________________

Primary Care Physician: ____Phone:______________

Who can I thank for referring you to me? ____

A note to patients: Please take the time to carefully complete this health history questionnaire. Naturopathic medicine involves providing the physician with a complete picture of the patient (physically, mentally & emotionally). This is a confidential record of your medical history and will not be released except when you have authorized me to do so.

Present Health Concerns: Please list your most important health concerns in their order of significance.

1.) ____________________________________ 4.) ____________________________________

2.) ____________________________________ 5.) ____________________________________

3.) ____________________________________ 6.) ____________________________________

What goals do you have for your visit today?

Primary Goal: ____

Other Goals: ____

Have you ever consulted a Naturopathic Physician or Acupuncturist?
Yes, ____________________________ No

Personal/Social History:
Please list the medications that you are currently taking, with dosages:
1.) ________________________________ 4.) ________________________________
2.) ________________________________ 5.) ________________________________
3.) ________________________________ 6.) ________________________________

Please list supplements, vitamins, herbs or homeopathic remedies that you are presently taking:
1.) ________________________________ 5.) ________________________________
2.) ________________________________ 6.) ________________________________
3.) ________________________________ 7.) ________________________________
4.) ________________________________ 8.) ________________________________

Please list any allergies that you have to any of the following:
Foods: ________________________ Animals:________________Drugs:______________
Environmental Sources: (ex. Pollen, grasses, etc…) ____________________________________
How do you react to the allergens?____
Have you ever been expose to toxic chemical, solvents or other possible toxins? YES NO
If yes, please describe: ____

Tobacco: ______ packs per day; smokeless tobacco, cigars
Coffee/black tea/cola: ______ cups per day/week/month
Alcohol: ______ drinks per day/week/month
Recreational drugs: _______________________________________
Do you follow any particular dietary regimens or restrictions? YES, _____________________ NO
Do you exercise regularly? YES, please describe: __________________________________ NO
Do you make time for rest, relaxation, or meditation during the day and/or before bed? YES NO
Do you Sleep well? __________ How many hours per night? _________________________
Bowel habits: How many per day? __________ Diarrhea? ____________ Constipation? ________
How frequently have you taken antibiotics? _______________________________________
Please circle those that apply: single married significant other
Do you have children? YES NO How many?__________ Ages:_______________
Have you traveled outside the US in the past year? YES NO Where?_______________

Past History:
Hospitalizations or Surgeries: (Please list reason and dates)
____
____
Serious Illnesses, Injuries or Accidents:
____
____
Date of last complete physical exam: _________________

Family History: Please fill in the boxes below for each condition that applies to one of your family members.

	YES	WHO	Comments		YES	WHO	Comments
Alcoholism				Hay Fever, Hives			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Diabetes				Stroke			
Eczema				Tuberculosis			
Epilepsy				Other:			

A Few Final Questions : (Optional)

1. How does your health affect your day to day life?

2. How would your life be different if you didn't have this condition(s)?

3. On a scale of 1-10, how committed are you to improving your state of health? ________

4. On a scale of 1-10, how much change are you willing to make for your state of health? ______

Prior Doctor-Patient Relationship

Please take a moment to reflect on your past relationships with doctors and note how the relationship with future doctors could improve to optimize your health care. What do you need from a doctor in relation to achieving your goals and goals of wellness (creativity, energy, enjoyment, health, balance, etc)? How can you become more effective in your role with your doctor?

____
____
____
____
____
____

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame and in the cause and prevention of disease." -Thomas A. Edison

Informed Consent for Naturopathic Treatment

I, ________________________________, acknowledge that I am accepting treatment from a Naturopathic physician at Lewis Healing Institute. I understand that there are intrinsic differences between the care of Naturopathic doctors and medical doctors. At this time it is my decision to pursue Naturopathic treatment for any condition I have. Also, I understand that, as with medical treatment, there is no guarantee that this treatment will offer complete resolution to any or all conditions that I may have.

Cancellation Policy

We require 24 hours notice received during our normal business hours for canceled or rescheduled visits.

There is no charge for visits canceled with 24 hours notice. Half the cost of the scheduled visit will be charged for cancellations with less than 24 hours notice. Full fee is charged if no notice is received.

Email / Phone Policy

It is the policy of Lewis Healing Institute to do email/phone consultations under the following conditions only:

1. For established patients of Optimal Health Institute;
2. For non-emergent issues;
3. In cases where the doctor determines that an office visit is not necessary or possible;
4. For clarification of on-going treatment or treatment received within the past 30 days;
5. When the doctor can address the concern with a single reply, requiring 10 minutes or less.
6. When the above conditions are met, and the patient has signed an informed consent acknowledging this policy.

No new health issue will be addressed by email / phone consultation, unless related to the above conditions.

If the doctor receives an email / phone call about a condition that in her/ his opinion cannot be properly assessed without an office visit, the patient will be notified by return email / phone call to schedule an appointment, with time frame recommended. In this case, no treatment advice will be given by email / phone.

Doctors generally respond to emails /phone calls within 48 hours, Monday through Friday only. **If you have emailed / phoned the doctor and have not received a response within these parameters, call the office at 973-486-0148 and leave a phone message for the doctor,** stating your question and/ or concern.

Email / phone communication with the doctor and the doctor's reply become part of the patient's permanent record—a copy is added to the patient's medical chart. Email communication is password protected for patient privacy—no one but the doctor can access your email communication.

I, __________________________(Patient Name), have read the above policies of Lewis Healing Institute. I have had an opportunity to ask questions about these policies. I understand the policy, and the conditions which are required for cancellations and email/phone consultation. I realize that I may not receive a response for up to 24 hours, and am expected to call the office to leave a message for the doctor by phone if I have not received a reply in that time frame. I agree to abide by the above policies.

____
Patient Name (Please Print)

____ ________________
Patient Signature Date

____ ________________
Physician/ Witness Date

Credit Card Authorization Form
Lewis Healing Institute
Dr. Lisa Lewis, P.C.

____
Name (as it appears on the card)

____
Billing Address
____

_________________________ ________________________ _________
City State Zip Code

____
Telephone Number

____
Email Address

____
Card Type (Visa, Mastercard, American Express, Discover)

____
Number of card

____
Expiration Date:

____
3 digit security code

Notice to Cardholder: (Please read before signing)
Cardholder agrees that his/her signature on this form constitutes his/her signature on file and becomes his/her agreement to pay all charges, fees related to services provided lab tests, supplements, shipping and handling, etc. as signed by the cardholder and that Dr. Lisa Lewis is authorized to charge the indentified account of Cardholder.

I, ______________________________ (Patient Name), hereby authorize, as signature below represents, the above credit card to be charged each and every time services or products are rendered. The authorization allows Dr. Lisa Lewis to continue to use this information and such information shall remain in full force and effect unless I revoke such authorization in writing.

____
Legal Patient Name (Please Print)

____________________________________ ______________
Patient Signature Date