# LotusRain Naturopathic Clinic, Inc.

**Dr. Kristine Reese, ND**
**5210 Balboa Ave., Suite F, San Diego, CA 92117**

**Phone: (619) 239-LIFE (5433)** **Fax: (619) 546-5422**

**Patient Information Form**

Last Name:_____ First Name:_____ M.I. ____ Today's Date:_____

Other names or nicknames your records may be kept under:_____

Mother's Name (minors only) _____ Father's Name (minors only) _____

Address:_____ Apartment #:_____

City: _____ State: _____ Zip code:_____ Home Phone: _(____)_____

Cell Phone: (____)_____ Work Phone: (____)_____ E-mail:_____

Occupation: _____ Employer/School: _____

Date of Birth:_____ Gender:_____ Social Security #: _____

Emergency Contact: _____ Contact's Phone #: (____)_____

Are you hearing impaired? Y N Are you visually impaired? Y N Do you need an interpreter or TTY line? Y N

Do you have non-English language needs?: _____ (or) Special needs?: _____

How did you hear about us? _____

Referral Source: _____ Internet Site Name:_____ Add/Flyer:_____

**Insurance Information**

**Please notify us if processing Labor and Industry (L & I) or Personal Injury Protection (PIP) Claims**

1. Does your insurance have alternative medicine benefits? Yes No

Who is your primary care provider (PCP)?: Dr. _____ Phone #: (____)_____

Clinic address: _____ City: _____ State: _____ Zip Code: _____

Does your plan require you to have a referral from your PCP to receive coverage? Yes No

2. Primary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of policy holder: _____ Policy holder's date of birth and SSN: _____

Relationship to policy holder: _____Is your primary a: (circle) POS PPO EPO HMO

3. Secondary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of policy holder: _____ Policy holder's date of birth: _____

Relationship to policy holder: _____Is your secondary insurance a: (circle) POS PPO EPO HMO

I, the undersigned, pledge that the above information is accurate and complete to the best of my knowledge. I understand that payment is due at the time of service for all visits at the clinic unless prior arrangements have been made. I understand that if I am providing insurance billing information, I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize LotusRain Naturopathic Clinic to release all information necessary to secure the payment of insurance benefits, and I authorize the use of this signature on all my insurance submissions.

X_____ _____ X_____ _____

Signature of patient* date Signature of guardian date

Relationship to patient: _____

* Guardian's signature required for minors.

*www.lotusrainclinic.com*

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**Dr. Kristine Reese, ND**
**5210 Balboa Ave., Suite F, San Diego, CA 92117**

**Phone: (619) 239-LIFE(5433)** **Fax: (858) 715-5434**

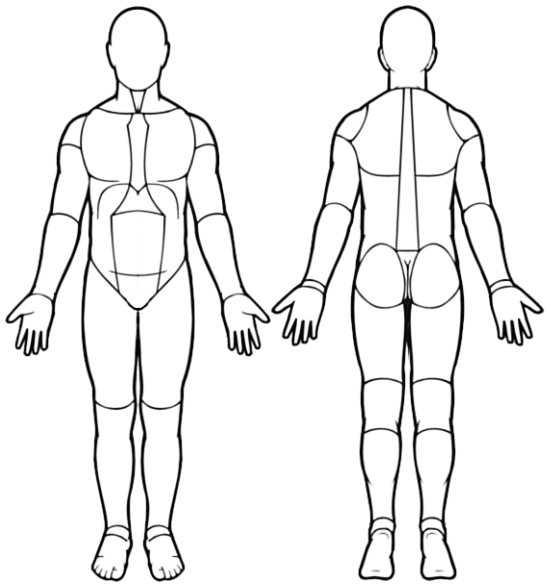

**Patient Intake Form** Date: _____

Last Name: _____ First Name: _____ M. I. _____

Nickname(s): _____ Birthdate: _____ Sex: _____

**A note to our patients:** Please complete this form as thoroughly as possible to aid in your diagnosis and treatment. This is a confidential record and will not be released, except when you have provided us with written authorization to do so. Thank you.

**PRESENT HEALTH CONCERNS**

| Please list most important health concerns in their order of significance. | Prior diagnosis of this problem? If so, what? | Indicate painful or distressed areas: |
|---|---|---|
| 1. | |  |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

What goals do you have for your visit at the clinic today? _____

_____

_____

_____

Do you have any questions about our clinic or care? _____

_____

_____

_____

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Please list prescription medications that you are currently taking with dosages: _____

**PLEASE LIST ON SUPPLEMENT/MEDICATION SHEET**

Please list over-the-counter medications that you are currently taking with dosages: _____

**PLEASE LIST ON SUPPLEMENT/MEDICATION SHEET**

Please list all supplements (vitamins, minerals, herbs, homeopathic remedies) that you are currently taking with dosages: _____

**PLEASE LIST ON SUPPLEMENT/MEDICATION SHEET**

Please list any drug allergies, and severe or life-threatening allergies: _____

**Personal habits**:
Please circle any of the following substances that you use regularly:

Tobacco Alcohol Coffee/black tea/cola Recreational Drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

Do you exercise regularly? Yes No What type? _____

How long? _____ How often? _____

What are the top stresses in your life currently? _____

**Women**: What is the date of your last menses? _____

**Men/Women**: Are you having any hormone imbalance symptoms, if yes please list? _____

**Past history:**

Hospitalizations/Surgery: _____

Serious Illnesses and Injuries: _____

Date of last **physical/annual exam**: _____ Date of **last blood** tests: _____

Date and type of last **Breast Imaging**: _____ Date/Result of **Colonoscopy**: _____

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**Personal and Family History:**
Please check the 'yes' box next to each condition that applies to **you or one of your family members**. Please note whether the condition is in the past or currently by denoting a **'P' for past, or 'C" for current**. Indicate who had the condition in the 'Relation' column.

| | YES | RELATION | DATE RESOLVED Past (P)/Current(C) | | YES | RELATION | DATE RESOLVED Past (P)/Current(C) |
|---|---|---|---|---|---|---|---|
| Alcoholism/ Drug Addiction | | | | Headaches | | | |
| Allergies | | | | Heart Disease | | | |
| Anemia | | | | Hepatitis | | | |
| Arthritis | | | | High Blood Pressure | | | |
| Asthma | | | | Kidney Disease | | | |
| Cancer | | | | Mental Illness | | | |
| Depression | | | | Stroke | | | |
| Diabetes | | | | Tuberculosis | | | |
| Eczema | | | | Other | | | |
| Epilepsy | | | | Autoimmune | | | |

**Social History:**
Please circle those that apply: Single Married Significant other/Partner

Spouse/Partner Name: _____

Do you have any children? Yes No Please list their names and age(s): _____

_____

_____

**Additional information which you would like to be noted:**

_____

_____

Please put a "X" if the condition is current or a "/" if you had it in the past

General
Insomnia
Dreams/nightmares
Irritability
Depression
Mood swings
Fatigue
Poor memory
Strongly like cold drinks
Strongly like hot drinks
Recent weight loss/gain
Cold hands & feet
Chills
Fever
Head & Neck
Headaches
Migraines
Stiff neck
Dizziness
Fainting
Swollen glands
Ears
Ringing
Hearing loss
Infections
Earache
Hearing aids
Vertigo
Eyes
Glasses/contact lenses
Blurred vision
Poor night vision
Spots or floaters
Eye inflammation
Double vision
Glaucoma
Cataracts
Nose, Throat & Mouth
Sinus infection
hay fever/allergies
Frequent sore throat
difficulty swallowing
Mouth & tongue ulcers
Frequent colds
Nosebleed
Dry nose
Nasal congestion
Loss of voice
Thirst
Excessive phlegm
TMJ
Facial pain
Gum problems

Skin
Hives
Rashes
Eczema/psoriasis
Night sweating
Excess sweating
Dry skin
Easy bruising
Changes in moles, lumps
Itching
Respiratory
Difficulty breathing
Difficulty breathing when lying down
Wheezing
Asthma
Chronic cough
Wet cough
Dry cough
Coughing up phlegm
Coughing up blood
Shortness of breath Tight chest
Pneumonia
Cardiovascular
High blood pressure
Low blood pressure
Chest pain or tightness
Palpitation
Rapid heart beat
Irregular heart beat
Poor circulation
Swollen ankles
Phlebitis
Anemia
History of heart attack
Gastrointestinal
Nausea
Indigestion
Stomach pain
Diarrhea
Constipation
Poor appetite
Excessive hunger
Vomiting
Gas
Hiccups
Acid regurgitation
Bloating
Bad breath
Laxative use
Bloody stool
Mucus in stool

Hemorrhoids
Gall Bladder disorder
Musculoskeletal
Joint pain/disorder
Sore muscles
Weak muscles
Difficulty walking
Neck/shoulder pain
Upper back pain
Lower back pain
Rib pain
Limited range of motion
Other (describe)
Neurological
Seizures
Tremors
Numbness or tingling
Pain
Paralysis
Poor coordination Other (describe)
Genito-urinary
Pain on urination
Frequent urination
Urgent urination Blood in urine
Unable to hold urine
Incomplete urination
Bedwetting
Wake to urinate
Increased libido
Decreased libido
Kidney stones
Impotence
Premature ejaculation
Nocturnal emission
Pain/itching of genitalia
Lumps in testicles
Infection Screening
HIV risks: self or partner
TB: self or household
Hepatitis risk: self or partner
History of sexually transmitted disease: self or partner
Gonorrhea
Chlamydia
Syphilis
Genital warts
Herpes: oral/genital
Other_____
Blood Type:

# Health Questionnaire (NTAF)

**Name:** _____ **Age:** _____ **Sex:** _____ **Date:** _____

*** Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.**

## SECTION A

- Is your memory noticeably declining? **0 1 2 3**
- Are you having a hard time remembering names and phone numbers? **0 1 2 3**
- Is your ability to focus noticeably declining? **0 1 2 3**
- Has it become harder for you to learn things? **0 1 2 3**
- How often do you have a hard time remembering your appointments? **0 1 2 3**
- Is your temperament getting worse in general? **0 1 2 3**
- Are you losing your attention span endurance? **0 1 2 3**
- How often do you find yourself down or sad? **0 1 2 3**
- How often do you fatigue when driving compared to the past? **0 1 2 3**
- How often do you fatigue when reading compared to the past? **0 1 2 3**
- How often do you walk into rooms and forget why? **0 1 2 3**
- How often do you pick up your cell phone and forget why? **0 1 2 3**

## SECTION B

- How high is your stress level? **0 1 2 3**
- How often do you feel that you have something that must be done? **0 1 2 3**
- Do you feel you never have time for yourself? **0 1 2 3**
- How often do you feel you are not getting enough sleep or rest? **0 1 2 3**
- Do you find it difficult to get regular exercise? **0 1 2 3**
- Do you feel uncared for by the people in your life? **0 1 2 3**
- Do you feel you are not accomplishing your life's purpose? **0 1 2 3**
- Is sharing your problems with someone difficult for you? **0 1 2 3**

## SECTION C

SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? **0 1 2 3**
- How often do you feel energized after eating? **0 1 2 3**
- How often do you have difficulty eating large meals in the morning? **0 1 2 3**
- How often does your energy level drop in the afternoon? **0 1 2 3**
- How often do you crave sugar and sweets in the afternoon? **0 1 2 3**
- How often do you wake up in the middle of the night? **0 1 2 3**
- How often do you have difficulty concentrating before eating? **0 1 2 3**
- How often do you depend on coffee to keep yourself going? **0 1 2 3**
- How often do you feel agitated, easily upset, and nervous between meals? **0 1 2 3**

SECTION C2

- Do you get fatigued after meals? **0 1 2 3**
- Do you crave sugar and sweets after meals? **0 1 2 3**
- Do you feel you need stimulants such as coffee after meals? **0 1 2 3**
- Do you have difficulty losing weight? **0 1 2 3**
- How much larger is your waist girth compared to your hip girth? **0 1 2 3**
- How often do you urinate? **0 1 2 3**
- Have your thirst and appetite been increased? **0 1 2 3**
- Do you have weight gain when under stress? **0 1 2 3**
- Do you have difficulty falling asleep? **0 1 2 3**

## SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? **0 1 2 3**
- How often do you feel overwhelmed with ideas to manage? **0 1 2 3**
- How often do you have feelings of inner rage (anger)? **0 1 2 3**
- How often do you have feelings of paranoia? **0 1 2 3**
- How often do you feel sad or down for no reason? **0 1 2 3**
- How often do you feel like you are not enjoying life? **0 1 2 3**
- How often do you feel you lack artistic appreciation? **0 1 2 3**
- How often do you feel depressed in overcast weather? **0 1 2 3**
- How much are you losing your enthusiasm for your favorite activities? **0 1 2 3**
- How much are you losing enjoyment for your favorite foods? **0 1 2 3**
- How much are you losing your enjoyment of friendships and relationships? **0 1 2 3**
- How often do you have difficulty falling into deep restful sleep? **0 1 2 3**
- How often do you have feelings of dependency on others? **0 1 2 3**
- How often do you feel more susceptible to pain? **0 1 2 3**
- How often do you have feelings of unprovoked anger? **0 1 2 3**
- How much are you losing interest in life? **0 1 2 3**

## SECTION 2 - D

- How often do you have feelings of hopelessness? **0 1 2 3**
- How often do you have self-destructive thoughts? **0 1 2 3**
- How often do you have an inability to handle stress? **0 1 2 3**
- How often do you have anger and aggression while under stress? **0 1 2 3**
- How often do you feel you are not rested even after long hours of sleep? **0 1 2 3**
- How often do you prefer to isolate yourself from others? **0 1 2 3**
- How often do you have unexplained lack of concern for family and friends? **0 1 2 3**
- How easily are you distracted from your tasks? **0 1 2 3**
- How often do you have an inability to finish tasks? **0 1 2 3**
- How often do you feel the need to consume caffeine to stay alert? **0 1 2 3**
- How often do you feel your libido has been decreased? **0 1 2 3**
- How often do you lose your temper for minor reasons? **0 1 2 3**
- How often do you have feelings of worthlessness? **0 1 2 3**

## SECTION 3 - G

- How often do you feel anxious or panic for no reason? **0 1 2 3**
- How often do you have feelings of dread or impending doom? **0 1 2 3**
- How often do you feel knots in your stomach? **0 1 2 3**
- How often do you have feelings of being overwhelmed for no reason? **0 1 2 3**
- How often do you have feelings of guilt about everyday decisions? **0 1 2 3**
- How often does your mind feel restless? **0 1 2 3**
- How difficult is it to turn your mind off when you want to relax? **0 1 2 3**
- How often do you have disorganized attention? **0 1 2 3**
- How often do you worry about things you were not worried about before? **0 1 2 3**
- How often do you have feelings of inner tension and inner excitability? **0 1 2 3**

## SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? **0 1 2 3**
- Do you feel your verbal memory is decreased? **0 1 2 3**
- Do you have memory lapses? **0 1 2 3**
- Has your creativity been decreased? **0 1 2 3**
- Has your comprehension been diminished? **0 1 2 3**
- Do you have difficulty calculating numbers? **0 1 2 3**
- Do you have difficulty recognizing objects & faces? **0 1 2 3**
- Do you feel like your opinion about yourself has changed? **0 1 2 3**
- Are you experiencing excessive urination? **0 1 2 3**
- Are you experiencing slower mental response? **0 1 2 3**

# Medication History*

**Please circle any of the following medication you have been or are currently taking.**

**Acetylcholine Receptor Antagonist – Antimuscarinic Agents**
Atropine, Ipratopium, Scopolamine, Tiotropium

**Acetylcholine Receptor Antagonist - Ganlionic Blockers**
Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

**Acetylcholinesterase Reactivators**
Pralidoxime

**Acetylcholine Receptor Antagonist - Neuromuscular Blockers**
Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Succinylcholine, Tubocurarine, Vecuronium, Hemicholinium

**Agonist Modulator of GABA Receptor (benzodiazpines)**
Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSom, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax, Restoril, Halcion

**Agonist Modulator of GABA Receptors (nonbenzodiazpines)**
Ambien, Sonata, Lunesta, Imovane

**Cholinesterase Inhibitors (irreversible)**
Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

**Cholinesterase Inhibitors (reversible)**
Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Edrophonium, Neostigmine, Physostigmine, Pyridostigmine, Carbamate Insecticidses

**Dopamine Reuptake Inhibitors**
Wellbutrin (Bupropion)

**Dopamine Receptor Agonists**
Mirapex, Sifrol, Requip

**D2 Dopamine Receptor Blockers (antipsychotics)**
Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, Fluanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

**GABA Antagonist Competitive binder**
Flumazenil

**Monoamine Oxidase Inhibitors (MAOI)**
Marplan, Aurorix, Manerix, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

**Noradrenergic and Specific Sertonergic Antidepressants (NaSSaa)**
Remeron, Zispin, Avanza, Norset, Remergil, Axit

**Selective Serotonin Reuptake Inhibitors**
Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil, Emocal, Seropram, Cipralex, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Paroxat, Lustral, Serlain, Dapoxetine

**Selective Serotonin Reuptake Enhancers**
Stablon, Coaxil, Tatinol

**Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)**
Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despiramin, Duloxetine

**Tricylic Antidepressants (TCAs)**
Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiaden, Adapin, Sinequan, Tofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil

***Please refer to prescribing physician for nutritional interactions with any medications you may be taking.**

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Phone: (619) 239-LIFE (5433) Fax: (619) 546-5422


## INFORMED CONSENT FOR TREATMENT

I, _____, hereby give consent to LotusRain Naturopathic Clinic and specifically to Dr. Kristine Reese ND, her associate, employees, nurse or staff to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

**Common diagnostic procedures:** e.g. venipuncture, Pap smears, radiography, laboratory, x-ray.
**Minor office procedures:** e.g. cleaning and dressing a wound, ear lavage, skin scraping
**Medicinal use of nutrition:** e.g. therapeutic nutrition, nutritional supplementation, and IV or intramuscular vitamin injections.
**Botanical medicine:** e.g. botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.
**Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
**Lifestyle counseling and hygiene:** diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
**Physical medicine/Modalities:** e.g. HBOT, Infrared Sauna, Quantum biofeedback, massage, hot and cold therapy, stretching, electrical muscle stimulation, and therapeutic ultrasound.
**Psychological Counseling**
**Contraception**
**Vaccination**
I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture, or procedures. Notify LotusRain Naturopathic Clinic if you experience any symptoms which may be secondary to the above procedures.

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, 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 doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

**With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by LotusRain Naturopathic Clinic, or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that LotusRain Naturopathic Clinic does not offer a refund for any services and that full payment for all services is due on the day of service.**

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or my representative, or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

_____ _____

Signature of patient Date

_____

Signature of Patient Representative or Guardian

Original: Chart
Copy: To patient (if requested)

*LOTUSRAIN NATUROPATHIC CLINIC, INC.*
**Dr. Kristine Reese, ND**

## Supplement and Medication List

**Patient Name:** **Date of Birth:**

| Date Started | Date Discontinued | Nutrient/Supplement/With Dosage | Doctor |
|---|---|---|---|
| | | | |
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| Date Started | Date Discontinued | Prescription and Over the counter Medications/Specific Dosage | Doctor |
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