Spring Tide Natural Health

Laura A. Enfield, ND, MSOM, LAc

205 E. 3rd Avenue, Suite 206, San Mateo, CA 94401

phone: 650.777.7966 fax 650.268.8625

Welcome!

Thank you for your interest in my wholistic medical practice. You may find more information about my practice on my website, www.springtidenaturalhealth.com. Please read through the information so you will be more familiar with my background, philosophy, and treatment approach.

There are several forms for you to fill out before you come in for your first visit. I encourage you to spend a minimum of one hour with this as it is your first step towards self-knowledge. The more information you include, the more I am able to get a complete picture of how to best educate, treat and empower your journey into wellness. Be thorough and enjoy the process. If you feel overwhelmed by the process, fill out what you can, do not let that be an obstacle for your journey towards health.

The following is a checklist of things to bring in and do before your first visit:

1. Complete Patient Health History. The more detailed it is, the less time we will need to spend during your visit on the same questions
2. Medical records, x-ray, MRI, blood-work, lab tests and results that you have access to.
3. Drink lots of water before your visit.
4. Wear comfortable loose clothing.
5. Please do not drink alcohol or take any recreational drugs before your visit.

For Future Visits:

1. Be sure to eat a meal with protein about one hour before you come in.
2. Drink lots of water before your visit.
3. Wear comfortable loose clothing.
4. Please do not drink alcohol or take any recreational drugs before your visit.

On Your First Visit
You can expect that we will discuss your health history and goals in detail. Further introduction to my philosophy will be presented. Treatment for that day may include naturopathy, acupuncture or massage. Labs may be ordered.

On Your Second Visit
The lab results and treatment plan are discussed and treatments will be done as necessary. All treatment plans are customized to meet the needs of the individual.

Please contact the office if you have any questions, we will be happy to assist you. I look forward to working together with you on your journey to health.

In good health,

Laura Enfield, ND, LAc

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Patient Health History

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Telephone: (mobile)_____ (work or home): _____

Age: _____ Date of Birth: _____ Education:_____

E-mail address: _____

Married: ____ Separated: ____ Divorced: ____ Widowed: ____ Single: ____ Partnership: ____

Live with: Spouse: ____ Partner: ____ Parents: ____ Children: ____ Friends: ____ Alone: ____

Do you have children Yes ____ No ____

How many? _____ Girls; ages _____ _____ Boys; ages_____

Occupation: _____

Employer: _____

Work Address: _____

Have you ever seen a Naturopathic physician or Licensed Acupuncturist before? _____

Describe your experience: _____

_____

What type of services are you interested in today? _____

How did you hear about my practice? _____

Has any other family member been seen at my practice? _____

Next of Kin or other to reach in case of emergency: _____

Relationship: _____ Phone: _____

Address: _____

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will assist me greatly in my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me in guiding you with your health needs.

[1] Why did you choose to come to see me as a Naturopath or Chinese medicine practitioner?

What do you know about our approach?

[2] What three expectations do you have from this visit today?

What long-term expectations do you have from working with me as a Naturopath or Chinese medicine practitioner?

What expectations do you have of me personally as your physician or health care provider?

[3] What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed.)

0% 1 2 3 4 5 6 7 8 9 10 100%

[4] What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (please list)

[5] What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and which may interfere in adhering to the therapeutic protocols which I will be sharing with you?

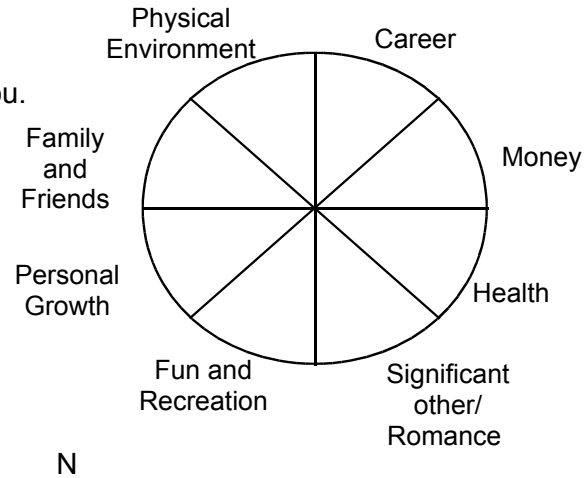
[6] Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Wheel of Balance

Wellness is a balance of many factors. Using the circle, please shade in your level of satisfaction in each area as it relates to you.

For example: if you are extremely happy in your career, shade in the entire pie shape for career.

Do this for each area starting from the center point radiating outwards.



Are you currently receiving health care? Y N

If yes, for what and from whom?_____

_____

If no, when and where did you last receive medical health care? _____

_____

What was the reason? _____

What are your most important health concerns? List as many as you can in order of importance.

[1] _____ [5] _____

[2] _____ [6] _____

[3] _____ [7] _____

[4] _____ [8]_____

Do you have any known contagious diseases at this time? Y N

If yes, what? _____

Diet – Please list

Do you have any special diet or eating restrictions? _____

☐ How much coffee/ caffeine do you drink daily? _____

☐ Do you drink or eat products with nutrasweet in them? _____

☐ How much water do you drink daily? _____

☐ Skip meals

☐ How many meals do you eat per day? _____

☐ Diet frequently?

For The Following, Please Circle

Y = Yes, currently have/ do this N = Never S = Significant problem in the past P = Past

Habits

Main interests and hobbies? _____

Do you exercise? Y N If yes, how often? _____

What type?_____

Average 6-8 hrs. sleep?	Y	N	S	P	Enjoy your work?	Y	N	S	P
Sleep well?	Y	N	S	P	Take vacations?	Y	N	S	P
Awake rested?	Y	N	S	P	Spend time outside?	Y	N	S	P
Have a supportive relationship?	Y	N	S	P	Watch television?	Y	N	S	P
Have a history of abuse?	Y	N	S	P	How many hours? _____				
Any major traumas?	Y	N	S	P	Read?	Y	N	S	P
Use recreational drugs?	Y	N	S	P	How many hours? _____				
Treated for drug dependence?	Y	N	S	P	Eat three meals a day?	Y	N	S	P
Use alcoholic beverages?	Y	N	S	P	Treated for alcoholism?	Y	N	S	P
How often? _____					Go on diets often?	Y	N	S	P
Use tobacco?	Y	N	S	P	Do you eat out often?	Y	N	S	P
How often? _____					Do you drink coffee?	Y	N	S	P
Smoked previously?	Y	N	S	P	Drink black or green tea?	Y	N	S	P
How many years? _____					Drink cola/ soda?	Y	N	S	P
How many packs per day? _____					Eat refined sugar?	Y	N	S	P
					Do you add salt?	Y	N	S	P

Do you have a religious or spiritual practice? Y N If yes, what? _____

Family History

Do you have a family history of any of the following conditions? (please circle)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay Fever	Hives	Eczema

Any other relevant family history? _____

What is your heritage? _____

Childhood Illness

Please circle whether you have had any of the following as a child:

Scarlet Fever	Diphtheria	Rheumatic Fever
Mumps	Measles	German Measles

Hospitalizations, Surgery, Imaging

What hospitalizations, surgeries, X-rays, CAT scans, EEG and/ or EKG's have you had?

_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

Allergies

Are you hypersensitive or allergic to …

Any drugs? _____
Any foods? _____
Environmental or chemical agents? _____

Current Medications

Do you take or use currently (Y or N) or in the past (P)?

Laxatives	Y	N	P	Pain Relievers	Y	N	P	Antacids	Y	N	P
Cortisone	Y	N	P	Appetite Suppressants	Y	N	P	Antibiotics	Y	N	P
Tranquilizers	Y	N	P	Thyroid medication	Y	N	P	Sleeping Pills	Y	N	P

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking…

[1] _____ [2] _____
[3] _____ [4] _____
[5] _____ [6] _____
[7] _____ [8] _____

Personal

Height: _____ Weight: _____ lbs Weight 1 year ago: _____ lbs
Maximum weight: _____ When: _____

At what time is your energy the best _____ Worst _____

Are you happy in your job or career _____

What would you like to change about your life _____

What behaviors, habits or thoughts would you like to eliminate _____

Take a deep breath…in…out….
...Relax…. Now you are ready to continue on…

Metabolic Assessment

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

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amounts of foul smelling gas	0	1	2	3
Have more than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Excessive belching, burping or bloating	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food in stools	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Gas immediately following a meal	0	1	2	3

Category III

Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine.	0	1	2	3

Category IV

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating.	0	1	2	3
Pain, tenderness or soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/ or vomiting	0	1	2	3
Difficulty losing weight	0	1	2	3
Stool is undigested, foul smelling, mucous-like Greasy or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category V

Greasy or high fat food cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in morning	0	1	2	3
Unexplained itchy eyes	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and / or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes	No		

Category VI

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or to get started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery or tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category VII

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	3	3

Category VIII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Weak nails	0	1	2	3
Dizziness when standing up too early	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Morning headaches that wear off as day progresses	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling out of hair	0	1	2	3
Dryness of skin and/ or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Male only)

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Male only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating females only)

Are you perimenopausal	Yes		No	
Alternating menstrual cycle lengths	Yes		No	
Extended menses, greater than 32 days	Yes		No	
Shortened menses, less than 24 days	Yes		No	
Do you take the oral contraceptive pill	yes		No	
Have you in the past	Yes		no	
Pain and cramping during period	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss / thinning	0	1	2	3

Category XVII (Menopausal Females only)

How many years have you been menopausal? _____

Have you ever had uterine bleeding since menopause	Yes		No	
Do you take hormone replacement therapy	Yes		No	
Have you in the past	Yes		No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

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I invite you to discuss with me any questions regarding my services. The best healthcare services are based on a friendly, mutual understanding between physician and patient that facilitates optimizing your health.

FEES: My services and fees are based on values determined to be usual and customary for this geographic region at this time.

METHOD OF PAYMENT: Payment is due at the time of service unless prior arrangements have been made with my office. Cash, checks and credit cards are accepted.

INSURANCE: Insurance will only be billed if discussed with the office. Not all insurance plans are accepted. If insurance does not cover the costs you are responsible for the charges. There is a $10 processing fee for insurance.

PLEASE READ AND INITIAL EACH OF THE FOLLOWING STATEMENTS OF AGREEMENT:

_____ I understand that I am ultimately responsible for all charges.

_____ I understand that payment is due at the time of service unless prior arrangements have made and that a 10% surcharge will be added to the total if the bill is not paid in full at that time.

_____ I understand the above information and guarantee that this form was completed to the best of my knowledge.

_____ I understand that I will be billed and am asked to pay $50 for appointments missed with less than 24 hours notice, regardless of my payment situation.

Patient/Guardian Signature: _____ Date: _____

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As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give or withhold my consent as to whether or not to undergo care with Laura Enfield, ND, LAc, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with Naturopathic medicine and Classical Chinese Medicine (CCM) by Laura Enfield, ND, LAc, and/ or other licensed doctors of Naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called *allied health care provider*. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Laura Enfield and/ or with the *allied health care provider* providing backup:

(1) my suspected diagnosis(es) or condition(s)
(2) the nature, purpose, goals and potential benefits of the proposed care
(3) the inherent risks, complications, potential hazards or side effects of treatment or procedure
(4) the probability or likelihood of success
(5) reasonable available alternatives to the proposed treatment procedure
(6) potential consequences if treatment or advice is not followed and/or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

5. Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
6. Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
7. Soft tissue and osseous manipulation (including therapeutic massage, neuro-muscular technique, Naturopathic/ osseous manipulation of the spine and extremities and muscle energy technique)
8. Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
9. 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, tropical creams, pastes, plasters, washes or other forms)
10. Homeopathic remedies (highly diluted quantities of naturally occurring substances)
11. Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
12. Counseling (including but not limited to visualization for improved lifestyle strategies)
13. Over the counter and hormone prescriptions.
14. Nutritional IV therapy and vitamin injections.

The scope of practice of acupuncture is outlined below. I understand that Classical Chinese medicine and acupuncture evaluation and treatment may include but are not limited to:

6. Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
7. Use of electrical, mechanical and magnetic devices
8. Moxa (indirect burning of herbal material in the form of a loosely compact her or stick)

9. Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
10. Gua sha (rubbing on an area of the body with a blunt or round instrument)
11. Shiatsu (Japanese massage)
12. Dietary advice (based on traditional Chinese medicine theory)
13. Herbs (use of herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials)

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies; allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider, Dr. Laura Enfield, of these conditions.

Please initial:
_____ I understand that Dr. Laura Enfield is not licensed to prescribe any controlled substances
_____ I understand that Dr. Laura Enfield will only prescribe medications if she believes that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescriptive medication needs.
_____ I understand the U.S. Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.
_____ I understand that Dr. Laura Enfield is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Dr. Laura Enfield and/ or any *allied health care provider* to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request Dr. Enfield to explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

_____	_____	_____
Printed Name of Patient	Signature of Patient or Guardian	Date