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WELLNESS FOR ALL

NATUROPATHIC INTAKE

Welcome! Thank you for choosing Ripple for your health care needs.
We are here to help and are excited to share our passion for healing.

Thank you for taking the time to fill out these forms. This information gives us a comprehensive picture of your health status and improves our ability to address your health concerns.

CLIENT INFORMATION

Name:

Date of Birth:_____ Gender:_____

Reason for visit:_____

_____

Name of previous or current primary care provider:_____

Date of last physical exam:_____

What is your preferred pharmacy? _____

Which location of this pharmacy do you prefer? _____

In general, would you say that your health is excellent, very good, good, fair, or poor?

Allergies: please list any allergies you have to:

1. Medications:

2. Foods:

3. Environmental:

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Medications & Supplements: Please list any that you are currently taking

Name	Strength	Frequency

Social History

Relationship / Marital Status:
Number of Children: Ages:
Occupation: Highest level of education:
Tobacco Use: ○ Current everyday - amount per day:_____ ○ Ocassional ○ Former - Quit date/year:_____ ○ Never Alcohol Use: Number of alcoholic beverages per week? ○ 0 ○ 1-7 ○ 8-14 ○ 15+ Drug Use: Do you use any recreational drugs?
Have you ever been in a sexual relationship: ○ Yes ○ No
Number of sexual partners in the past 12 months:
In the past, have you had sex with: ○ Men ○ Women ○ Both
Do you have any history of sexually transmitted infections: ○ Yes ○ No If yes, specify:

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Past Medical History: (Check all conditions that you have been diagnosed with in the past)

Eye/Ear/Nose/Throat		**Musculoskeletal**		**Endocrine**	
Eye Conditions:		Rheumatoid Arthritis		Diabetes	
Hearing Loss		Osteoarthritis		Thyroid Problems	
Achalasia/Dysphagia		Gout			
		Osteoporosis/Osteopenia		**Gastrointestinal**	
Neurological				GERD/Acid Reflux	
Seizures		**Infectious Disease**		Peptic Ulcer Disease	
Multiple Sclerosis		HIV/AIDS		IBD (Crohn's or Ulcerative Colitis)	
Stroke		Hepatitis		Celiac Disease	
Headaches		Tuberculosis		IBS (Irritable Bowel Syndrome)	
Dementia		Malaria		Liver Disease or Fatty Liver	
Respiratory		**Cardiac**		**Dermatology**	
Asthma		High Blood Pressure		Skin Cancer	
COPD		High Cholesterol		Herpes/Cold Sores	
Emphysema		Heart Attack		Psoriasis	
Pneumonia		Heart Failure		Eczema	
		Arrhythmia			
Genitourinary				**Mental Health**	
Kidney Disease		**Other**		Anxiety	
Enlarged Prostate		Cancer:		Depression	
Incontinence				Bipolar	
Kidney Stones				Suicide Attempt	

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Past Surgical History

List all past surgeries	Doctor/Location	Date or Year

Gynecological History (Females Only)

Are you pregnant or is it likely that you could be pregnanat at this time: ○ Yes ○ No If yes, due date:
Do you have periods: ○ Yes ○ No Are they regular: ○ Yes ○ No Last Menstrual Period:
Have you ever had a PAP: ○ Yes ○ No
Have you had a history of an abnormal PAP: ○ Yes ○ No
Date of last PAP: ○ Yes ○ No
Would you like to discuss birth control options: ○ Yes ○ No
Current birth control method:

Family History: List any chronic medical conditions. Include high blood pressure, high cholesterol, heart attack, stroke, cancer, mental health, and any know or suspected genetic diseases.

Mother:	Siblings:
Father:	
Maternal Grandmother:	
maternal Grandfather:	Children:
Paternal Grandmother:	
Paternal Grandfather:	

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Review of Systems: Please check all symptoms that you ****CURRENTLY**** have.

General:
- ○ Fever
- ○ Chills
- ○ Unintentional weight loss
- ○ Abnormal weight gain
- ○ Fatigue

Eyes:
- ○ Double vision
- ○ Blurred vision
- ○ Eye pain

Ears:
- ○ Tinnitus/ringing in ears
- ○ Ear pain
- ○ Difficulty or changes to hearing

Nose:
- ○ Runny nose
- ○ Congestion
- ○ Nose bleeds

Head:
- ○ Headaches
- ○ Migraines
- ○ Sinus pressure

Skin:
- ○ Itching
- ○ Rashes
- ○ Changes in moles

Respiratory:
- ○ Cough
- ○ Shortness of breath
- ○ Wheezing
- ○ Sputum
- ○ Coughing up blood

Cardiovascular:
- ○ Chest pain
- ○ Palpitations
- ○ Difficulty catching breath
- ○ Shortness of breath when lying flat
- ○ Leg swelling

Musculoskeletal:
- ○ Arthritis
- ○ Back pain
- ○ Joint pain
- ○ Muscle pain

Neurological:
- ○ Dizziness
- ○ Numbness
- ○ Tingling
- ○ Weakness

Mental Health:
- ○ Depression
- ○ Nervousness
- ○ Change in mood
- ○ Poor memory

Gastrointestinal:
- ○ Abnormal pain
- ○ Nausea
- ○ Vomiting
- ○ Heartburn/acid reflux
- ○ Diarrhea
- ○ Constipation
- ○ Blood in stool
- ○ Black, tarry stool
- ○ Change in bowel habits
- ○ Excessive hunger
- ○ Excessive thirst

Genitourinary:
- ○ Pain in urination
- ○ Frequency of urination
- ○ Urgency
- ○ Incontinence
- ○ Awakening frequently to urinate
- ○ Dishcarge
- ○ Itching
- ○ Odor

Other:

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INFORMED CONSENT

I, _____, hereby give my consent to services (examination and treatment) rendered and provided to me (or the patient named below, for whom I am legally responsible) as a patient of Ripple Wellness and Dr. Cesilie Cocks.

I understand I have the right to ask questions and discuss to my satisfaction with the above-mentioned provider regarding:

- My suspected diagnosis(s) or condition(s)
- The nature, purpose, goals, and potential benefits of the proposed care
- The inherent risks, complications, potential hazards, and/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, laboratory testing of blood, saliva, urine, and stool.
- Soft tissue and osseous manipulation (including therapeutic massage deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, muscle energy technique and cranio-sacral therapy).
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements, and intravenous 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, topical creams, pastes, plasters, washes, or other forms.
- Homeopathic remedies (highly diluted quantities of naturally occurring substances).
- Counseling (including but not limited to visualization for improved lifestyle strategies).
- Over-the-counter and prescription medications (including only those medications on Formulary of Washington Naturopathic Physicians with regards to ND's).
- Hydrotherapy procedures which may consist of hot and cold water, baths, sauna, ice,

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towels and/or sheets and/or hydrocollator packs either heated or cooled, electrical stimulation, ultrasound and diathermy, and other therapies. Possible risks associated with and complications associated with this procedure may include: Mild skin burns or irritation, overheating, contact dermatitis, dizziness, temporary decrease in blood pressure.

Accordingly, I sign this Informed Consent, to express that it is my own decision without undue persuasion to see Dr. Cocks for naturopathic treatment. I hold no party responsible for my own actions. I hereby release Dr. Cesilie Cocks and Dr. Maria Russell from liability for any results that may occur to me thereafter.

Patient Signature_____

Parent or guardian signature_____

Date_____