Natural Rhythms
AYURVEDIC NATUROPATHY

INTAKE FORM

I. PERSONAL INFORMATION

Today's Date_____

Full Name_____I like to be called _____
(First Middle Initial Last)

Age_____ Date of Birth_____ Gender_____ Social Security #

Address_____Email_____

City_____ State_____ Zip _____

Phone (best to be reached)_____ (alternate)_____May we leave messages?__

Occupation_____Hours per week _____

Employer _____ Education_____

Military Service?_____

Are you: ___Married ___Separated ___Divorced
___Single ___Cohabitating ___Widowed

Live with: ___Spouse ___Parents ___Alone
___Children ___Partner ___Friends

Children's Ages_____

Emergency Contact (name and relation)_____

Contact's Phone (home)_____ (work)_____ (cell)_____

How did you hear about our clinic?

_____

II. PERSONAL HEALTH HISTORY

Please list your 3-5most important health concerns:

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

Please check the relevant areas and give some details below.

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Colitis
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Disorders
- ☐ Herpes Genitalis
- ☐ High Blood pressure
- ☐ Hypoglycemia
- ☐ Injury (serious)
- ☐ Liver Disorders
- ☐ Psychological Disorders
- ☐ Skin Disorders
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Other: _____

Please note when and why you had following exams:

X-Rays: _____ MRI/Cat Scans: _____
Ultrasounds: _____ TB Test: _____
HCV: _____ HIV:_____
Last Dental Visit: _____ Last Eye Exam: _____

HOSPITALIZATIONS: (Dates and type of illness/operation)

_____
_____
_____

KNOWN ALLERGIES: (to medications, foods, pollens, etc.)

_____
_____
_____

MEDICATIONS & SUPPLEMENTS: (prescription & non-prescription items), and for WHAT CONDITION:

1) 4)

2) 5)

3) 6)

III. FAMILY HISTORY

Do your close relatives (parents, siblings, children) have any of the following medical conditions? Please circle and indicate the relative with the disease:

Disease	Specify illness	Relatives	Disease	Specify illness	Relatives
High Blood Pressure			Birth Defects		
Heart Attack			Suicide		
Stroke			Depression		
Obesity			Mental Illness		
Diabetes			Alcoholism		
Glaucoma			Epilepsy		
Asthma			Ulcers		
Hay Fever			Arthritis		
Eczema			Gout		
Skin Disease			Thyroid disease		
Food allergies			Easy Bleeding		
Emphysema			Sickle Cell		
Tuberculosis			Anemia		
Lung Cancer			Osteoporosis		
Breast Cancer			Arthritis		
Other Cancer			Other		

Natural Rhythms
AYURVEDIC NATUROPATHY

Informed Consent and Request for Naturopathic Treatment

I, _____, as a patient, have the right to be informed about my condition and recommended care. 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 having had the opportunity to discuss the potential benefits, risks, and hazards involved.

Anup Mulakaluri, N.D. holds a degree of Doctor of Naturopathic Medicine (N.D.) and is a licensed, board-certified Naturopathic Doctor in the State of Washington. A naturopathic doctor (N.D.) is trained as a physician specializing in natural and preventative medicine and is recognized as such by medical licensing laws in the state of Washington. Dr. Mulakaluri specializes in Ayurvedic Wellness that utilizes natural therapies and treatments like nutrition, lifestyle practices, herbs, manual therapy, fasting, etc. as modes of promoting optimal health. Dr. Anup Mulakaluri, ND, and his covering physicians, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Physical Exam: e.g., general, musculoskeletal, cardiovascular, abdominal, respiratory.
Common diagnostic procedures (laboratory evaluation of blood, urine, stool, and saliva)
Medicinal Use of Nutrition: therapeutic nutrition, nutritional supplements.
Botanical Medicine: botanical substances may be prescribed as teas, alcohol-based tinctures, capsules, tablets, creams, plasters, or suppositories.
Lifestyle Counseling and Hygiene: nutrition therapy and promotion of wellness, including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Psychological Counseling
Hydrotherapy
Cranial Sacral

I recognize the Potential Risks and Benefits of these Procedures as described below:
Potential Risks: Nausea, fainting, weakness, aggravation of existing symptoms, allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, or injury from procedures.
Potential Benefits: restoration of health and the body's maximum functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Notice to Pregnant Women: All female patients must alert Dr. Porter if they know or suspect that they are pregnant, as some of the therapies used could present a risk to the pregnancy.

I hereby request and consent to examination and treatment with Naturopathic Medicine by Dr. Anup Mulakaluri. I understand that unanticipated risks and complications can occur in treatment, and I wish to rely on Dr. Mulakaluri to exercise all judgment during the course of treatment, based on the known facts. I understand that it is my responsibility to request that Dr. Mulakaluri explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees have been made to me concerning the results intended from the treatment. By signing below I acknowledge that I have been given ample opportunity to read this form or that it has been read to me. I understand 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 condition for which I seek treatment.

Print patient name _____ Signature of patient _____
Date _____

Print parent/guardian name_____ Signature parent/guardian_____
Date _____