**Welcome to WCCM**

Washington Center for

Complementary Medicine

Welcome to the Washington Center for Complementary Medicine - WCCM. We look forward to working with you and we are honored that you have chosen us to help you achieve your wellness goals . Be sure tovisit and **“like us” on Facebook** to receive discount coupons and weekly postings on news articles and research to keep you informed on the latest health and wellness issues.

**Please read, fill out and sign the attached forms and bring these forms with you to your appointment.**

If you need to reschedule or cancel an in-person or phone appointment, please notify our office **by phone** **24 hours or more** before your appointment. We can not accept cancellations by email. **We charge a fee of 100% of the cost of the visit for missed appointments or appointments in which less than 24 hours notice is given**. Phone visits are charged in advance of visit and require a credit card on file to schedule.

**E-Mail correspondences:** In order to facilitate patient care in the most effective, responsible and efficient manner, and allowing for critical doctor/patient exchange of detailed information, we ask for your cooperation in refraining from email correspondences. We do accept reordering of supplements by email at wccmmail@gmail.com. Please refer to below instructions for phone calls for further information.

**Phone calls –** please refrain from phone calls between visits and hold your questions until your next visit – unless you have a simple yes or no question about your dosing, etc.. We simply can not handle the volume of calls and what may seem like a simple question to patients often requires that Dr. Becker have your file to study your history of symptoms and medications and supplements before she can responsibly answer questions. Generally, if Dr. Becker needs to open your file to answer your question, this is considered a visit.

If you have a change in symptoms or new symptoms, schedule a follow-up visit to discuss with Dr. Becker or make a note of these changes and discuss in your next visit.

If you feel you are having an adverse reaction to a supplement given by Dr. Becker, either schedule a visit to discuss these new symptoms or discontinue the supplement until symptoms are gone and try to re-introduce the supplement again or discontinue until your next visit to discuss.

**Insurance and Medicare:** WCCM does not bill insurance companies, but we will supply you with all insurance codes necessary to submit your claims for reimbursement at the time of your visit. Our doctors are not preferred providers for any insurance company. Insurance companies cover our visit fees as “out of network” physicians. We are not a Medicare provider. Medicare will not reimburse you for services rendered at WCCM.

**Flexible Spending Plans & Health Savings Accounts**

Both Flex Spending Plans and Health Savings Accounts can often be used to cover any visit fees not covered by your insurance. In addition, they will usually cover any laboratory fees not otherwise covered and most nutritional or herbal supplements prescribed.

**Payment Requirements:** Fees are due at the time of service. We accept Visa, MasterCard, checks or cash. A $30 fee will be charged for each returned check.

I understand that my insurance company may not reimburse me for the expenses incurred in this office. I understand that I am fully responsible for all debt. Any unpaid balances will be billed to my (or my guardian’s, if under age) credit card account**.**

Name of Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have read and understand the above statements.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 Print Name Signature (guardian’s signature if under age) Date

WCCM

**Washington Center for**

**Complementary Medicine**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_ ( First, Middle Initial, Last) Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ Sex: F M

Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason For Office Visit** Date Began Reason For Office Visit Date Began

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**What conditions have you been diagnosed with?**

 Diagnosis Date Began Diagnosis Date Began

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**Past Surgeries, Major Hospitalizations, Injuries and Complications:**

Year Surgery, Illness, Complications Outcome

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What types of therapies have you tried** **?** □diet modification □fasting □herbs □vitamins/minerals ◻homeopathy ◻chiropractic ◻acupuncture ◻conventional drugs ◻other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle the level of stress you are experiencing on a scale of 1 to 10 ( 1 being the lowest)**

 1 2 3 4 5 6 7 8 9 10

**Identify your major causes of stress (e.g. job change, work, home, finances, legal problems)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your job or lifestyle associated with potentially harmful chemicals (e.g. pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g. fireman, mechanics) ?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you consider yourself:**

◻underweight ◻ overweight ◻ just right Your weight today \_\_\_\_\_\_\_ Height \_\_\_\_\_

Have you had unintentional weight loss or gain of 10 pounds or more in the last 3 months? If so, explain.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What are your current health goals?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have You Had Allergy Testing Done In The Past ?** Y N **When?** \_\_\_\_\_\_\_

If Yes, What Type of Test? \_\_\_\_\_\_\_ Skin \_\_\_\_\_\_\_\_ Blood \_\_\_\_\_\_\_\_ Other

 **List Any Allergies, sensitivities or intolerances:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Frequency and/or approximate dates of use of the following:**

Antibiotics \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Steroids (include injections, inhalers, creams) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Screening tests: Date: Enter most recent only Leave shaded areas blank.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Screening Test |  |  |  | Dates  |  |  |  |  |  |  |
| Mammogram |  |  |  |  |  |  |  |  |  |  |
| Thermogram |  |  |  |  |  |  |  |  |  |  |
| Bone Density |  |  |  |  |  |  |  |  |  |  |
| Colonoscopy |  |  |  |  |  |  |  |  |  |  |
| Ultrasound |  |  |  |  |  |  |  |  |  |  |
| Sonogram |  |  |  |  |  |  |  |  |  |  |
| **Other** |  |  |  |  |  |  |  |  |  |  |

 **Medical History**

**HEAD**

\_\_\_\_ Headaches

\_\_\_\_ Migraine headaches

\_\_\_\_ Glaucoma

\_\_\_\_ Visual Disorder

\_\_\_\_ Sinus Problems

\_\_\_\_ Dental Problems

\_\_\_\_ Hearing Loss

\_\_\_\_ Ringing In Ears

\_\_\_\_ Ear Infections

**RESPIRATORY**

\_\_\_\_ Asthma

\_\_\_\_ Bronchitis

\_\_\_\_ Emphysema

\_\_\_\_ Pneumonia

\_\_\_\_ Tuberculosis

\_\_\_\_ Heart Disease

**GASTRO-INTESTINAL**

\_\_\_\_ Colitis/Chron’s

\_\_\_\_ Celiac Disease

\_\_\_\_ Reflux

\_\_\_\_ Inflammatory Bowel

 Disorder

\_\_\_\_ Hepatitis

\_\_\_\_ Gallbladder

\_\_\_\_ Constipation

\_\_\_\_ Diverticulitis

\_\_\_\_ Diarrhea

\_\_\_\_ Vomiting

\_\_\_\_ Gas/bloating

**CARDIOVASCULAR**

­­\_\_\_ High Blood Pressure

\_\_\_ Cholesterol, Elevated

\_\_\_ Arrhythmia

\_\_\_ Circulatory Problems

\_\_\_ Clotting Disorder

\_\_\_ Heart Attack

\_\_\_ Stroke

**GENITOURINARY**

\_\_\_ Kidney or Bladder Disease

**MUSCULOSKELETAL**

\_\_\_\_ Back Pain

\_\_\_\_ Carpel Tunnel Syndrome

\_\_\_\_ Gout

\_\_\_\_ Osteoporosis

\_\_\_\_ Rheumatoid Arthritis

\_\_\_\_ Osteoarthritis

**SKIN**

\_\_\_\_Acne

\_\_\_\_Itching

\_\_\_\_Rashes

\_\_\_\_Easy Bruising

\_\_\_\_Hives

\_\_\_\_Eczema

\_\_\_\_Psoriasis

\_\_\_\_Varicose Veins

\_\_\_\_Allergies/Hay Fever

 **ENDOCRINE**

\_\_\_\_ Chronic Fatigue

 Syndrome

\_\_\_\_ Diabetes

\_\_\_\_ Thyroid Disorder

\_\_\_\_ Obesity

\_\_\_\_ Seasonal Affective

 Disorder

\_\_\_\_ Fatigue, General

\_\_\_\_ Fatigue, Chronic

\_\_\_\_ Insomnia

**NERVOUS SYSTEM**

\_\_\_\_ Alzheimer’s Disease

\_\_\_\_ Epilepsy

\_\_\_\_ Parkinson’s

\_\_\_\_ Multiple Sclerosis

\_\_\_\_ Restless Legs Syndrome

**MENTAL/EMOTIONAL/**

**OTHER**

\_\_\_\_ Depression

\_\_\_\_ Anxiety

\_\_\_\_ Drug Addiction

\_\_\_\_ Eating Disorder

\_\_\_\_ Learning

\_\_\_\_ Alcoholism

**BLOOD, IMMUNE**

\_\_\_\_ Autoimmune Disease

\_\_\_\_ Infection, chronic

\_\_\_\_ Anemia

**MALE REPRODUCTIVE**

 \_\_\_\_ Enlarged Prostate

 \_­\_\_\_ Prostate Cancer

 \_\_\_\_ Decreased sex drive

\_\_\_\_ Infertility

\_\_\_\_ Sexually Transmitted

 Disease

Date of last prostate exam \_\_\_\_\_\_

**FEMALE REPRODUCTIVE**

 \_\_\_Menstrual Irregularities

 \_\_\_ Endometriosis

 \_\_\_ Fibrocystic Breasts

 \_\_\_ Fibroids/ovarian cysts

 \_\_\_ PCOS

 \_\_\_ Premenstrual

 Syndrome (PMS)

 \_\_\_ Breast Cancer

 \_\_\_ Vaginal Infections

 \_\_\_ Decreased Sex Drive

 \_\_\_ Sexually Transmitted

 Diseases

 \_\_\_ Urinary Tract Infection

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of last menstrual cycle** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of cycle \_\_\_\_\_\_\_ days Interval of time between cycles\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ days

**Date of last GYN exam** \_\_\_\_\_\_\_ PAP + -- Date \_\_\_\_\_\_\_\_\_\_\_\_

Form of Birth Control \_\_\_\_\_\_\_\_\_

# of children \_\_\_\_\_\_\_\_\_\_\_\_\_

# of pregnancies \_\_\_\_\_\_\_\_\_

# of miscarriages \_\_\_\_\_\_\_\_

# of abortions \_\_\_\_\_\_\_\_\_\_

Are you pregnant? Y N

Age of first period \_\_\_\_\_\_\_\_\_

List any PMS symptoms (e.g. heavy/scanty flow, clots, cramping, breast tenderness, bloating, mood changes, other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_ Menopause

\_\_\_\_ Surgical menopause

**CANCER**

Type Date Diagnosed

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 **Family Health History**

**(M/Mother, F/Father, B/Brother, S/Sister, FP/Father’s Parents, MP/Mother’s parents, C/Children)**

 \_\_\_ Alcoholism

 \_\_\_Allergies

 \_\_\_ Alzheimer’s Disease

 \_\_\_ Cancer

 \_\_\_Chron's Disease

 \_\_\_ Diabetes

 \_\_\_Drug abuse

 \_\_\_Epilepsy

 \_\_\_ Hearing Loss

 \_\_\_ Heart Disease

 \_\_\_ High Blood Pressure

 \_\_\_ Kidney Disease

 \_\_\_ Liver Disease

 \_\_\_ Nervous or Mental Disorder

 \_\_\_Migraine Headaches

 \_\_\_Neurological Disorders

 \_\_\_Obesity

 \_\_\_Osteoporosis

 \_\_\_Rheumatoid Arthritis

 \_\_\_ Thyroid Disorder

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Your Health Habits**

\_\_\_Tobacco

Cigarettes: #/day \_\_\_\_\_

Cigars: #/day \_\_\_\_\_

\_\_\_Alcohol

\_\_\_Wine: # \_\_\_\_\_glasses/d or wk \_\_\_ Liquor: #\_\_\_\_glasses/d or wk \_\_\_ Beer: #\_\_\_\_\_ glasses/d or wk \_\_\_\_ \_\_\_Caffeine:

Coffee: # 8 oz cups/d\_\_\_\_\_

 Tea: # 8 oz cups/d \_\_\_\_\_

 Soda: # cans/d\_\_\_\_\_

Other caffeine: \_\_\_\_\_\_\_\_\_\_\_\_\_

Water: #oz./d\_\_\_\_\_\_\_

**EXERCISE**

Days/wk \_\_\_\_

Run/Jog \_\_\_\_ d/wk

Cycle \_\_\_\_ d/wk

Swim \_\_\_\_ d/wk

Other Cardio \_\_\_ d/wk

Walk \_\_\_\_\_ d/wk

Weight Train \_\_\_\_\_ d/wk

Stretch \_\_\_\_\_ d/wk

Yoga \_\_\_\_\_ d/wk

\_\_\_45 minutes or more

 duration per workout

\_\_\_ 30-45 minutes

 duration per workout

\_\_\_ Less than 30 minutes

Other exercise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NUTRITION & DIET**

\_\_\_Mixed Food Diet

 ( animal and vegetable)

\_\_\_Vegetarian

\_\_\_Vegan

\_\_\_ Organic Food

\_\_\_Salt Restriction

\_\_\_Fat Restriction

\_\_\_Starch/ carbohydrate

 Restriction

\_\_\_ Calorie Restriction

­­­\_\_\_ Dairy Restriction

\_\_\_ Wheat Restriction

\_\_\_ Egg Restriction

\_\_\_ Soy Restriction

\_\_\_ Wheat Restriction

\_\_\_ Gluten Restriction

 **FOOD FREQUENCY**

 ( # of times per day)

 Fruits \_\_\_\_\_\_\_\_

 Vegetables \_\_\_\_\_\_

 Whole Grains \_\_\_\_\_

 Beans, nuts, legumes \_\_\_\_\_

 Fish \_\_\_\_\_\_\_

 Meat, poultry \_\_\_\_\_\_\_\_

 Dairy \_\_\_\_\_\_\_

 Eggs \_\_\_\_\_\_\_\_

**EATING HABITS**

Skip meals – list which one(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eat \_\_\_\_\_\_# of meals/d \_\_\_Graze (small frequent meals)

 \_\_\_Generally eat on the run \_\_\_ Eat constantly whether hungry or not

**ENERGY-VITALITY**

**I WOULD LIKE TO:**

\_\_\_Feel more vital

\_\_\_ Have more energy

\_\_\_Have more endurance

\_\_\_Be less tired after lunch

\_\_\_Sleep better

\_\_\_Be free of pain

\_\_\_Get less colds and flus

\_\_\_Get rid of allergies

\_\_\_Not be dependent on

 over-the-counter

 medications like aspirin, ibuprofen, anti-histamines,

\_\_\_Sleeping aids, etc.

\_\_\_Improve sex drive

**BODY COMPOSITION**

\_\_\_Loose weight

\_\_\_Burn more body fat

\_\_\_Be stronger

\_\_\_Have better muscle tone

\_\_\_Be more flexible

**STRESS, MENTAL, EMOTIONAL**

 ­­\_\_\_Think more clearly and be more focused

 \_\_\_Improve memory

 \_\_\_Be less depressed

 \_\_\_Be less moody

 \_\_\_Feel more motivated

 **LIFE ENRICHMENT**

 \_\_\_Reduce my risk of degenerative disease

 \_\_\_Slow down accelerated aging

\_\_\_Maintain a healthier life longer

\_\_\_Change from a “treating-illness” orientation to creating a wellness lifestyle

|  |
| --- |
| **PLEASE LIST ANY VITAMINS, MINERALS, HERBAL SUPPLEMENTS, HOMEOPATHICS, MEDICATIONS AND PRESCRIPTION CREAMS THAT YOU ARE TAKING.****NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **SUPPLEMENT/ MEDICATION** | **MANUFACTURER** | **FORM** | **DOSAGE** | **FREQUENCY** |
| EXAMPLE:VITAMIN C | PERQUE | CAPSULE | 1000 MG | 2 PER DAY |
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**Comments:**

**Washington Center for**

**Complementary Medicine, PLLC**

# NATUROPATHIC MEDICINE

# INFORMED CONSENT FOR TREATMENT

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize the naturopathic doctors at the Washington Center for Complementary Medicine, LLC (WCCM) to perform the following specific procedures as necessary to facilitate my treatment:

**Physical exam**: e.g., general, musculoskeletal, cardiovascular, abdominal, respiratory.

**Medicinal use of nutrition**:therapeutic nutrition, nutritional supplementation.

**Botanical medicine**: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, solid extracts, or suppositories.

**Hormone therapies**: natural, bio-identical hormone therapies

**Homeopathic medicine**: the use of highly dilute quantities of naturally occurring plant, animal, and mineral substances to gently stimulate the body’s healing responses.

**Lifestyle and nutritional counseling and hygiene**: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.

## Psychological Counseling

## Contraception

## Hydrotherapy.

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

**Potential risks**: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from procedures.

**Potential benefits**: restoration of health and the body’s maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, prevention of disease or its progression.

**Notice to Pregnant Women**: All female patients must alert the doctor(s) at WCCM if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

**Notice of Degree and License**: Dr. Becker holds a degree of Doctor of Naturopathic Medicine (N.D.) and is a licensed, board-certified Naturopathic Physician in the District of Columbia.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the doctors at WCCM 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. I understand that it is not being recommended to me to discontinue any other treatment or care being provided by any other health care professional. I understand that the doctors do not function as a primary care physicians in Maryland, and that in Maryland they offer services in addition to other services I receive. I understand that this care not replace the service of my primary care physician.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless required by law. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that full disclosure of information has been made to me and all my questions have been answered to my full satisfaction.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Name ( if less than 18 yrs) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_