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| Sage Moon Naturopathic Medicine Inc.  707-634-4795  DrRyanOlsonND.com  [Dr.RyanOlson.ND@gmail.com](mailto:Dr.RyanOlson.ND@gmail.com) | | | | | | | | | | | | | | | | | | | | | | Original Date: | | | | |  | | | |
| Dates Revised: | | | | |  | | | |
| HEALTH HISTORY QUESTIONNAIRE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| All questions contained in this questionnaire are strictly confidential  and will become part of your medical record. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name (Last, First, M.I.): | | | |  | | | | | | | | | | | DOB: | |  | | | | | | | | | | | | | |
| Marital status: | | | Single  Partnered  Married  Separated  Divorced  Widowed | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Previous or referring doctor: | | | | | |  | | | | | | | | Date of last physical exam: | | | | | | | | | |  | | | | | | |
| Date of most recent blood work: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Date of last colonoscopy: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Please list all other medical professionals involved in your care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | Specialty | | | | | | | | Contact info | | | | | | | | | | | | |
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| Do you have insurance? Y/N | | | | | | | | | | | | | If yes, what is your carrier? | | | | | | | | | | | | | | | | | |
| PERSONAL HEALTH HISTORY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Childhood illness: | | | | 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio 🞎 Strep Throat ( )approx. # 🞎 Ear Infections ( ) approx. # 🞎 Scarlet Fever 🞎 Epilepsy/Seizures | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Immunizations and dates: | | | | | Tetanus | | |  | | | | | | Pneumonia | | | | | | |  | | | | | | | | | |
| Hepatitis | | |  | | | | | | Chickenpox | | | | | | |  | | | | | | | | | |
| Influenza | | |  | | | | | | MMR Measles, Mumps, Rubella | | | | | | | | |  | | | | | | | |
| Previously diagnosed medical conditions (with approx. date of diagnosis) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Any previous conditions or infections from which you never fully recovered?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Current major concerns in order of importance for you | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Concern | | | | | | | | | | Since | | | | | | | | Cause(s) | | | | | | | | | | | | |
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| Surgeries | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | | | | | | | | | | | | Hospital | | | | | | | | | | |
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| Other hospitalizations | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | | | | | | | | | | | | Hospital | | | | | | | | | | |
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| **Have you ever had a blood transfusion?** | | | | | | | | | | | Yes | | | | | | | | No | | | | | | | | | | | |
| Current Medications | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name the Drug | | | | | | | | | | Dose (mg, mcg, mL…) | | | | | | | | Frequency Taken | | | | | | | | | | | | |
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| Supplements | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | Dose (mg, mcg, mL…) | | | | | | | | Frequency | | | | | | | | | | | | |
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| Allergies to medications/herbs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name the Drug | | | | | | | | | | Reaction You Had | | | | | | | | | | | | | | | | | | | | |
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| HEALTH HABITS AND PERSONAL SAFETY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Exercise | | Sedentary (No exercise) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes or more) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diet | | Are you dieting? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| If yes, are you on a physician prescribed medical diet? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| # of meals you eat in an average day? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How much water do you drink in a day? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you drink filtered water? | | | | | | | Do you drink well water? | | | Any food allergies/intolerance? | | | | How would you describe your relationship to food? | | | | | | | | | | | | | | |
| Yes  No | | | | | | | Yes  No | | | Yes  No | | | |  | | | | | | | | | | | | | | |
| Caffeine | | None | | | | | | | Coffee | | | Tea | | | | Cola | | | | | | | | | | | | | | |
| # of cups/cans per day? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Alcohol | | Do you drink alcohol? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| If yes, what kind typically? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How many drinks per week? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you concerned about the amount you drink? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Have you considered stopping? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Have you ever experienced blackouts? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Are you prone to “binge” drinking? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Do you drive after drinking? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Tobacco | | Do/did you use tobacco? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Cigarettes – pks./day | | | | | | | | | | Chew - #/day | | | | Pipe - #/day | | | | | | | | | Cigars - #/day | | | | | |
| # of years | | | | | | | Or year quit | | | | | | | | | | | | | | | | | | | | | |
| Drugs | | Do you currently use recreational drugs? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Have you ever given yourself drugs with a needle? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Sex | | Are you sexually active? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| If yes, are you trying for a pregnancy? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| If not trying for a pregnancy list contraceptive or barrier method used: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any discomfort with intercourse? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? | | | | | | | | | | | | | | | | | | | | | | | |  | |  |  |  |
|  | | Yes |  | No |
| Personal Safety | | Do you live alone? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Do you have frequent falls? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Do you have vision or hearing loss? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Do you have an Advance Directive and/or Living Will? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Would you like information on the preparation of these? | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes |  | No |
| Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | | | | | | | | | | | | | | | | | | | | | | | |  | |  |  |  |
|  | | Yes |  | No |

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| FAMILY HEALTH HISTORY | | | | | | | |
|  | | | | | | | |
| \*Check if deceased | Age | | Significant Health Problems |  | Age | | Significant Health Problems |
| Father |  | |  | Children | M  F |  |  |
| Mother |  | |  | M  F |  |  |
| Siblings | M  F |  |  | M  F |  |  |
| M  F |  |  | M  F |  |  |
| M  F |  |  | Grandmother Maternal |  | |  |
| M  F |  |  | Grandfather Maternal |  | |  |
| M  F |  |  | Grandmother Paternal |  | |  |
| M  F |  |  | Grandfather Paternal |  | |  |

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| MENTAL HEALTH | | | | |
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| Is stress a major problem for you? |  | Yes |  | No |
| Do you feel depressed? |  | Yes |  | No |
| Do you panic when stressed? |  | Yes |  | No |
| Do you have problems with eating or your appetite? |  | Yes |  | No |
| Do you cry frequently? |  | Yes |  | No |
| Have you ever attempted suicide? |  | Yes |  | No |
| Have you ever seriously thought about hurting yourself? |  | Yes |  | No |
| Do you have trouble sleeping? |  | Yes |  | No |
| Have you ever been to a counselor? |  | Yes |  | No |

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| WOMEN ONLY | | | | | | | |
|  | | | | | | | |
| Age at onset of menstruation: | | | | | | | |
| Date of last menstruation: | | | | | | | |
| Still having a period? |  | | Yes |  | | No | |
| Period every       days | | | | | | | |
| Heavy periods, irregularity, spotting, pain, or discharge? | |  | Yes | |  | | No |
| Number of pregnancies       Number of live births | | | | | | | |
| Are you pregnant or breastfeeding? | |  | Yes | |  | | No |
| Have you had a D&C, hysterectomy, or Cesarean? | |  | Yes | |  | | No |
| Any urinary tract, bladder, or kidney infections within the last year? | |  | Yes | |  | | No |
| Any blood in your urine? | |  | Yes | |  | | No |
| Any problems with control of urination? | |  | Yes | |  | | No |
| Any hot flashes or sweating at night? | |  | Yes | |  | | No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | |  | Yes | |  | | No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | |  | Yes | |  | | No |
| Date of last pap and rectal exam? | | | | | | | |
| Date of last DEXA (bone density) scan: | | | | | | | |
| Date of last colonoscopy: | | | | | | | |
| MEN ONLY | | | | | | | |
|  | | | | | | | |
| Do you usually get up to urinate during the night? | |  | Yes | |  | | No |
| If yes, # of times | | | | | | | |
| Do you feel pain or burning with urination? | |  | Yes | |  | | No |
| Any blood in your urine? | |  | Yes | |  | | No |
| Do you feel burning discharge from penis? | |  | Yes | |  | | No |
| Has the force of your urination decreased? | |  | Yes | |  | | No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | |  | Yes | |  | | No |
| Do you have any problems emptying your bladder completely? | |  | Yes | |  | | No |
| Any difficulty with erection or ejaculation? | |  | Yes | |  | | No |
| Any testicle pain or swelling? | |  | Yes | |  | | No |
| Date of last prostate and rectal exam? | | | | | | | |
| Date of last colonoscopy: | | | | | | | |
| OTHER PROBLEMS | | | | | | | |
|  | | | | | | | |
| Check if you currently, or have previously had, any symptoms in the following areas to a significant degree and briefly explain. | | | | | | | |

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| --- | --- | --- | --- | --- | --- |
|  | Skin |  | Chest/Heart |  | Recent changes in: |
|  | Head/Neck |  | Back |  | Weight |
|  | Ears |  | Intestinal |  | Energy level |
|  | Nose |  | Bladder |  | Ability to sleep |
|  | Throat |  | Bowel |  | Other pain/discomfort: |
|  | Lungs |  | Circulation |  |  |

What is the best way to contact you?

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**Sage Moon Naturopathic Medicine Inc.**

**Dr. Ryan Olson ND**

**(707) 634-4795**

**Informed Consent for Naturopathic Treatment**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the licensed naturopathic doctor and medical personnel of **Sage Moon Naturopathic Medicine Inc.** to perform with my approval and consent the following procedures for my diagnosis and treatment:

\*\*If you do not want any of these procedures or have any questions it is important to ask Dr. Olson\*\*

**Physical Exam**: general, cardiac, lung, eye/ear/nose/throat, neurological, musculoskeletal, palpation, vital signs

**Common Diagnostic Procedures**: venipuncture, diagnostic imaging, laboratory evaluation of blood, urine, stool, saliva, and hair.

**Physical Medicine**: muscle release techniques, naturopathic osseous manipulation of the spine and extremities, trigger point therapy, and Craniosacral therapy.

**Dietary Advice and Therapeutic Nutrition**: which may include lifestyle and nutritional counseling, diet plans, oral nutritional supplements (with vitamins, minerals, and amino acids), intra-muscular and intravenous vitamin or supplemental injections.

**Botanical Medicine**: with teas, tinctures, capsules, tablets, and creams.

**Homeopathic Medicine**: using highly dilute quantities of naturally occurring plant, animal, or other substances for healing.

**Telehealth:** diagnosis, consultation, treatment, education, care management, self-management via information and communication technologies.

**Pharmaceutical drugs:** prescriptions as indicated.

**Infrared sauna:** Heating of the body to raise core temperature. Benefit is to detoxify, raise Heat Shock Proteins (HSP) and indirectly bring about weight loss.

**I recognize the potential risks and benefits of these procedures as described below:**

**Potential Risks**: allergic reactions to prescribed supplements, medications, and herbs, which may be severe such as anaphylaxis, cardiac arrest and death. Side effects between natural medications and pharmaceuticals, inconvenience of lifestyle changes, aggravation of present conditions, injuries such as pain, discomfort, discoloration, and pneumothorax from injections, venipuncture, and other procedures. Soft tissue or bony injury from physical manipulation may result as well. Symptoms may arise within 1-2 days of beginning treatment, this may be normal, however if they persist beyond this range please notify Dr. Olson.

**Potential Benefits**: Restoration of health and the body’s maximal functional capacity, relief of pain and symptoms of disease, and prevention of disease and its progression. Relief from overlying symptoms causing deeper symptoms to arise.

**Notice to Cancer Patients:** We do not treat cancer. We treat the immune system to be able to respond better to cancer. All healing is done by restoration of the immune system to full function. When the patients’ own immune system is strong enough then it will take care of the cancer.

**Notice to Women:** all female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present risk to the pregnancy and fetus.

**I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment in recommending the treatments that the doctor feels at the time, based on the facts then known, are in my best interest. I have had the opportunity to ask questions and discuss with Dr. Olson to my satisfaction:**

1) my suspected diagnosis or condition

2) the nature, purpose and potential benefit of the proposed care

3) the inherent risks, complications, potential hazards, or side effects of the treatment or procedure

4) the probability or likelihood of success

5) reasonable available alternatives to the proposed treatment / procedure

6) the possible consequences if treatment or advice is not followed and/or nothing is done.

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 any event, 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. 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.

With this knowledge I voluntarily consent to the above procedures realizing that no guarantees have been given to me by **Sage Moon Naturopathic Medicine Inc.** or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation at any time.

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Signature of patient or representative Date

If signed by representative, please indicate relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_