DR. JULIE LACHMAN
addressing the cause...not the symptom!
Julie Lachman, ND ● 1432 Easton Rd, Suite 3G ● Warrington, PA 18976
● P: 267-406-0782 ● F: 888-972-5592

Adult Intake

First Name:_____Last Name:_____Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Preferred Phone: (_____)_____(cell or home?) Alt. Phone: (_____)_____(cell or home?)

Date of Birth:___/___/___ Age: _____Sex: M / F Occupation/Hobbies: _____

Referred by:_____Email Address:_____

At what phone number can we leave confidential voice mail: (_____)_____

Emergency contact person_____ Relationship_____

Phone number_____Address_____

Married:____ Separated:____ Divorced:____ Widowed:____ Single:____

Live with: Spouse:____ Partner:____ Parents:____ Children:____ Friends:____ Alone:____

Other:_____ Hours per week working (if applicable)_____

Are you currently receiving healthcare? Yes / No If yes, where and from whom?

_____

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

_____

What was the reason? _____

Please list your most important health concerns in order of importance:

1) _____
2)_____
3)_____
4)_____
5) _____
6)_____
7)_____

Do you have any known contagious diseases at this time? Yes / No If yes, what?

_____

The best day and time for my appointments generally are:

MON TUE WED THUR FRI _____morning _____afternoon specific time:_____

My alternate day and time if I cannot make my regular appointment are:

MON TUE WED THUR FRI _____morning _____afternoon specific time:_____

Are you coming for any specific therapy (i.e. homeopathy, nutritional counseling, botanicals, "anything that works")?_____

OFFICE POLICIES

Client Name: _____ Date:_____

- All items must be paid for upon receipt. If you are a teleconsult patient, your items will be shipped upon receipt of payment. A shipping charge applies. Initial:_____
- Fee for services is due upon receipt, unless prior discussion for extenuating circumstances has occurred. Fees for services rendered via teleconsult are the same as for in-office visits and are due via credit card upon completion of the visit, unless prior arrangements have been made. Initial:_____
- Acute calls (5-30 minutes) range in price from $75-125, depending on how long you speak with the doctors. Initial:_____

Appointment Policies

- If weather or other circumstances such as car trouble do not allow us to come to the office, phone or teleconsults may replace your in-person visit at your regularly-scheduled time, if you request. This ensures you will get the care you need in a timely manner should there be a weather event. Initial:_____
- The office has a 48-hour Notice of Cancellation policy. **Canceling your appointment within 48 hours will result in a $35 fee**, some of which will go to a local charity.
- Appointment times have been arranged specifically for you. If you arrive late your session will be shortened in order to accommodate others whose appointments follow yours. If you are late, ***please call in*** *at your appointment time to get your visit started on the phone*. Initial:_____
- I understand that my intake visit is in 3 parts: the intake visit the results visit and the therapeutic assessment visit. I understand that one fee of $695 covers all three visits and any time for the doctor to study the case outside of our visits,as well as a homeopathic remedy kit Initial:_____
- There are no refunds on this payment, regardless of the number of visits you attend. Initial:_____

I look forward to being of service to you/your family.

Signature of client or parent/guardian:_____

CONTEXT OF CARE OVERVIEW

Why did you choose to come to this clinic?

What do you know about our approach?

What **long-term** expectations do you have from working with our clinic?

What three expectations do you have from **your first full visit** to our clinic?

i.
ii.
iii.

What expectations do you have of me personally as your clinician?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 1 to 10, 10 being 100% committed)
1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do?

Were you aware that naturopathic and homeopathic care has helped people recover from 'flu, cough, colds, ear infections, stomachaches, rashes, and other acute conditions?____Yes____No

Remember, if you get sick with a cold or acute infection, this can give the doctor a lot of information about helping you with other concerns you have. I understand that keeping the doctor informed about acute issues is beneficial (and may also prevent overuse of antibiotics). _____

Should you have an acute illness that naturopathic and homeopathic care can help, would you prefer that over a drug treatment, if possible and if during regular business hours? ____Yes____No_____Not sure

Environmental Intake

Do you have a sudden onset of symptoms (headaches, skin rashes, nausea, fatigue, shortness of breath, etc.) on exposure to chemicals, mold, dust, pollens, or other environmental allergens? What symptoms?_____
When do you last remember feeling really great?_____
Do you heat food in a microwave?_____
Do you use scented cleaning products, detergents, or candles?_____
Do you regularly get your nails done?_____
Do you have silver (mercury) fillings? If so, how many?_____
How often do you eat fish? _____What kinds of fish?_____

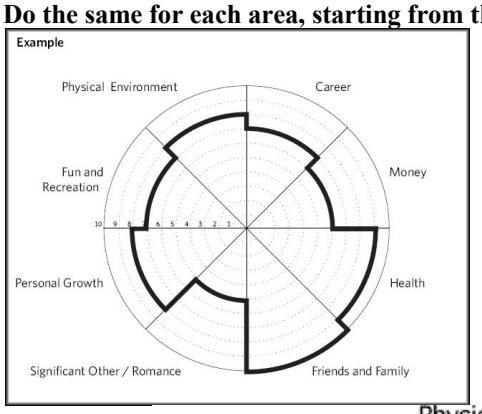
The rainbow of foods: Please fill in 3 foods for EACH color that you enjoy eating:

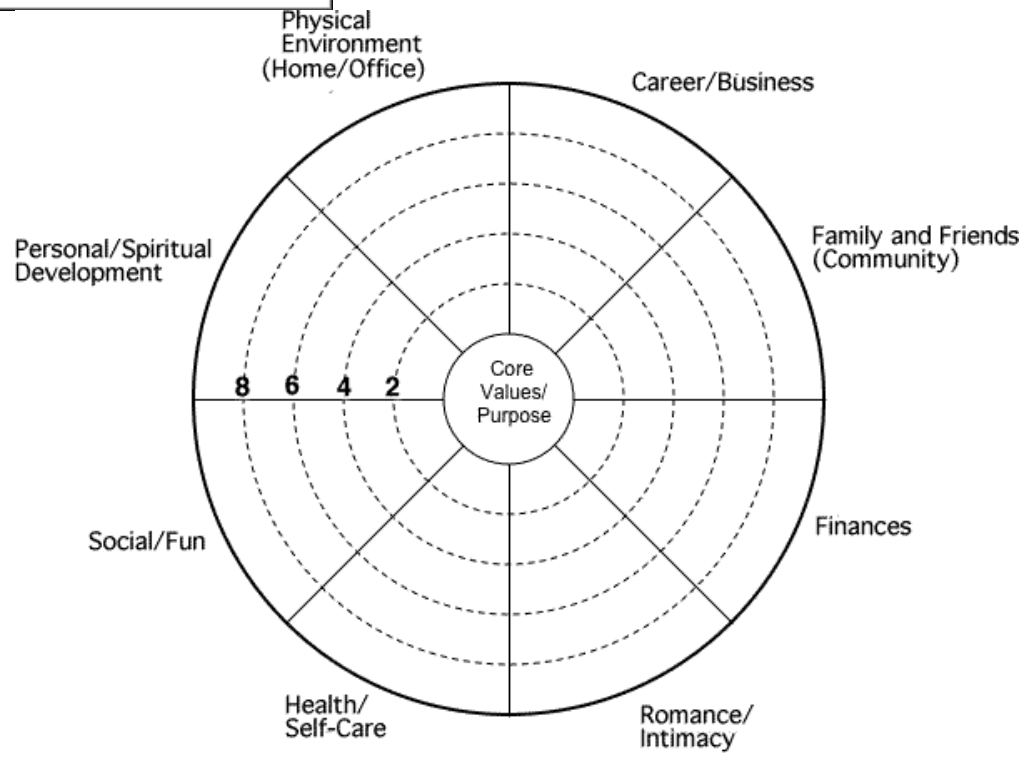
RED:_____,_____,_____
ORANGE:_____,_____,_____
YELLOW:_____,_____,_____
GREEN:_____,_____,_____
BLUE/PURPLE:_____,_____,_____
BLACK:_____,_____,_____
WHITE:_____,_____,_____

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards. See the example:





Please Note When & Why You Have Had Each of the Following:

X-Rays:_____ MRI/Cat Scans:_____

Ultrasounds:_____ Accidents:_____

TB Test:_____ Last Dental Visit: _____

HIV:_____ Last blood work:_____

Last Eye Exam: _____

Did you have the following **D**isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**):

Measles: D I N	Chicken Pox: D I N	Hemophilus (Hib): D I N
Rubella: D I N	Tetanus: D I N	Whooping Cough: D I N

Mumps: D I N Hepatitis B: D I N

Any vaccination reactions: _____

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

Antacids:	Y	N	P	Steroids:	Y N P
Pain medicine (Tylenol, etc):	Y	N	P	Laxatives:	Y N P
Smoking:	Y	N	P	Packs per day & number of years:_____	
Coffee:	Y	N	P	Cups per day if Yes/Past:_____	
Soda Pop:	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		

List all Prescription Medicines (*including dosage,times per day), date you started taking them (month/year) and please bring them with you:*

Drug and Dose/Frequency	Date Started
_____	_____
_____	_____
_____	_____
_____	_____

List supplements/vitamins (*including dosage, times per day), date you started taking them (month/year) and please bring them with you:*

Supplement and Dose/Frequency	Date Started
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any allergies to (please list) below:

FOOD: Y/N DRUGS: Y/N MSG: Y/N ENVIRONMENTAL: Y/N

Place a check in the box next to symptoms that you experience (**Y**), don't experience (**N**), or have experienced in the past (**P**).							
GENERAL SYMPTOMS	Y	N	P	**NOSE AND THROAT**	Y	N	P
Tired, weak lack of energy				Hay fever, sinusitis, runny nose			
Depression, melancholy				Dry mouth or nose			
Worry, anxiety nervousness, irritability				Nosebleeds			
Don't sweat enough				Cracks in corner of mouth			
Sweat too much; odor?_____				Dry or chapped lips			
Night sweats				Sore throats or tonsillitis			
Dizziness, fainting, convulsions				Clear throat often			
Loss or gain of weight				Sore, red, or cracked tongue			
				Cold sores or herpes			
HEAD	Y	N	P	Inability to smell or taste			
History of head trauma/concussion				Lots of cavities			
Headaches; frequency?_____				Bleeding gums			
Migraines; frequency?_____				Grinding teeth			
Other:_____							
				CARDIOVASCULAR	Y	N	P
EYES	Y	N	P	Heart beats fast or irregularly			
Blurred or failing vision				Tightness in chest			
Dry, or itchy eyes				Dizzy or weak upon standing up			
Eyes water excessively				Swollen ankles or feet			

Sensitive to light				Cold hands or feet			
Night blindness				Hands or feet turn blue			
Bloodshot or puffy eyes				Blue fingernails			
Other:_____				Leg pains when walking			
				Varicose veins			
EARS	Y	N	P	Tendency to anemia			
Earaches				Easy bruising			
Noises or ringing in the ears				High blood pressure			
Ear discharges				Low blood pressure			
Loss of hearing				**MUSCULOSKELETAL**	Y	N	P
Excessive wax				Muscle pain or stiffness? Where?_____			
Other:_____				Swollen, painful, or stiff joints			
				Bone pain			
				Painful feet, ankles, or calves			
				Tremors or twitches			
				Loss of strength			
				Hernia			
				Muscle wasting			
				Other:_____			
RESPIRATORY	Y	N	P	**URINARY**	Y	N	P
Cough frequently				Difficulty urinating			
Spitting up mucus or blood				Urinating frequently at night			
Difficulty breathing or sleep apnea				Bedwetting			
Shortness of breath on exercise				Incomplete urination or dribbling			
Chest pain				Pain when urinating			

History of TB				Bladder infections			
Asthma				Kidney infections			
				Kidney stones			
				Lower back pain			
				Other:_____			
SKIN AND HAIR	Y	N	P	**GASTROINTESTINAL**	Y	N	P
Acne or pimples				Loss of appetite			
Skin rashes				Gagging, difficulty swallowing			
Hives				Nausea or vomiting			
Dryness, roughness or scaling skin:				Bad breath			
scalp, elbows, knees, feet				Metallic or bitter taste in mouth			
nose, ears, eyebrows, etc				Food cravings or strong desires			
Dry, coarse hair or split ends				For what?_____			
Nails weak, ridged or split easily				Can't eat fats			
Brown spots or bronzing on skin				Heartburn			
Moles, warts or skin tags				Heaviness after eating			
Sunburn easily				Headache, dizziness, irritability if skipping a meal			
Cuts heal slowly or scar badly				Bloating			
Flush easily				Stomach or abdomen tender or painful			
Hands or feet numb or tingly				Belching or gas (circle one)			
Athlete's foot				Symptoms worse after eating			

GASTROINTESTINAL Cont'd

Other:_____				Bowel movements per day:____			
MALE	Y	N	P	Diarrhea or loose stools			
Prostate problems				Constipation			
Difficult or unusual urination				Change in bowel movements			
Discomfort or pain in genital area				Light colored or greasy stools			
Diminished sexual desire				Dark colored or bloody stools			
Excessive sexual desire				Feeling of incomplete evacuation			
Difficulty maintaining an erection				Undigested food in stool			
Waking at night to urinate				Foul odor or stool or gas			
Other:_____				Hemorrhoids			
				Other:_____			
FEMALE	Y	N	P	**FEMALE, cont'd**	Y	N	P
Hot flashes				Pain with intercourse			
Diminished sexual desire				Number of pregnancies_____			
Excessive sexual desire				Number of children_____			
Inability to conceive				Miscarriages _____ Abortion_____			
Difficulty having orgasm				Vaginal discharge			
Irregular menstruation				Lumps in breast			
Pain prior to or with periods				Discharge from breast			
Depressed, tense, or irritable around periods				Any symptoms that are monthly			
Painful or swollen breasts				Pain, discomfort, or itching in genital area			

				Other:_____			

Date of last period_____# of days between periods_____ How many days does the flow last?
Clots in menstrual flow? Y/N Color (pale, dark, etc):_____
Date of last PAP smear_____ Have you ever had an abnormal PAP?_____
Are you sexually active? _____If so, present type of birth control_____
Have you ever used birth control pills or an IUD?_____
What type and for how long?_____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:	_____	_____	_____	_____	_____	_____
Age when died:	_____	_____	_____	_____	_____	_____
Reason for death:	_____	_____	_____	_____	_____	_____
Cancer type:						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

Thank you for taking the time to fill out this questionnaire. For additional comments use other side.

Our goal is to help as many people as possible. Therefore:

- ***48 business*** **hours advance notice is required** when rescheduling an appointment. This allows the opportunity for someone else to schedule an appointment. As receptionist do not have access to the Naturopath's email account, all scheduling is done via **phone.** Initial:_____
- If you are unable to give us 48 hours advance notice you will be charged $35 to the credit card on file or to your account, a portion of which will be donated to the Nature Conservancy. If you reschedule to another time within the next 2 weeks, this fee will be waived. Initial: _____

Julie Lachman, ND LLC ● 1432 Easton Rd, Suite 3G ● Warrington, PA 18976

Your Name:_____Date:_____

Informed Consent and Additional Information about Dr. Lachman's services:

- Our doctors graduated from a 4-year Naturopathic Medical program at an accredited Naturopathic Medical School, Southwest College of Naturopathic Medicine in Arizona. Dr. Lachman is a primary care physician licensed in the state of Vermont. As Pennsylvania does not have regulations licensing Naturopathic physicians, the practice of naturopathic medicine is therefore unregulated. Initial:_____
- Due to the current lack of regulation of naturopathic doctors in Pennsylvania, insurance companies are not at liberty to cover naturopathic services. Submitting information to your insurance company is unlikely to benefit you. However Health Savings Accounts (HSAs) may be used at this office. Flexible spending accounts cannot generally be used because they require medical necessity Initial:_____
- Email is useful for sending files. For privacy and in order to ensure a timely response, please *call* the office with any health-related concerns. Initial:_____
- If you notice what you believe to be an adverse effect from one of the components of your health plan, you should discontinue it then call Dr. Lachman and inform her of what occurred. Effective management of these symptoms will facilitate your healing process. Initial:_____
- Treatment with other physicians or healthcare providers are not necessarily to be discontinued. Consult the physician who prescribed your medications before discontinuing medications. Initial:_____
- Refunds/Returns: returns on unopened, unused products will be accepted within 30 days. There are no refunds on opened products, custom formulae, or refrigerated products. Initial:_____

Our goal is to help as many people as possible. Therefore, it is the office policy to charge in full for missed appointments. *These charges will be your responsibility and billed directly to you or charged to your credit card (below): Initial*_____

Payments may be made via cash, check, charge, or Health Savings Account. However, a credit or debit card is required on file should either of the above circumstances occur and we would need to charge your card. This does not apply for emergencies or extenuating circumstances.

Office may use the card on file INITIAL:_____

or

MasterCard/Visa/Discover number:_____Exp:_____
CCV:_____

I authorize this card to be used should there be an untimely cancellation (<48hrs) or should I fail to show up for my appointment. INITIAL:_____
Date:_____

- Signature for above items on this page:_____

AUTHORIZATION FOR USE AND DISCLOSURE OF CUSTOMER PARTICIPANT DATA

Our office has partnered with Lab Testing API to provide cost-effective lab tests for our patients should any testing be required by the doctor. Please read this document and sign so that we can efficiently get any testing.

I hereby authorize Lab Testing API LTD, PWNHealth, LLC, and its affiliates, including each's physicians, staff, agents and designees (collectively, "PWN") to use and disclose protected health information about me in the manner and for the purposes stated below.

In addition to the above I authorize the following health provider access to my personal health information, lab orders and results in the manner and the purposes stated below. *****

This authorization applies to the use and disclosure of the following information about me: all information in requests(s) submitted by me or with my consent and the laboratory test values/results/information which are the result of the request(s) so submitted. For avoidance of doubt, I specifically authorize the transfer and release of this information to, between and among myself and the following individuals, organizations and their representatives: (a) Julie Lachman, ND LLC, their staff and agents; (b) Lab Testing API, Ltd.; (c) PWN; (d) the applicable laboratory of record and its staff and agents; and (e) certain providers for the purposes herein, and as required or permitted by law.

The information which is the subject of this authorization will be used or disclosed for the following purposes: (a) to facilitate and execute the services requested by me or performed with my consent (including receiving, reviewing and approving a laboratory request; reviewing, processing and delivering the laboratory test value(s)/result(s)); (b) for treatment, health care operations and payment services; (c) to provide me with information and materials on treatment alternatives, health related offerings and services and products which may assist me with my health, wellness and overall care or be of interest to me; and (d) to conduct statistical research studies, and as required or permitted under state and federal laws. Remuneration may be received in exchange therefor. I may opt to not have my protected health information disclosed for some purposes above with prior written notice to the LTA as set forth below. I understand that such opt-out may affect the services I have voluntarily elected to receive.

This authorization evidences my informed decision to allow release of the information to the parties referenced in this authorization. This authorization is effective immediately and will expire ten years after the date of this authorization.

Upon my written request, I may inspect or copy the information that I have permitted to be used or disclosed, if permitted by law. LTA Parties may receive payment or other remuneration related to the use and disclosures herein.I understand that I have a right to receive a copy of this authorization. I have the right to refuse to agree to this authorization in which case my refusal may affect the services provided to me. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing at any time, except that the revocation will not apply to any information already disclosed by the parties referenced in this authorization have acted in reliance upon this authorization. My written revocation must be submitted to LTA's General Counsel at:

Lab Testing API, Ltd.Attn: General Counsel 280 Madison Avenue
9th Floor, Room 912 New York, NY 10016

Patient Name:_____ Name of Guardian if minor:_____

Signature:_____Date:_____