



Dear Patient,

Welcome to Giving Tree Natural Health! Thank you for choosing us for your family health care needs. We are here to serve your medical needs, help educate you about natural therapies and ways to optimize your overall health, and to answer your health care questions.

Enclosed in this packet are several forms that we will review at your first appointment. Your detailed and thoughtful responses will help us to utilize our time together more effectively. **Please bring these forms to your first appointment.** Your first visit will be a thorough assessment of your health and you should allow up to two hours for this visit.

If you are unable to keep your scheduled appointment, please let us know at least 24 hours prior to the scheduled time so that we may allow other patients to be seen during that time. We will be glad to reschedule your visit if it becomes necessary to do so.

Please remember to bring in copies of any recent lab work or medical records and a complete list of medications and dosages you are currently taking.

I look forward to seeing you. My goal is to become a trusted partner in assisting you with your health care needs.

Yours in health,

Margaux French, ND
Giving Tree Natural Health, LLC



Consent for Treatment & Financial Policy Statement

Thank you for choosing Giving Tree Natural Health, LLC for your healthcare needs. We are committed to enhancing the quality of your care and overall health. This policy statement is designed to inform you of our policies and answer questions regarding payment for services.

Treatment:

Treatment at this clinic requires an agreement between you, the patient, and Dr. Margaux French, ND. Any therapy will proceed only with mutual consent. It is possible that certain adverse effects may result from treatments. These could include, but are not limited too, local skin irritation, bruising, temporary pain or discomfort, adverse reactions to prescribed herbs or supplements such as allergic reaction, headache, nausea; and the possible temporary aggravation of symptoms existing prior to treatment.

Because of the possibility of drug interaction with herbal formulas, we require our patients to inform the practitioner of any medications they may be taking, including any dietary supplements and herbs.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, as some of the therapies used could present a risk to the pregnancy.

Emergency Care:

Our clinic **does not** administer emergency medical care. In the case of an emergency, please see your medical or osteopathic doctor, the emergency room, or the nearest hospital. After emergency care has been administered, patients often respond well to naturopathic care to accelerate the healing process.

Payment: Naturopathic Doctors are currently unable to bill insurance in the state of New Hampshire. Giving Tree Natural Health, LLC is a fee for service clinic and payment is expected at the time of service. Patients are to assume all financial responsibility for the office visit and services rendered during the time of service.

We accept cash or personal checks as payment. Returned checks are subject to \$25 return fee and no further personal checks will be accepted.

Phone Calls:

Phone support is to aid in answering any questions or concerns that may arise, or to clarify instructions. We would prefer that people call with questions rather than leave them unanswered. There is no charge for any call to clarify instructions given at a previous visit.

Phone support is not intended to take the place of an office visit. Phone consultations that cover *new material, require new information, take an extensive amount of time, or require a change in treatment plan* are considered substitutes for an office visit. These will be billed at the same rate



as the visit for which they substitute.

Cancellation Policy:

We all have circumstances come up occasionally that make it difficult to keep appointments. With that in mind, we are happy to accept cancellations or postponements 24 hours in advance. There is no charge if an appointment is cancelled with 24 hours notice. A cancellation with less than 24 hours notice does not allow enough time for other interested patients to be scheduled and is an inconvenience.

This office requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. There is a \$50 charge for new patient cancellations and a \$25 charge for follow-up appointment cancellations that are made with less than 24 hours notice.

- I agree to pay for services rendered at the time of service. I acknowledge that I may request the fees for various procedures before they occur and include that information in my decision regarding my healthcare.
- I am aware that my practitioner may charge for telephone consultations.
- I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- I consent to treatment as agreed upon between the doctor and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the doctor.

Patient's Signature: _____ Patient's Guardian Signature: _____

Print Name: _____ Print Name: _____

Date: _____ Date: : _____



NEW PATIENT INTAKE FORM

Date: _____

New Patient Information

Name: _____ DOB: ___/___/___ Age: _____
(Last) (First) (Gender)

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Permission to leave detailed messages regarding your medical care at: ___home ___work ___cell

Social Security# _____ Email Address: _____

If minor, name of parent/guardian(s) _____

Address: _____ Phone: (____) _____

Additional Patient Information

Occupation: _____ Employer/Business: _____

Marital Status (circle): Single Married Partnered Separated Divorced Widow(er)

Children: Y N Number of children: _____ Age(s): _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (____) _____

Do you have a primary care physician? Y N

If yes, Physician's Name: _____ Physician's Phone: (____) _____

Address: _____ City: _____ St: _____ Zip: _____

Referral Information

How did you hear about us? _____

Whom may we thank for referring you? _____

Adult Medical History

Please list your health concerns, in order of importance:

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

Entered by: _____

Family History

	Mother	Father	Siblings	Grandparents	Spouse	Children
Age, if living:	_____	_____	_____	_____	_____	_____
If deceased, cause: and age of death	_____	_____	_____	_____	_____	_____
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
Tuberculosis:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N
Arthritis:	Y N	Y N	Y N	Y N	Y N	Y N
Thyroid Problems:	Y N	Y N	Y N	Y N	Y N	Y N
Alcoholism/Addiction:	Y N	Y N	Y N	Y N	Y N	Y N
Cancer:	Y N	Y N	Y N	Y N	Y N	Y N

Personal History

List all surgeries, hospitalizations, or major accidents including date occurred:

- 1) _____ 4) _____
 2) _____ 5) _____
 3) _____ 6) _____

What is your blood type: _____

Have you ever had any infectious disease from which you never fully recovered? _____

Ever taken antibiotics for a prolonged period of time? Y N For what condition? _____

Current Medications

Prescription Medications	Dose	Since	Adverse effects?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Supplements and/or Over the Counter Medications

Supplement/OTC Medication	Dose, Frequency	Supplement/OTC Medication	Dose, Frequency

Do you have difficulty swallowing pills? Y N

Do you use any of the following?

Cigarettes or tobacco: Y N How much?: _____ For how long? _____

Marijuana or other drugs: Y N Frequency: _____

Alcohol: Y N Drinks per day/week? _____ Type of alcohol: _____

History of alcohol addiction: Y N History of alcohol treatment? Y N

History of drug addiction: Y N History of drug treatment? Y N

History of eating disorder? Y N

Are you allergic to any medications? If so, which one(s) and what is your reaction? _____

Review of Systems:

Present Weight: _____ Height: _____ Weight one year ago: _____

Maximum weight and when: _____ Minimum weight as adult & when: _____ Ideal Weight: _____

IN THE NEXT SECTION: Please circle (Y) if you **CURRENTLY** have the problem, (N) if you've **NEVER** had the problem, (P) if you had the problem in the **PAST**.

GENERAL

Fatigue	Y N P	Poor Sleep	Y N P
Frequent Colds, illness	Y N P	Night Sweats	Y N P
Poor Memory	Y N P	Fainting	Y N P
Poor Concentration	Y N P	Dizziness	Y N P

SKIN & HAIR

Rash	Y N P	Color Change	Y N P
Hives	Y N P	Skin Cancer	Y N P
Psoriasis/Eczema	Y N P	Itchy	Y N P
Dry Skin	Y N P	Warts, moles	Y N P
Weak, brittle nails	Y N P	Excessive Perspiration	Y N P
Dry Hair	Y N P	Hair Loss	Y N P

HEAD & NECK

Headaches	Y N P	Head Injury	Y N P
Migraines	Y N P	Dandruff	Y N P
Swollen Glands	Y N P	Neck Stiffness	Y N P

EYES & EARS

Blurry Vision	Y N P	Glaucoma	Y N P
Itchy	Y N P	Cataracts	Y N P
Dry	Y N P	Discharge	Y N P
Watery	Y N P	Styes	Y N P
Sensitive to Light	Y N P	Dark circles under eyes	Y N P
Ear infections	Y N P	Ringing in Ears	Y N P
Hearing Loss	Y N P	Excessive ear wax	Y N P

NOSE, MOUTH, & THROAT

Frequent Colds	Y N P	Nosebleeds	Y N P
Congestion	Y N P	Post-Nasal Drip	Y N P
Polyps	Y N P	Seasonal Allergies	Y N P
Sinusitis	Y N P	Toothache	Y N P
Canker Sores	Y N P	Cold Sores	Y N P
Loss of taste/smell	Y N P	Bleeding Gums	Y N P
Dry Mouth	Y N P	Hoarse Voice	Y N P
Sore throat	Y N P	Cavities	Y N P

RESPIRATORY

Cough	Y N P	Asthma	Y N P
Shortness of Breath with exertion	Y N P	Bronchitis	Y N P
Shortness of Breath lying down	Y N P	Pneumonia	Y N P
Wheezing	Y N P	Tuberculosis	Y N P
		Chemical fume exposure	Y N P
		Painful Breathing	Y N P

CARDIOVASCULAR

High Blood Pressure	Y N P	Rheumatic Fever	Y N P
Low Blood Pressure	Y N P	Murmurs	Y N P
Irregular Heart Beat	Y N P	Palpitations	Y N P
Swollen feet or ankles	Y N P	Chest Pain	Y N P
Varicose Veins	Y N P	Leg Pain with walking	Y N P

GASTROINTESTINAL

Heartburn	Y N P	Changes in BM frequency	Y N P
Indigestion	Y N P	Constipation	Y N P
Bloating	Y N P	Diarrhea	Y N P
Nausea	Y N P	Hemorrhoids	Y N P
Vomiting	Y N P	Ulcer	Y N P
Change in Appetite	Y N P	Mucous in stool	Y N P
Pancreatitis	Y N P	Blood in stool	Y N P
Irritated by fatty/greasy food	Y N P	Use antacids	Y N P
Difficulty Swallowing	Y N P	Feel bad if skip a meal	Y N P
Liver Disease	Y N P	Excessive gas	Y N P
Gall Bladder Disease	Y N P	Anal Itching	Y N P
# Bowel movements/day_____			

URINARY TRACT

Frequent Infections	Y N P	Increased Urinary Frequency	Y N P
Incontinence	Y N P	Kidney Stones	Y N P
Urgency	Y N P	Discharge, Blood w/ Urination	Y N P
Pain with Urination	Y N P	Frequent urination at night	Y N P

MUSCULOSKELETAL

Loss of Strength	Y N P	Pain	Y N P
Stiffness of joints	Y N P	Arthritis	Y N P
Tremors	Y N P	Leg Cramps	Y N P

Swelling of joints Y N P

Muscle Pain Y N P

NERVOUS SYSTEM

Paralysis Y N P
 Tingling/Numbness Y N P
 Seizures Y N P

Sciatica Y N P
 Carpal Tunnel Syndrome Y N P
 Fainting Y N P

MENTAL/EMOTIONAL

Depression Y N P
 Anxiety Y N P
 Suicidal Thoughts Y N P
 Panic Attacks Y N P

Anger/irritability Y N P
 High-strung/tense Y N P
 Fear/ phobias Y N P
 Psychiatric Hospitalization Y N P

FEMALE HEALTH

Age of first period _____
 # Days of flow _____
 Length of cycle _____
 # of Pregnancies _____
 # of children _____
 Miscarriages/abortions _____
 Date of last PAP _____
 History of Abnormal PAP Y N P
 When _____
 Diagnosis _____
 PMS Y N P
 Symptoms _____
 Breast Tenderness Y N P
 Heavy menstrual flow Y N P
 Irregular Periods Y N P

Hysterectomy Y N P
 Reason: _____
 Menopausal since what age _____
 Use of hormones Y N P
 Type: _____
 Low Libido Y N P
 Difficulty with conception Y N P
 Pain with intercourse Y N P
 Ovarian Cyst Y N P
 Fibroids Y N P
 Endometriosis Y N P
 Vaginitis Y N P
 STD Y N P
 Do you do self-breast exams Y N P
 DEXA Bone Scan Y N P
 Mammography Y N P

Current birth control method _____

Have you ever used hormonal birth control or an IUD? When and for how long? _____

MALE HEALTH

Testicular pain/swelling Y N P
 Hernia Y N P
 Discharge from penis Y N P
 Impotence Y N P

STD Y N P
 Prostate disease/symptoms Y N P
 Low Libido Y N P
 Weakness or forking of stream with urination Y N P

Exercise

How often do you exercise? _____ What type of exercise? _____

For how long? _____

Sleep

How many hours per night? _____ Quality of sleep? _____

If you wake up frequently, what is the reason? _____

Nightmares: Y N P

Wake Refreshed: Y N P

Must nap during the day: Y N P

Sleep walk: Y N P

Grind teeth: Y N P

Snore: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

Social History

Enjoy work: Y N P Hours worked per week: _____

Active spiritual practice: Y N P

Quality of significant Relationship: _____

History of sexual abuse: Y N P

Stress Level: _____

What activities do you enjoy doing: _____

How committed are you towards making changes in your health: Little Moderate Very

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

How much per day/week: Coffee _____ Energy Drinks _____ Black Tea _____ Soda _____

Water _____ tap filtered bottled

List all known Allergies (food, environmental): _____

Foods craved: _____

Foods avoided: _____

Thank you for your patience in completing this form.