naturallyhealthy
WITH DR. LISA, NATUROPATHIC DOCTOR

Congratulations on taking this important step toward improving your health. I am dedicated to providing you personalized care with an emphasis on science-based natural therapies.

If this is your first visit to a Naturopathic doctor, it is important that you understand our health care philosophy and how we differ from conventional medical practices. If you have not done so already, please review the content of our website www.NaturallyHealthyWithDrLisa.com as it discusses in detail everything you need to know about the doctor, services, and other general information regarding your appointment.

Included in this document, please find the comprehensive Health Questionnaire/Intake form, which I ask that you complete in advance of your initial visit. I ask this because much of the information required on the form is readily available to you at home. Completing the form prior to your appointment will ensure that we have all the information necessary to provide you the best care possible.

Also included in this document is the Informed Consent/Financial Policies form. Please carefully review and sign the document prior to your appointment.

If you have any questions or concerns regarding either of the above-mentioned forms, please contact Dr. Lisa.

On your initial appointment, please also remember to bring the following items for a more thorough consultation.

- Recent Lab Results
- Pathology Reports
- Current Medications
- Current Supplements

I appreciate you having entrusted me with your health care needs, and I am excited that you are taking this very important step toward achieving your health goals.

I am looking forward to working with you.

Yours in Health,

Dr. Lisa Marie Leonard, ND

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Informed Consent and Financial Policies

This form provides important information regarding Naturally Healthy's services and financial policies. Please read it carefully and sign at the bottom indicating you read, understand, and agree to its content. Please ask questions if you would like clarification or additional information. A copy of this form is available upon request.

Dr. Lisa is a graduate of National University of Health Sciences in Lombard, Illinois. She is trained and licensed as a primary care physician in the state of California. At this time, the state of Illinois does not license Naturopathic physicians and has not adopted any educational or training standards for Naturopaths or Naturopathic physicians. This statement of credentials is for informational purposes only.

Under Illinois law, a Naturopath or Naturopathic physician may not provide a medical diagnosis, prescribe medical treatments or recommend discontinuance of these treatments. Therefore, our services are not to be misconstrued as directly or indirectly dispensing medical advice for the cure or mitigation of any disease or condition. Nor is it an attempt to diagnose or prescribe, being that Lisa Marie Leonard, N.D. is not a licensed M.D, D.O., chiropractor, nurse, dietitian, physical therapist or any other type of licensed practitioner in the state of Illinois. If a client desires a diagnosis or service from one of these licensed practitioners, the client may seek or continue such services at any time.

The client understands that our recommendations and services are primarily that of an educator, consultant or "coach" in regard to the utilization of natural methods for building and maintaining health. The client agrees to hold harmless and waive any claim of present or future liability or negligence against Lisa Marie Leonard, N.D., and /or Naturally Healthy with Dr. Lisa for recommendations, services rendered or products purchased. The client understands that the recommendations and services rendered by Naturally Healthy with Dr. Lisa may differ from those usually offered by a conventional medical doctor or other health care provider.

The client is aware that Naturopathic health care is not an exact science and acknowledges that no guarantees have been made as to the results of services and accepts no responsibility for their outcomes.

Confidentiality: All information provided on the health questionnaire/intake form or during office visits is confidential. Information will only be released outside of our center with the patient's written and signed request.

Fees and Payment: Fees for office visits and phone consultations are based on a rate of $120.00 per hour. Naturally Healthy with Dr. Lisa requires payment in full at time of service for office visits, supplements and/or products sold. Payment methods include cash, checks and major credit cards.

Insurance: Most insurance coverage is limited to those states that offer licensure to Naturopathic doctors. Currently, Illinois is not a licensed state and therefore it is unlikely your insurance provider will cover services rendered by a Naturopathic doctor. However, as demand for complementary and alternative medicine increases, more insurers are providing coverage. Naturally Healthy with Dr. Lisa does not bill insurance providers.

Cancellation Policy: Naturally Healthy with Dr. Lisa requires that cancellations for scheduled appointments be received 24 hours in advance during regular office hours (M-F,9am-5pm). We reserve the right to charge for missed or canceled appointments that do not follow this policy.
Fees are based on a rate of $120.00 per hour.

I fix my signature to certify that I,

(Print Name)_____

am voluntarily seeking the services of Lisa Marie Leonard, N.D. and/or Naturally Healthy with Dr. Lisa and have read, understand and agree to the above statements and policies.

(Signature)_____

(Date) _____

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Patient Intake and Health History Questionnaire

Personal Profile

Date _____

Name_____

Gender □ Male □ Female

Date of Birth _____ Age _____

Height _____'_____" Current Weight_____ Goal Weight_____

If current weight differs from goal weight, how long has it been since you were at your goal weight? _____

Address _____

_____

City/State_____ Zip Code _____

Phone: Home _____ Work _____ Cell _____

Which phone numbers may we use to leave messages? □ Home □ Work □ Cell □ None

E-mail _____

Would like to be emailed the monthly newsletter? □ Yes □ No

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Partnership

Live with: □ Spouse □ Partner □ Parents □ Children □ Friends □ Pets □ Alone

Occupation _____ Hours per week_____

□ Retired □ Student □ Stay-home parent □ Unemployed

Employer _____

Ethnicity _____

Emergency Contact_____ Phone _____

How did you hear about Naturally Healthy with Dr. Lisa? _____

_____

Naturopathic health consulting requires a complete picture of the patient physically, mentally and emotionally. For us to fully evaluate your health, please fill out this intake form and questionnaire to the best of your ability. The more information provided, the better we can serve your needs. Please fill out the following the best you can, not every section will apply to you.

All information provided on this intake form or during office visits is confidential.
Information will only be released with your written and signed request. Take your time while completing this form, thoroughness and honesty will significantly aid us in assessing your needs and restoring your health. Consider copying this form for your records.

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Medical Information

Please bring copies of **current** (within past 2 years) medical reports and laboratory tests to your appointment

Primary Care Provider _____

Date of last medical or health care visit_____

Reason for medical visit_____

Date of last physical exam_____ Blood Type (If known) _____

Have you ever contracted an illness while traveling outside the country or shortly upon your return? □ Yes □ No

If Yes, describe_____

What is your major complaint _____

_____

Other complaints _____

_____

How long have you had this condition _____

Have you ever had this or a similar condition in the past?

_____

How long has it been since you REALLY felt good?

_____

List previous diagnosis and treatments you have received prior to your present complaint:

_____

_____

_____

For Males Only

Date of last testicular exam_____ results _____

Date of last Digital rectal exam (i.e. prostate exam) _____ results_____

Date of last prostate specific (PSA) blood test _____ results_____

Are you sexually active? □ Yes □ No

If Yes, Current form of contraception_____

Are there any questions/concerns regarding your sex life or intimacy you wish to discuss? _____

_____

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For Females Only

Date of last OB/GYN exam_____ results _____

Date of last PAP Smear _____ results _____

Have you ever had an abnormal PAP? □ Yes □ No If Yes, describe_____

_____

Date of last mammogram _____ results _____

Date of last manual breast exam (performed by physician)_____

How do you wipe after urinating? □ Front-to-back □ Back-to-front

How do you wipe after bowel movement? □ Front-to-back □ Back-to-front.

Are you sexually active? □ Yes □ No Current form of contraception_____

Have you ever used birth control pills? □ Yes □ No If Yes, for how long_____

Side effects of birth control pills, if any_____

Have you ever used an IUD? □ Yes □ No If Yes, for how long? Type of IUD_____

Age of first menstruation _____

Did you have a difficult time during puberty (i.e., physically, emotionally)? □ Yes □ No

If Yes, explain_____

_____

If you experience PMS (Premenstrual Syndrome), please check the following symptoms that apply:

PMT-A
□ Nervous tension
□ Irritability
□ Mood changes
□ Anxiety
□ Insomnia

PMT-D
□ Depression
□ Forgetful
□ Crying
□ Confusion

PMT-C
□ Headache
□ Cravings for sweets
□ Increased appetite
□ Heart pounding
□ Dizziness or fainting
□ Fatigue

PMT-H
□ Weight gain
□ Bloating
□ Swelling of extremities
□ Breast tenderness
□ Cramping

Periods occur every _____days (e.g. 28) Do you ever skip periods? □ Yes □ No

Are your periods consistent (occur the same time each month)? □ Yes □ No

Date of last period _____

Periods usually last _____days on average (e.g., 5 days) Quantity of flow: □ Light □ Moderate □ Heavy

Number of tampons and/or pads used per day: tampons _____ pads _____

Quality of menstrual blood: □ Dark red □ Bright red □ Large clots Describe: _____

_____

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For Females Only (continued)

Are you currently pregnant? □ Yes □ No

Pregnancies (include current): # Births_____ # Miscarriages _____# Abortions _____

Any complications of pregnancy? □ Yes □ No If Yes, please explain_____

History of breastfeeding? □ Yes □ No If any problems with breastfeeding, please explain_____

Are there any questions/concerns regarding your sex life or intimacy you wish to discuss? _____

_____

Have you reached: □ Peri-menopause □ Menopause □ Post-menopause?

Date of last menstrual cycle _____

Have you or are you taking Hormone Replacement Therapy? □ Yes □ No Duration of use _____

Type of Hormone Replacement Therapy _____ Dose _____ (i.e. milligrams/day)

Have you had a hysterectomy? □ Yes □ No

If Yes: □ Partial □ Complete Date_____

Childhood/Adolescence History

How was your health as a child? □ Excellent □ Good (typical illnesses) □ Chronically ill

Were you troubled by:

□ Acne □ Allergies □ Asthma □ Chronic Bronchitits □ Chronic Sore Throats

□ Constipation □ Chronic Ear Infections □ Depression □ Fatigue

□ Seizures □ Eczema □ Cancer □ Diarrhea □ Headaches

□ Skin problems □ Learning/Behavior Problems □ other _____

List all medication(s) used for an extended period of time (e.g., antibiotics, cortisone, etc.)?

Were you overweight as a child/adolescent? □ Yes □ No What age range _____

How would you describe your experience of childhood/adolescence: □ Happy/Secure □ Lonely

□ Stressed/Pressured □ Deprived of Love/Affection □ Abused: □ Verbally □ Physically □ Sexually

Any significant childhood/adolescent injuries/illnesses/traumatic events?_____

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Medications

List prescription and over-the-counter drugs you are currently taking or have previously taken for extended periods of time (greater than one month). Please bring your medications to your appointment.

Drug Name	Reason for Taking	Dose (mg/day)	Date Started	Date Discontinued	Side Effects

Please list allergies or negative reactions to medications _____

Immunizations (if known):

□ Polio □ Rubella □ Flu Vaccine □ Tetanus □ Measles □ Diphtheria

□ Smallpox □ Mumps □ Hepatitis B □ Pertussis □ Other: _____

Nutritional Supplements

Examples: Vitamins, minerals, herbal & homeopathic remedies.
For evaluation of content and quality please bring supplements to your appointment.

Name/Type	Reason for Taking	Dose	Date Started	Results/Benefits

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Hospitalizations, Surgeries & Outpatient Procedures

Type	Date	Reason for Procedure/Admission	Outcome/Results

Major Accidents & Traumatic Events

Examples: car accident serious shock, nervous breakdown, divorce, death of loved one.

Type	Age	Duration	Complete Recovery? (yes/no)	Treatment (include medications)

Family History

Use the key below to identify family members and their associated health conditions.
Please list type where parentheses are present.

M: Mother F: Father S: Sister B: Brother G: Grandparent A: Aunt U: Uncle O Child

Condition	Relative	Condition	Relative
Allergies		Eczema	
Alcoholism		Epilepsy	
Anemia		Gout	
Alzheimer's		Heart Disease	
Arthritis (Rheumatoid)		High Blood Pressure	
Arthritis (Osteo)		High Cholesterol	
Asthma		Kidney Disease	
Bleeding Disorder		Lupus	
Cancer( )		Mental Disorder	
Cancer ( )		Nervous System Disease	
Celiac Disease		Obesity	
Crohns Disease		Stroke	
Colitis		Thyroid (Hypo/Hyper)	
Depression		Other ( )	
Diabetes Type 1		Other ( )	
Diabetes Type 2		Other ( )	

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Deceased Relatives

Please provide age at death and cause of death if known.

Relative	Age	Cause of Death
Mother		
Father		
Grandfather (maternal)		
Grandmother (maternal)		
Grandfather (paternal)		
Grandmother (paternal)		
Sister(s)		
Brother(s)		

Personal Habits

Substance Use	Tobacco	Alcohol	Caffeine	Drugs
Currently Use				
Previously Used				
Never Used				
How much/many per day/week/month				
Specify Type: (cigarettes/cigars/ pipe/chewing tobacco; beer/wine/ spirits; tea/coffee/espresso/soft drinks/ energy drinks/ weight loss products; cocaine/marijuana/ heroin/ ecstasy)				
Duration of use (month/years)				
Date Quit				

Exercise (complete this section only if you exercise regularly.)

Type of exercise (biking, walking, yoga, jogging, weights, swimming)	How long per session (minutes, hours)	Frequency (daily, weekly)	How long have you been doing this specific activity (weeks, months, .years)

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Sleep

Average Hours per night_____

Do have trouble falling asleep? □ Yes □ No If Yes, what keeps you up? _____

How long does it take you to fall asleep? _____

Do you have trouble staying asleep? □ Yes □ No If Yes, how many times do you wake per night and is there a consistent time that you wake throughout the night? _____

Do you snore excessively □ Yes □ No Date diagnosed with sleep apnea_____

Do you have any recurring dreams? □ Yes □ No If Yes, please describe: _____

_____

Do you wake refreshed? □Yes □ No

What time do you go to bed? _____ What time do you rise in the morning? _____

Recreation & Relaxation

How much time per day do you spend watching television? _____

How much time per day do you spend on computers?_____

How much time per day do you spend outdoors? _____

What are your interests and hobbies? _____

Do you have a lot of clutter in your life (i.e. home and/or work)? □ Yes □ No

What do you do for relaxation?_____

Do you consider yourself a "relaxed" individual? □ Yes □ No

Environmental History

Where do you live (e.g., house, apartment)?

Where do you work or go to school? _____

Has the air quality in your home, place of work or school been a concern to you or others? □ Yes □ No

If yes, explain: _____

Are you exposed to any harsh chemicals at work or at home? □ Yes □ No

If yes, explain:_____

What is the source of drinking water currently_____ childhood _____ ex Well, City, Filtered, Distilled

Does your work or home environment have any history of mold? □ Yes □ No

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Social History

What are the major sources of happiness in your life? _____

Are you presently happy with your life? □ Yes □ No Why or why not? _____

What are the major sources of stress in your life? _____

Stress level (rate on scale of 1-10, 1=lowest stress, 10=severe, chronic stress) _____

How do you cope with stress? _____

How important is religion or spirituality in your life? _____

Do you have a good support network (friends, family, pets)? □ Yes □ No

Are you fulfilled by your work? □ Yes □ No If No, why not? _____

_____

Do you have short and long term goals for your life? □ Yes □ No

Do you take regular vacations? □ Yes □ No If Yes, how often and how long (per year)? _____

Is there a noticeable change in your health while on vacation? □ Yes □ No. Describe _____

_____

Allergies

Do you suffer from allergies? □ Yes □ No

If Yes, to what (ex. pollens, grasses, dust, animals, food)? _____

Have you ever experienced an anaphylaxis reaction (i.e., severe allergic reaction requiring medical attention)?

□ Yes □ No If Yes, to what? _____

Have you had allergy testing? □ Yes □ No If Yes, what type of testing (e.g., blood, skin scratch test)?_____

Results _____

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Diet

List any specific foods or beverages you exclude from your diet, when and why?_____

_____

How many meals do you generally eat each day? _____

Have you "yo-yo" dieted in the past? □ Yes □ No Explain_____

How often do you eat out or eat take-out food? _____

Do you crave any specific foods or beverages (e.g., sweets, chocolate, salty snack foods, bread, soda)? □ Yes □ No

If Yes, which foods or beverages?_____

Are there specific foods that you feel you can't live without? □ Yes □ No If Yes, which ones? _____

_____

List any food or beverage that does not agree with you_____

Explain how they do not agree with you _____

How much oil do you use for cooking _____

Typical day water intake would be _____ oz. or _____ glasses

2-Day Diet Assessment

Please list all **foods** and **beverages** consumed in the last two days.

	Day 1	Day 2
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Dessert		
Evening Snack		

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General Diet Assessment

Please check the appropriate boxes, (daily, weekly, monthly or never), to help us assess your diet.

Food Category	Daily	Weekly	Monthly	Never
Baked sweet goods (cakes, cookies, muffins, pastries, pies)	☐	☐	☐	☐
Deep-fried foods/Harmful fats (french fries, fried chicken/fish, chips, donuts, margarine)	☐	☐	☐	☐
Candy	☐	☐	☐	☐
Chocolate	☐	☐	☐	☐
Soda	☐	☐	☐	☐
Juice/Sweetened beverages/Sports drinks	☐	☐	☐	☐
Hot/Cold cereal (specify type)	☐	☐	☐	☐
Bread / Baqels / Rolls (specify type)	☐	☐	☐	☐
Pizza	☐	☐	☐	☐
Rice	☐	☐	☐	☐
Potatoes	☐	☐	☐	☐
Milk	☐	☐	☐	☐
Cheese	☐	☐	☐	☐
Yogurt (type)	☐	☐	☐	☐
Butter	☐	☐	☐	☐
Ice cream	☐	☐	☐	☐
Fruits	☐	☐	☐	☐
Vegetables	☐	☐	☐	☐
Eggs	☐	☐	☐	☐
Fish	☐	☐	☐	☐
Chicken/Turkey	☐	☐	☐	☐
Red meat (steak, pork, bacon, sausage, hamburgers, hot dogs)	☐	☐	☐	☐
Beans/Legumes	☐	☐	☐	☐
Soy (tofu, tempeh, miso, soy milk, edamame)	☐	☐	☐	☐
Nuts/Seeds	☐	☐	☐	☐
White/Brown sugar, Honey	☐	☐	☐	☐
Artificial sweeteners (Aspartame, Nutrasweet, Equal, Splenda)	☐	☐	☐	☐
Other:	☐	☐	☐	☐

Thank you for taking the time to fill this out. Please bring completed copy to your initial visit or email completed copy to drlisamleonard@gmail.com .

Dr. Lisa