

Naturopathic Med / David Graves, ND

2607 S. Southeast Blvd. B111, Spokane, WA 99223

509-413-1530, fax 509-497-0654

Natpathmed.com natpathmed@gmail.com

Dear Prospective Patient,

Welcome! And thank you for choosing Dr. Graves as one of your health care providers.

HOW THE PROCESS WORKS:

STEP 1: During your initial consultation Dr. Graves will review your health history, conduct any pertinent physical exam, and make recommendations for lab tests that are appropriate for your specific health issues.

STEP 2: Once you have completed your lab tests, Dr. Graves will explain the meaning of your test results to you in a follow up consultation. He will create an individualized therapeutic program for you based on your lab results and initial evaluation.

STEP 3: Subsequent consults are scheduled to monitor your progress. Dr. Graves will also design an on-going wellness program to be reviewed and updated every three to six months.

We invite you to contact us via email or phone should you have any questions during the course of your treatment. We may be reached at 509-413-1530, natpathmed@gmail.com.

Office hours are: Mon & Wed 9:30am – 5:30pm, Thurs 9am – 12pm.

We look forward to assisting you in achieving your current wellness goals, and to guide you in maintaining wellness throughout your life.

In Health,

David Graves, ND and Staff

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New Patient Paperwork

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize David Graves, ND to release my personal medical information to me.

Patient's Signature: _____

Date: _____

Name:			Date:		
Address:					
City:		State:		Zip/Postal Code:	
Home Phone:		Work Phone:		Fax:	
E-mail:			Cell Phone:		
Please mark your preference for occasional follow up communication from our office: ___ Email ___ Phone					
Age:	Birth date:	Sex: M F	Status: M S W D	No. Children:	
Occupation:		Employer:		Years Employed:	
Spouse's Name:		Occupation:		Employer:	
Person responsible for this account:				Referred by:	
Insurance Provider:				<i>Please present card at first appointment</i>	
What is your major complaint?					
Other complaints?					
What are your overall health goals once your complaints are resolved?					
How long has it been since you really felt good?					

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight _____ Height _____ Blood Pressure (if known) _____ % Body Fat (if known) _____

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1. Are you presently taking any medications, nutritional supplements or vitamins? Yes No

please list (attach sheet if necessary), also list any recently discontinued

when started name/brand dose prescribed by date stopped

2. In the past, have you used birth control pills and/or antibiotics? _____

a. For how long? _____

3. If you have fillings, please list material(s) used: _____

4. Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent Headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	Allergy: list type(s)
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

5. How much sleep do you get each night on average? _____

6. Do you have any food allergies, sensitivities or restrictions? _____

7. Do you smoke, drink alcohol or use recreational drugs? _____

a. How much, how often? _____

b. How often do you drink caffeinated beverages? _____

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.): _____

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9. Are there foods that you eat on a daily basis, almost daily basis? _____

a. Do you "miss" these foods if you do not eat them? _____

10. Write briefly about your weight gain/loss history: _____

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits boredom

b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity: _____

12. What methods have you tried to lose/gain weight _____

13. How is your energy level? _____

a. Are there times in the day that you feel best? _____ worst? _____

14. Are you happy in your life right now? _____

15. What are your main sources of stress _____

16. How do you deal with your stress? _____

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes _____ No _____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes _____ No _____

c. I get tired and/or hungry in the mid-afternoon. Yes _____ No _____

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. Yes _____ No _____

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e. Now and then I think I am a secret eater. Yes _____ No _____

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes _____ No _____

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes _____ No _____

h. I experience cravings for sugar, breads, pasta and baked goods. Yes _____ No _____

i. I feel shaky if I don't eat on time or if I don't snack. Yes _____ No _____

j. I often find myself irritable or angry. Yes _____ No _____

18. Check off any of the following that have applied to you within the last 30 days:

_____ Do you feel nauseous?	_____ Do you have abdominal/intestinal pain?
_____ Do you have bloating?	_____ Do you get bloated after meals?
_____ Do you get heartburn?	_____ Do you have diarrhea?
_____ Do you have constipation?	_____ Do you travel outside of the U.S.?
_____ Do you have gas?	_____ Are your stools compact/hard to pass?
_____ Do you belch following meals?	_____ Do you have gurgles in your stomach?
_____ Do your bowel movements alternate between constipation and diarrhea?	

24. In your estimation, how physically fit are you right now?

Unfit _____ Below average _____ Average _____ Above average _____ Very fit _____

25. How often do you exercise? _____

a. What is your regimen? _____

(continued on next page)

26. If you do not currently exercise, what types of exercise have you enjoyed doing in the past? _____

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27. What are your fitness goals? (circle all that apply)

___ General fitness endurance _____	Muscle toning
___ Weight loss/maintain weight	___ Muscle strengthening
___ Osteoporosis prevention	___ Muscular coordination/balance
___ Specific sport enhancement _____	Other _____
___ Flexibility	_____

28. Surgeries, starting with most recent: _____

29. Hospitalizations: _____

30. Briefly describe where you have lived since childhood: _____

31. What is your heritage? (Irish, German, Spanish, etc.) _____

32. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:	Do you often:
Now Past Satisfactory	Now Past Feel depressed
Now Past Boring	Now Past Have anxiety
Now Past Demanding	Do you often:
Now Past Unsatisfactory	Now Past Have irrational fears
Do you worry over:	Now Past Feel upset
Now Past Home life	Now Past Feel things go wrong
Now Past Marriage	Now Past Feel shy
Now Past Children	Now Past Cry
Now Past Job	Now Past Feel inferior
Now Past Income	Have you:
Now Past Money problems	Now Past Seriously considered suicide
	Now Past Attempted suicide

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POLICIES AND PROCEDURES

New Patients

First Appointment

Your first consultation will be 45 minutes – 1 hour. During this time Dr. Graves will determine the appropriate lab tests to address your specific health concerns.

Fee Schedule (*fees reflect prepay price with 15% discount*)

New Patient consultation: \$242 (45 minutes - 1 hour)

1 hour: \$242

45 minutes: \$170

30 minutes: \$126

15 minutes: \$84

Phone appointments \$3.00/min (*note: cannot be billed to insurance*)

- ☐ Payment is due at time of consultation; limited insurance billing is available.
- ☐ Methods of payment are: Cash, Check or money order (in advance), Debit, Visa, MasterCard or Discover.
- ☐ All consultations are timed from the time the appointment begins; you will only be billed for the actual time used.

Appointments

- ☐ Follow-up consults may be scheduled in 15, 30, 45, or 60-minute blocks of time.
- ☐ We encourage you to book your appointments 2 weeks in advance.
- ☐ You will receive an email a day in advance regarding your scheduled appt.

Lab Tests

- ☐ The results of your lab test(s) will be sent to Dr. Graves 2 – 4 weeks after mailing your specimens to the lab.
- ☐ Dr. Graves will evaluate the results. After evaluation you will be contacted to schedule a follow-up appointment.

Cancellations

- ☐ If you are unable to keep your scheduled appointment, you must notify our office a minimum of 24 hours before your scheduled time or you may be charged for that appointment.

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Returned Products

- PRE-APPROVAL is REQUIRED on ALL RETURNS.
- Refrigerated items CANNOT be returned.
- 15% restock fee of purchase price less shipping and handling may be refunded on unopened and non-refrigerated items.
- No supplement returns will be accepted after 30 days on all regularly stocked items. Special orders CANNOT be returned!
- Prepaid tests can be returned for credit within one year of purchase.

Important Notes

- Dr. Graves is not a medical doctor; he does not service medical emergencies. If you have a medical emergency, you must contact your closest urgent care, primary care physician, or dial 911!
- As a Naturopathic Doctor in WA State, Dr. Graves can provide non-emergent primary care and is able to prescribe some prescription medication as deemed appropriate.
- Please contact the office if you are not clear on any of our policies or procedures.

I _____ have read and understood Naturopathic
Med, David Graves, ND Policies and Procedures.
(please print name)

Date _____

Signature _____

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Please complete this form if you would like us to share information about your progress with another person.

Authorization to Release Medical Information

To: (practitioner or clinic name here) _____

Address: (address here) _____

I, _____ request the following information:

Test results History Records Diagnosis

Treatment Reports Progress

concerning my: Accident Injury Illness

Other _____

To be released to: _____
(Name of Practitioner, Doctor, family member etc.)

Address: _____

Fax: _____

For the purpose of: _____
(Specify)

Signed: _____ Date: _____

Patient Spouse Parent Guardian