Dr. Robert Maki
Toll Free: 877-521-9779
Local: 760-515-1945
Fax: 800-584-1763
contact@progressyourhealth.com
www.progressyourhealth.com

Patient Contact Information

Name: DOB: Date:

Address:

City: State: ZIP:

Phone (Home):

Cell:

Work:

Email:

Emergency Contact: Relationship:

Optional:

Credit Card #: Exp: Code:

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Office of Dr. Robert Maki
Licensed Naturopathic Doctor

Informed Consent and Request for Naturopathic Medicine

I understand that the evaluation, diagnosis and treatment by a naturopathic doctor, and specifically by, Dr. Robert Maki, may include but is not limited to:

- Medical history
- Physical examination
- Common diagnostic procedures (such as, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Dietary advice and therapeutic nutrition (such as the therapeutic use of foods, diet plans, nutritional supplements; intravenous and intramuscular injections under supervision)
- Botanical medicines and nutraceuticals [also referred to as supplements] (such as the 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 or other forms.
- Homeopathic remedies (highly diluted substances)
- Vitamin and homeopathic injections
- Nutrient IV's (intravenous therapy)
- Over the counter medications
- Prescription medications to be filled at either a local or compounding pharmacy

I understand and I am informed that in the practice of Naturopathic Medicine there are risks and benefits with evaluation, diagnosis and treatment including, but not limited to the following:

- Potential risks: pain, discomfort; allergic reaction to prescribed herbs, supplements, prescription medications; an aggravation of pre-existing symptoms especially with heavy metal detoxification.
- Potential benefits: restoration of the body's maximal functioning 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 the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

By signing below, I(print name) _____, acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees have been given to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

_____ _____

Signature Date

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Patient Paperwork – Female

Name: ***DOB:***

Blood Type:

Chief Complaints – what symptoms/ problems are you experiencing

Current medications – what medications and/or vitamins are you currently taking

Drug or Vitamin Name	Strength	How many (take)	How often (frequency)	Date Started

Past Medical History – Current or Previous Medical Problems

Please describe any medical issues or concerns. Include any current issues, previous problems, or concerns.	When did it start?

Drug Allergies – drug allergies or vitamin allergies

Drug or Vitamin Name	Strength	What happened when you took this drug/ vitamin?

Food or General Allergies – any food allergies (i.e. wheat) or environment allergies (i.e. pollen)

Food or Allergy Description	What happened when you had this allergic reaction?

Surgical History – Any surgeries or procedures you have had

Please describe any surgeries both minor (wisdom teeth removal) or major	Date of surgery

Hospitalizations – describe any hospital stays and why

Reason for hospitalization	Start and End Date

Family Medical History – Current or Previous Medical Problems

Family Member	Alive/ Deceased	Medical Issues
Father		
Mother		
Grandfather – Father's Side		
Grandmother – Father's Side		
Grandfather – Mother's Side		
Grandmother – Mother's Side		
Siblings		

Social History – Current or Previous Medical Problems

Marital Status	☐ married ☐ divorced ☐ widowed ☐ single
Work History	
What is your current occupation?	
Exercise	
Do you exercise?	☐ Yes ☐ No
If yes, at your home or gym?	☐ Home ☐ Gym
Do you have a trainer?	☐ Yes ☐ No
Do you sweat when exercising?	☐ Yes ☐ No
How often do you exercise?	Cardio per week: Weights per week
Sleep	
Average # hours you sleep at night?	
Usual bedtime	
Usual wake-time	
Stress	
Do you have stress?	☐ Yes ☐ No
If yes, is how would you describe it?	☐ mild ☐ moderate ☐ severe
Alcohol	
Do you drink alcohol?	☐ Yes ☐ No
If yes, please describe your drinking?	☐ social drinking ☐ frequent drinking
Smoking	
Do you smoke?	☐ Yes ☐ No
If yes, how much?	

Gynecological History

First day of Last Menstrual Period	On what date did you begin your last menstrual period?
How old were you when you first had your period? (Menarche)	
How often do you have your period?	☐ every 28 days ☐ every month ☐ every 20-25 days ☐ every 35-40 days Other:
Describe the flow	☐ normal blood loss ☐ light bleeding ☐ heavy bleeding
Last Pap Smear	On what date did you have your last pap smear?
Abnormal Pap Smear	Have you ever had an abnormal pap? If so, please describe:
Last Mammogram	On what date did you have your last mammogram?
Sexual Activity	☐ sexually active ☐ not sexually active
Sexual Partners	Number of current sexual partners:
Contraception	Do you use contraception: ☐ Yes ☐ No If so, what type(s):

Obstetric History

Number of pregnancies	
Number of children	
Have you had any miscarriages or stillbirths?	
Have you had an abortion?	
If you have had children, please describe the births. Were they were delivered vaginally or via C-Section **Please note this for each child**	

Body Composition/Nutrition/Diet

What was your maximum body weight?	
What is the date of your maximum weight?	
What is your desired weight	
How many meals do you eat per day?	
How many snacks?	
How many times do you feel hungry a day?	
How many meals do you eat out per week?	
Do you travel? If so how often.	

Beverages
Please list your consumption per day of the following beverages:

Water	
Coffee	
Alcohol	
Green/black tea	
Soda	
Juice	
Milk	

Meals
Please list a typical meal for your diet. Please indicate if you skip any meals or snacks regularly.

List a typical breakfast	
List a typical lunch	
List a typical dinner	

Symptom Questionnaire

DERMATOLOGY

Dry or Sensitive Skin	☐ Yes ☐ No
Acne	☐ Yes ☐ No
Eczema	☐ Yes ☐ No

ENDOCRINOLOGY

Hair Changes	☐ Yes ☐ No

FEMALE REPRODUCTIVE

Abnormal Vaginal Discharge	☐ Yes ☐ No
Irregular Menses	☐ Yes ☐ No
Hot Flashes	☐ Yes ☐ No
Pelvic Pain	☐ Yes ☐ No
Dysmenorrhea (pain before period)	☐ Yes ☐ No
Dyspareunia (pain during intercourse)	☐ Yes ☐ No
Infertility	☐ Yes ☐ No
Frequent Yeast Infections	☐ Yes ☐ No
Breast Pain	☐ Yes ☐ No
Nipple Discharge	☐ Yes ☐ No

GASTROENTEROLOGY

Abdominal Pain	☐ Yes ☐ No
Nausea	☐ Yes ☐ No
Heartburn	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No
Constipation	☐ Yes ☐ No

MUSCULOSKELETAL

Joint Pain	☐ Yes ☐ No
Joint Stiffness	☐ Yes ☐ No
Joint Swelling	☐ Yes ☐ No
Back Pain	☐ Yes ☐ No
Myalgia (muscle pain)	☐ Yes ☐ No
Leg Cramps	☐ Yes ☐ No
Sciatica	☐ Yes ☐ No
Osteoporosis Treatment	☐ Yes ☐ No

NEUROLOGY

Headache	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No

PSYCHOLOGY

Anxiety	☐ Yes ☐ No
Sleep Disturbances	☐ Yes ☐ No

UROLOGY

Urinary Urgency	☐ Yes ☐ No
Blood in Urine	☐ Yes ☐ No
Urinary Incontinence	☐ Yes ☐ No
Nocturia (waking 2+ at night for urination)	☐ Yes ☐ No
Previous UTIs	☐ Yes ☐ No

Other Relevant Information / Comments: