Natural Wellness Center

Name_____Date_____
Address_____
(street) (town) (state) (zip)
Phone(H)_____(W)_____(C)_____Email_____
Birthdate_____Place of
employment_____Occupation_____
List
surgeries_____
_____
List major injuries (physical or emotional)
_____
_____
List
medications_____
_____
List supplements presently
taking_____
_____
_____
How many cigarettes/tobacco daily?_____
How much alcohol daily?_____
How many dental fillings?_____
List allergies: Food_____Medication_____Environment_____
How many times have you had cortisone or antibiotics in last year?_____
How many sugar products (cookies, candy, soda, carbohydrates) do you have each day?_____
How much caffeine(tea, coffee, soda, chocolate) daily?____
How many fat, fried, fast foods do you eat daily?____
How many glasses water daily?_____
How many times do you exercise weekly?_____
Do you have a BM every day?_____
Do you sleep well at night? ____Do you have difficulty going to sleep?_____
Do you wake up & have difficulty returning to sleep? What time do you do this?___
What is your stress level ?(0 low-10 high)_____Is this more emotional or physical?_____
How many emotional factors (fear, anger, anxiety, depression) do you experience weekly?_____
How many toxic exposures in the last year (x-rays, chemical sprays, etc)_____
Is there a possibility that you are pregnant?_____ On birth control/hormones?_____What?_____
Is there a history of seizures or epilepsy?_____History of blood clots?____
Do you have a pacemaker, insulin pump or implanted electrical device?_____
Are you electrically sensitive?_____
Who may we thank for referring you?_____
What are the most important issues that you wish to have evaluated?_____
_____
_____
_____
List others seen for this condition?_____
_____
Have you ever seen a natural health practitioner before?_____
Birthdate-_____

Do NOT wear metal belts, jewelry, magnets, cell phone, beepers for visit. Do NOT apply lotion to hands or feet day of visit. Bring all BOTTLES of any vitamins, supplements, prescriptions you are taking.

Please complete the Symptom Questionnaire **before visit.**

Signature_____Date_____

Client Record Form

Natural Wellness Center
2106 N. 7th St, W.Monroe, LA 71291

CONSENT FOR SERVICES

I request that Natural Wellness Center *(hereafter referred to as NWC*) & Dr. Carolyne Yakaboski perform an evaluation and assist me in preparing a program of lifestyle changes that will enhance my health. Under the Ninth Amendment, I understand that I have a constitutional right for freedom of choice in my health care. This includes the right to choose my diet, obtain therapy, remedy or products recommended by the practitioner of my own choosing.

DISCLOSURE OF CREDENTAILS

I understand that NWC & Dr. Carolyne Yakaboski are qualified to perform consultations to assist the client in maintaining their health, evaluate their nutritional status & make recommendations. The state of Louisiana does not have licensing laws for naturopathy or nutritional counseling. Please refer to www. natural health.org for Senate Bill 189 that allows practitioners to recommend the usage of dietary supplements, food or other remedies. Dr. Yakaboski has completed extensive training and seminars with many leaders in this field to prepare for her consulting. These include Doctor of Natural Medicine & PhD in BioNutrition, Registered Nurse, and Licensed Massage Therapy.

DISCLAIMER

I understand that Dr. Carolyne Yakaboski is not a licensed Medical Doctor nor an allopathic physician under the meaning of the "Medical Practice Act9LA Revised Statutes 37:1292) (as amended 1993) and that Dr. Carolyne Yakaboski does NOT diagnose, treat, prescribe, or cure any disease process nor perform invasive procedures or prescribe synthetic drugs. Dr. Carolyne Yakaboski is not a Primary Care Physician and does not treat urgent, emergency or acute care conditions. For medical conditions and certain diagnostic procedures, referral to a medical specialist will be advised. I understand that recommendations are advisory and educational in nature and not intended to replace or prevent medical care and advice.

FINANCIAL POLICY

All charges are due at the time of service. Our office does not file insurance claims as natural and preventative health services are not covered by ANY insurance policy. Payment may be made by check or cash. Visa/MasterCard credit card (no debit cards) are accepted when necessary.

PRIVACY PRACTICE NOTICE

Under HIPAA, providers are required to follow certain rules of privacy that may affect the client's personal health information. The information you provide to NWC is Confidential and Private and cannot be disclosed to any individual or agency without your written authorization. The HIPAA privacy rule gives individual the right to request a restriction on uses and disclosures of their protected health information.

You MUST fill in blanks and CIRCLE how we can contact you: Failure to complete this denotes NO restrictions.

Home phone_____ok to leave detailed message/*leave call back number only*/do NOT contact here.
Work phone_____ ok to leave detailed message/*leave call back number only*/do NOT contact here.
Fax number_____ ok to leave detailed message/*leave call back number only*/do NOT contact here.
Cell number_____ ok to leave detailed message/*leave call back number only*/do NOT contact here.
Email_____ ok to leave detailed message/*leave call back number only*/do NOT contact here.
Address_____ *ok to mail here*/do NOT mail here.

I have been provided an opportunity to review the "Notice of Privacy Practice" that is posted in this office.
If you feel your privacy rights have been violated, you may contact Dr. Carolyne Yakaboski at 318-387-3000 to report your complaint. I will respect confidentiality of all complaints and work at resolving them as quickly as possible.

Please sign acknowledging your understanding & agreement. Thanks

_____

Client/Legal guardian signature Date