



NEW CLIENT PROFILE

This provides us with very basic information so that we can understand your health history and your current concerns and goals. Please complete as accurately and completely as possible before we begin.

Today's date: _____

Name: _____ Gender: Male Female

Date of birth: _____ Current age: _____ Height: _____ Weight: _____

Home street address: _____

City: _____ State: _____ Zip code: _____

Mailing address (if preferred): _____

City: _____ State: _____ Zip code: _____

Home phone: _____ OK to leave message? Yes No

Work phone: _____ OK to leave message? Yes No

Mobile phone: _____ OK to leave message? Yes No

E-mail: _____ OK to leave message? Yes No

Occupation: _____ Employer: _____

Emergency contact: _____ Phone: _____

HEALTH INFORMATION-CONFIDENTIAL

PRESENT HEALTH CONCERNS: Please list your most important health concerns. If possible, please list them in order of importance to you. For example, #1 is most important, and #5 is least important.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

YOUR MAJOR GOALS FOR THE FIRST VISIT: Please tell me what you would like to accomplish on the first visit.

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

YOUR QUESTIONS: What questions do you have for today's visit?

ALLERGIES: Please list all food, environmental, and/or drug allergies.



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DIET: Do you follow any particular diet regimens or restrictions?

EXERCISE: Do you exercise regularly? If YES-what do you do? If NO-what keeps you from exercising?

HABITS & LIFESTYLE: Please circle or list which of the following you use.

Tobacco/cigarettes alcohol coffee black tea cola/soda aspirin/Tylenol/analgesics
antacids recreational drugs prescription drugs

Other: _____

CURRENT PRESCRIPTION MEDICATIONS (e.g. Prozac, atenolol, etc.), **NON-PRESCRIPTION MEDICATIONS** (e.g. aspirin, Tylenol, ibuprofen) **AND/OR HEALTH SUPPLEMENTS** (e.g. vitamins, minerals, herbs): Please list the medications and/or supplements that you are currently taking, with dosages:

NAME of medication or supplement-drugs, vitamins, herbs, minerals	DOSE in milligrams or grams or number of capsules, tablets	FREQUENCY: Times per day/week/month	DURATION: Been taking for how long?

MOST RECENT VISIT TO A DOCTOR: When was the last time you consulted a doctor, and for what reason? _____

Date of last complete physical exam _____

Date of most recent lab/blood tests: _____

WOMEN-Date of last PAP smear: ____ **Results:** ____ **Currently pregnant?** YES NO UNSURE

MEDICAL PROCEDURES, HOSPITALIZATIONS, MAJOR INJURIES, AND SERIOUS ILLNESS: Please list previous medical procedures, surgeries, hospitalizations, and serious illnesses:

Approximate date/year	Surgery/hospitalizations/procedure/serious illnesses/injuries



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MUTUAL UNDERSTANDINGS AND CONSENT TO TREATMENT

The following information is provided to enable our sharing of a common understanding of our rights and roles in this professional therapeutic relationship. Please read this agreement and sign at the end indicating that you have read, understood and agreed to the following. Please ask any questions if you would like clarification or additional information.

- Information revealed during counseling and discussion sessions is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.
- Jennifer Echert and sub-contracted therapists provide counsel to educate clients interested in taking an active role in their healthcare. Our services are not meant to replace your regular physician, nor do we diagnose illnesses, nor prescribe treatments. The information shared is for educational purposes only. You are encouraged to ask questions on any health-related topic. Ours is a team approach, and naturopathic programs may involve educating you to make changes in your diet and lifestyle that can help you attain your highest level of health.
- Treatments with other healthcare professionals are not necessarily to be discontinued. Please let Dr. Echert know if you are being treated by physicians, therapists, etc.
- It is your responsibility to disclose changes in your condition, symptoms, contact information, or treatments between visits.
- The recommendations made for you are for educational purposes only. If you choose to utilize a program, it is to be used under supervision of a healthcare professional to ensure safety and effectiveness. Every effort will be made to answer all of your questions and to ensure the safety and effectiveness of your program: however if you make self-directed changes in your program, add or remove components, or use a "short-term" plan for an extended period of time, then there is an increased risk for adverse effects. Please use your program as recommended and with supervision, and not for longer than two months without counsel that long-term use is both beneficial and safe for you.
- Each program/approach carries with it both benefits and risks. There may be additional alternative approaches available. You are encouraged to ask questions if you would like more information. No guarantees or warranties are expressed or implied concerning the outcome of the program(s).
- Physical examination and massage may result in injury and does involve physical contact, which may be uncomfortable for some persons. If you are uncomfortable with physical contact or unfamiliar with an approach, please let Dr. Echert know so that she can assist you and/or help you find an alternative that is more comfortable for you.
- Dr. Echert is not available on a 24-hour basis. If you have a serious health problem that requires immediate attention, you should call your physician(s), call 911, or have someone take you to the nearest hospital emergency room. If you notice an adverse effect from one of the components of your program, you should discontinue it then call Dr. Echert to inform her of what occurred.
- Fees are charged for professional services and full payment with cash or check, or credit card via PayPal is expected at the time services are rendered. Examples of professional services are consultations (whether in office, by phone or e-mail), treatments, and correspondence or extended research on your behalf. You are responsible for payment of fees and lab tests regardless of insurance coverage. We do NOT submit claims to health insurance providers, although we will provide a detailed receipt so you may attempt to submit on your own. Medicare/Medicaid does not reimburse for lab tests, nutrition consultation or preventative medicine regardless of your need for these services. If a Medicare provider uses natural medicine instead of pharmaceutical drugs with Medicare/Medicaid patients, they can face fines of thousands of dollars and federal prison.
- You are welcome to bring a friend or relative with to your visits if you so desire.

PRINT Client's name

Date

SIGNATURE of client or guardian

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For educational purposes only.