Regenerate
P D X

11830 Kerr Parkway #208
Lake Oswego, Oregon 97035
(503) 334-2312

Thank you for scheduling with us, we strive to provide the best possible integrative care for our clients. During your initial evaluation your practitioner will do their best to do a thorough evaluation and give you a treatment plan. You can assist us in that by making sure you have fully completed the intake paperwork enclosed.

Please be aware that we ask patients to give us 48 hours notice if they need to reschedule or cancel an appointment. Late cancellation or missed appointments will incur a fee, as we are unable to reschedule the appointment with another patient without sufficient notice.

It will be a pleasure to support you on your path towards wellness.

Informed Consent and Request for Care

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with practitioners of RegeneratePDX having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with RegeneratePDX practitioners.

I understand that I have the right to ask questions and discuss to my satisfaction with the above mentioned providers and/ or with the allied health care provider providing backup:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/ or nothing is done

Medical and Naturopathic Evaluation information:
I understand that Medical evaluation and/or Naturopathic evaluation treatment may include, but is not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory
- Evaluation of blood, urine, stool and saliva
- Soft tissue and osseous manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, pregnancy massage (to relieve muscular discomfort associated with pregnancy), muscle energy technique and cranio-sacral therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Trigger point injection therapy with or without vitamin substances
- Botanical/ herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians with regards to NDs)

Notices

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor- stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. Any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.
Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider of these conditions.

Please INITIAL the following:
_____ I understand that the above mentioned providers are not licensed to prescribe any controlled substances or for those providers who are licensed to prescribe controlled substances, they do not prescribe these types of medication at this facility.
_____ I understand that the above mentioned providers will only prescribe medications if they believe that they are in the best interest of myself, the patient. Referrals will be provided to manage my prescriptive medication needs when appropriate.
_____ I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.
_____ I understand that the above mentioned providers are not psychologists or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect the above mentioned providers and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the above mentioned providers explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

Printed Name of Patient	Signature of Patient	Date
Printed Name of Guardian	Signature of Guardian	Date

Basic Information

Name _____ Date _____

Address _____

City _____ State _____ Zip code _____

Telephone # (home) _____ (work) _____

(cell) _____ Email Address _____

Age _____ Date of Birth _____ Gender _____

Relationship Status: Choose One...

Live with: Choose One...

Occupation _____ Hours per week _____ Retired _____

How did you hear about our clinic? _____

Emergency Contact: Name _____ Relationship _____

Phone _____

What are your most important health concerns? List in order of importance and for how long you have had each of these concerns or conditions.

1) _____
2) _____
3) _____
4) _____

Are you currently under the care of a medical professional? (Y) (N)
If yes, whom and where from? _____

If no, when and where did you last receive medical or health care and for what reason? _____

_____

General Information

Weight _____ lbs. Weight one year ago _____ lbs. Maximum Weight _____ lbs.

When? _____ Height _____

Significant Traumas (auto accidents, falls, etc) _____

Birth history (prolonged labor, forceps delivery, etc) _____

Occupational Stresses (chemical, physical, psychological) _____

Exercise _____

Please list any prescription medications, overotheocounter medications, vitamins, or supplements you are currently taking or have taken **within the last two months, including dosage** (attach additional sheet if necessary):

1)_____ Dosage_____ 2)_____ Dosage_____
3)_____ Dosage_____ 4)_____ Dosage_____
5)_____ Dosage_____ 6)_____ Dosage_____
7)_____ Dosage_____ 8)_____ Dosage_____

Do you have allergies? If yes, what kind?

Drugs _____
Foods _____
Environmentals _____

What hospitalizations, surgeries, or traumas have you had?

_____ year:_____ _____ year:_____
_____ year:_____ _____ year:_____
_____ year:_____ _____ year:_____

How many hours of screen time (TV, Phone, Computer) per day/week?_____ /_____

Habits: ☐Cigarettes ☐Coffee ☐Tea ☐Cola ☐Alcohol ☐Drugs ☐Sugar ☐Salt ☐Other_____

Average Daily Diet:

Morning _____

Afternoon _____

Evening _____

Snacks/Desserts _____

Please check any that apply to you currently

☐ Poor appetite	☐ Heavy appetite	☐ Poor sleep	☐ Heavy sleep
☐ Insomnia	☐ Fatigue	☐ Tremors	☐ Vertigo
☐ Cold hands	☐ Cold feet	☐ Cold back	☐ Cold abdomen
☐ Fevers	☐ Chills	☐ Night sweats	☐ Sweat easily
☐ Cravings (sweet/salty)	☐ Localized weakness	☐ Poor coordination	☐ Change in appetite
☐ Sudden energy drop at _____(time)		☐ Peculiar tastes/smells_____	
☐ Strong thirst (cold/hot drinks) _____		☐ Bleed or bruise easily (where)_____	

Family History

Please indicate if a close relative (parent, grandparent, sibling) has any of the following:

Condition	Relative	Condition	Relative
❒ Allergies/Hay fever		❒ Eczema/Psoriasis	
❒ Anemia		❒ Food Intolerances	
❒ Arthritis		❒ Heart Disease	
❒ Asthma		❒ High Blood Pressure	
❒ Autoimmune Disease		❒ Juvenile Arthritis	
❒ Birth Defects		❒ Kidney Disease	
❒ Bleeding Disorder		❒ Mental Illness	
❒ Cancer		❒ Seizures	
❒ Depression/Anxiety		❒ Stroke	
❒ Diabetes		❒ Tuberculosis	
❒ Other:		❒ Other:	

❒ I don't know the family medical history

For the following sections (please check)

Y = a condition you have now **N** = never had **P** = a condition you had previously

Childhood Illnesses					
Scarlet Fever	Y N P	Diphtheria	Y N P	Rheumatic Fever	Y N P
Mumps	Y N P	Measles	Y N P	German Measles	Y N P
Chicken Pox	Y N P				
Immunizations					
Polio	Y N P	Pertussis	Y N P	Flu	Y N P
Tetanus	Y N P	Diphtheria	Y N P	Chicken Pox	Y N P
Measles/Mumps/Rubella	Y N P	Hep B	Y N P	H. Influnzae (HIB)	Y N P
Head					
Headaches	Y N P	Migraines	Y N P	Head Injury	Y N P
Jaw/TMJ problems	Y N P				
Eyes					
Spots in Eyes	Y N P	Cataracts	Y N P	Impaired vision	Y N P
Glasses or contacts	Y N P	Blurriness	Y N P	Eye pain/strain	Y N P
Color Blindness	Y N P	Tearing or dryness	Y N P	Double vision	Y N P
Glaucoma	Y N P				
Ears					
Impaired hearing	Y N P	Ringing	Y N P	Earaches	Y N P
Dizziness	Y N P				
Nose and Sinuses					
Frequent colds	Y N P	Nose bleeds	Y N P	Stuffiness	Y N P
Hay fever	Y N P	Sinus problems	Y N P	Loss of smell	Y N P
Neck					
Lumps	Y N P	Swollen glands	Y N P	Goiter	Y N P
Pain or stiffness	Y N P				

Mouth and Throat					
Frequent sore throat	Y N P	Copious saliva	Y N P	Teeth grinding	Y N P
Sore tongue/lips	Y N P	Gum problems	Y N P	Hoarseness	Y N P
Dental cavities	Y N P	Jaw clicks	Y N P		
Cardiovascular					
Heart disease	Y N P	Angina	Y N P	Murmurs	Y N P
High/Low blood pressure	Y N P	Blood clots	Y N P	Fainting	Y N P
Palpitations/fluttering	Y N P	Phlebitis	Y N P	Rheumatic fever	Y N P
Swelling in hands/feet	Y N P	Chest pain	Y N P		
Blood/Peripheral Vasc.					
Easy bleeding/bruising	Y N P	Varicose veins	Y N P	Cold hands/feet	Y N P
Deep leg pain	Y N P	Anemia	Y N P	Thrombophlebitis	Y N P
Gastrointestinal					
Trouble swallowing	Y N P	Heartburn	Y N P	Change in thirst	Y N P
Change in appetite	Y N P	Nausea	Y N P	Vomiting	Y N P
Vomiting blood	Y N P	Blood in stool	Y N P	Pain or cramps	Y N P
Belching or passing gas	Y N P	Constipation	Y N P	Diarrhea	Y N P
Gall bladder disease	Y N P	Black stools	Y N P	Ulcer	Y N P
Jaundice (yellow skin)	Y N P	Liver disease	Y N P	Hemorrhoids	Y N P
Sensitive Abdomen	Y N P	Bloody Stools	Y N P	Laxative Use	Y N P
Bowel movements:	Frequency?				
	Color?				
	Formed?				
Respiratory					
Cough	Y N P	Sputum	Y N P	Spitting up blood	Y N P
Wheezing	Y N P	Asthma	Y N P	Bronchitis	Y N P
Short of breath lying down	Y N P	Pleurisy	Y N P	Emphysema	Y N P
Difficulty breathing	Y N P	Pain on breathing	Y N P	Shortness of breath	Y N P
Short of breath at night	Y N P	Tuberculosis	Y N P	Pneumonia	Y N P
History of smoking	Y N P				
Urinary					
Pain on urination	Y N P	Incr. frequency	Y N P	Incontinence	Y N P
Frequency at night	Y N P	Frequent infections	Y N P	Kidney stones	Y N P
Condyloma (genit. warts)	Y N P	Chlamydia	Y N P	Gonorrhea	Y N P
Herpes	Y N P	Syphilis	Y N P	Blood in Urine	Y N P
Female Reprod./Breast					
Age of first menses		Are cycles regular?	Y N	Length of cycle	
Age of last menses		Duration of menses		Clotting	Y N P
First day of most recent menses?		Date of last Pap?			
Bleeding between cycles	Y N P	Painful menses	Y N P	Discharge	Y N P
Heavy or excessive flow	Y N P	Light flow	Y N P	PMS	Y N P

PMS symptoms	Ⓨ Ⓝ Ⓟ	Endometriosis	Ⓨ Ⓝ Ⓟ	Ovarian cysts	Ⓨ Ⓝ Ⓟ
Pain during intercourse	Ⓨ Ⓝ Ⓟ	Abnormal PAP	Ⓨ Ⓝ Ⓟ	Breast self-exams	Ⓨ Ⓝ Ⓟ
Are you sexually active	Ⓨ Ⓝ Ⓟ	Breast pain/tenderness	Ⓨ Ⓝ Ⓟ	Nipple discharge	Ⓨ Ⓝ Ⓟ
Breast lumps	Ⓨ Ⓝ Ⓟ	Mastitis	Ⓨ Ⓝ Ⓟ		
Breast feeding	Ⓨ Ⓝ Ⓟ	Menopause symptoms	Ⓨ Ⓝ Ⓟ	# of Live births	
Birth control	Ⓨ Ⓝ Ⓟ	What type?		# of miscarriages	
Menopause	Ⓨ Ⓝ Ⓟ	# of Abortions		#of pregnancies	
Male Reproduction					
Testicular masses	Ⓨ Ⓝ Ⓟ	Hernias	Ⓨ Ⓝ Ⓟ	Prostate disease	
Testicular pain	Ⓨ Ⓝ Ⓟ	Discharge	Ⓨ Ⓝ Ⓟ	Sores	Ⓨ Ⓝ Ⓟ
Premature ejaculation	Ⓨ Ⓝ Ⓟ	Impotence	Ⓨ Ⓝ Ⓟ		
Are you sexually active?	Ⓨ Ⓝ	Sexual orientation?		Birth control type?	
Musculoskeletal					
Joint pain or stiffness	Ⓨ Ⓝ Ⓟ	Broken bones	Ⓨ Ⓝ Ⓟ	Weakness	Ⓨ Ⓝ Ⓟ
Muscle spasms/cramps	Ⓨ Ⓝ Ⓟ	Arthritis	Ⓨ Ⓝ Ⓟ	Sciatica	Ⓨ Ⓝ Ⓟ
Immune					
Chronic Fatigue Synd.	Ⓨ Ⓝ Ⓟ	Chronic Infections	Ⓨ Ⓝ Ⓟ	Slow wound healing	Ⓨ Ⓝ Ⓟ
Chronic swollen glands	Ⓨ Ⓝ Ⓟ				
Neurologic					
Seizures	Ⓨ Ⓝ Ⓟ	Paralysis	Ⓨ Ⓝ Ⓟ	Muscle weakness	Ⓨ Ⓝ Ⓟ
Numbness or Tingling	Ⓨ Ⓝ Ⓟ	Loss of memory	Ⓨ Ⓝ Ⓟ	Vertigo or dizziness	Ⓨ Ⓝ Ⓟ
Loss of balance	Ⓨ Ⓝ Ⓟ	Concussion	Ⓨ Ⓝ Ⓟ		
Endocrine					
Hypothyroid	Ⓨ Ⓝ Ⓟ	Diabetes	Ⓨ Ⓝ Ⓟ	Heat/Cold intoler.	Ⓨ Ⓝ Ⓟ
Hyperthyroid	Ⓨ Ⓝ Ⓟ	Excessive thirst	Ⓨ Ⓝ Ⓟ	Weight loss/gain	Ⓨ Ⓝ Ⓟ
Hypoglycemia	Ⓨ Ⓝ Ⓟ	Fatigue	Ⓨ Ⓝ Ⓟ	Seasonal Depression	Ⓨ Ⓝ Ⓟ
Skin					
Rashes	Ⓨ Ⓝ Ⓟ	Acne, Boils	Ⓨ Ⓝ Ⓟ	Hives	Ⓨ Ⓝ Ⓟ
Itching	Ⓨ Ⓝ Ⓟ	Color Change	Ⓨ Ⓝ Ⓟ	Dandruff	Ⓨ Ⓝ Ⓟ
Perpetual hair loss	Ⓨ Ⓝ Ⓟ	Ulcerations	Ⓨ Ⓝ Ⓟ	Acne	Ⓨ Ⓝ Ⓟ
Psychological					
Depression	Ⓨ Ⓝ Ⓟ	Bad temper	Ⓨ Ⓝ Ⓟ	Easily Stressed	Ⓨ Ⓝ Ⓟ
Anxiety	Ⓨ Ⓝ Ⓟ	Considered Suicide	Ⓨ Ⓝ Ⓟ	Attempted Suicide	Ⓨ Ⓝ Ⓟ
Eating Disorder	Ⓨ Ⓝ Ⓟ	Treated for psychological problems	Ⓨ Ⓝ Ⓟ	History of abuse?	Ⓨ Ⓝ Ⓟ
Treated for emotional problems	Ⓨ Ⓝ Ⓟ				