Dr. Solbrig's Initial Intake Form

Name _____Today's Date _____

Guardian _____ Relationship_____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone (Cell) _____

Phone (other) _____

Is it ok to communicate to you via: Texting? ☐Yes ☐No E-mail? ☐Yes ☐No

E-Mail Address _____

Date of Birth _____ Age _____ Gender: ☐Male ☐Female

Marital Status ☐Married ☐Single Height _____ Weight _____

Occupation _____

How did you hear about Doctor Solbrig? ☐Website ☐Brochure ☐Word of Mouth

☐Referral ☐Other _____

Who referred you? For? _____

Emergency Contact Person _____

Phone Number _____ Relationship To You _____

Notice of Privacy Practices

Dr Solbrig is required by law to protect the privacy of your medical and personal information. Only with your approval will any records be shared or utilized for any purpose. Upon request we can provide you or direct you towards more information regarding the California Confidential Medical Records Act. Sign below that you understand.

Signature:_____ Date:_____

Informed Consent for **Naturopathic** therapies

Dr. Matthew L. Solbrig, ND
Bee Naturopath LLC

This document is a binding "agreement" between Dr. Matthew Solbrig (Doctor of Naturopathic Medicine), Bee Naturopath LLC, and the individual (patient) whose signature is below. In consideration of the health care services which may be provided to you by Dr. Solbrig at present and in the future, you agree to all that follows by initialing each section):

1. **Consent for Treatment.** The "practice" of medicine is not an exact science and diagnosis and treatment may involve risk of injury or death. In medicine, holistic, conventional, or otherwise, there are no guarantees of "outcomes." By initialing below you consent to and authorize Dr. Solbrig, ND, to provide you with one of or more of the following therapies depending on your situation and collaborative communication with the doctor, may include one or more of the following procedures: Hormone replacement therapy, peptide therapy, intravenous Infusions, Intramuscular Injections, Herbal Medicine, Intra-Articular and Extra-Articular Injection Therapy, Neural therapy(procaine), Ozone therapy, Hoshindo, Bee Venom, Microcurrent frequency(FSM), Therapeutic Ultrasound, Craniosacral therapy, Muscle Energy Stretching, Hydrotherapy, Dietary and Nutritional Consultation, Lymph drainage massage, Ionic Foot Bath, Homeopathy, Chelation Therapy, Muscle Stimulation, general Naturopathic Medicine. You are aware that although Dr. Solbrig provides you with his professional opinion, he has not made any guarantees regarding specific outcomes nor suggested any relevant efficacy regarding your treatment and therapy.
2. **Experimental Nature of Treatments.** Even though Naturopathic Medicine is governed by principles that include 1) First do No Harm and 2) Invoking the healing power of Nature 3) Doctor as teacher, not to mention the practice of Naturopathic Medicine is facilitated by "The Therapeutic Order" that ensures the least invasive or least consequential approaches to health are explored first; including bio-identical before synthetic. You acknowledge and agree that the Treatments may consist in whole or part of experimental procedures and methods, in which no governmental (including the U.S. Food and Drug Administration), scientific or medical authority has confirmed the safety or efficacy thereof. You acknowledge that the safety and efficacy record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe and effective. Dr Solbrig, ND has discussed with you the likely outcomes of the Treatments, and that they may alter, address, or decrease your pain, symptoms, and/or complaints; or increase your sense of wellbeing, but also may have no effect. (Initials) _____
3. **Intravenous Therapy, BVT, Injection Therapy Risks, Side Effects, Complications.** Despite all the precautionary measures taken, there is the potential of a serious reaction, albeit rare, to occur. Whether or not the event is deemed "allergic" or "extreme healing state reaction" the potential risks, side effects, and complications include but not limited to swelling, severe pain, bleeding, dizziness, numbness, scarring, allergic reactions, itching, headaches, soreness, inflammation, bruising, phlebitis, vomiting, fainting, anaphylaxis, irritation, psycho-endo-immunological disturbance, fainting, metabolic disturbances. Treatments may very rarely cause infection, injury to nerves, Frozen Shoulder, Pneumothorax (temporary lung collapse), the need for additional surgery or hospitalization, or other serious or debilitating injuries or death. (Initials) _____
4. **Description of Treatments.** The exact procedure, as well as the recommended sequence of Treatments, will be explained after you and Doctor Solbrig discuss your treatment plan. The plan will be the outcome of your collaborative and symbiotic relationship with Dr Solbrig. Dr. Solbrig values working at your pace and relying on using your input as well as signs and symptoms as the guiding force, in other words he requires subjective and objective feedback, as well as an ongoing awareness of your comfort level and readiness to any new therapy. You always have the right to

refuse or request other forms of therapy. You acknowledge that many of the Treatments offered may involve "hands on" techniques that target sensitive, or injured areas of your body such as sore muscles, painful joints, areas of pain, areas such as your face, neck, and mouth, abdomen, or feet, or in and around scar tissue or any area where pathology is present. The practice physical and topical medicine involves applying therapies and working directly with compromised tissues and body parts. The practice of needle insertion into Your skin and veins and the injection of standardized formulas which may include various nutritional substances, homeopathic medicine, chelation agents, and FDA approved prescriptive medicines, local anesthetic (i.e. Procaine), concentrated sugar water (Dextrose), concentrates of your own blood (platelet rich plasma), and other substances which will be explained to You before injections. (Initials)_____

5. **Personal Information.** You have provided Bee Naturopath LLC with a complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and a complete list of all known allergies you may have, and all allergic or adverse reactions you have had in the past to any medicines, dietary supplements, or medical treatments of any kind. You agree to update Bee Naturopath periodically should this list change. (Initials)_____
6. **Assumption of Risk.** You hereby, acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any questions about this Agreement of the Treatment that You have, you are willing to assume any and all risks associate with the Treatments, including without limitation those described in the Agreement. You acknowledge that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may/or could arise from the Treatments, but that by initialing and signing this Agreement, you are acknowledging Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed.
(Initials) _____
7. **Alternatives.** You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action. (Initials) _____
8. **Miscellaneous.** You agree that this Agreement constitutes the entire agreement between You and Bee Naturopath LLC regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by You. This Agreement shall be binding on You and Your successors, heirs, legal representative and assigns. In case anyone of the provisions of this Agreement is held invalid or illegal, such provisions shall be curtailed, limited, or severed only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the State of California without regard to any choice of law principal. (Initials) _____

By signing this Agreement, you indicate that You have read, understood and agree to its terms, you have received a copy of this Agreement, and that You are the patient, Guarantor, the patient's legal representative or legally authorized to sign this Agreement and accept its terms.

Name_____ Legal Guardian_____

Signature _____Date_____ Signature _____Date_____

What are your major health concerns (ca include allopathic diagnosis'/labs)?

Who is your primary care physician?_____
When was your last visit to your PCP? _____
List your known allergies:_____
List all the hospitalizations and surgeries you have had and include the year:

Have you been on any kind of Hormone replacement therapy before?_____
If yes, please elaborate on your experience:

List any questions/concerns you have regarding Hormone Replacement therapy:

What are your desired outcomes and expectations for today's visit:

Current Medications and supplements

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking, include dose and frequency if able

24 Hour Diet Recall

Please list everything you have eaten in the last 24 hours:

Review of Symptoms

(**Y** = a condition you have now. **N** = never had. **P** = condition you have had in the past)

General

Weight _____
Weight 1 yr. ago _____
Maximum Weight _____
When _____
Height _____
Fatigue Y P N

Skin

Rashes Y P N
Other skin conditions Y P N
Itching Y P N
Color Change Y P N
Lumps Y P N
Night Sweats Y P N

Head

Headaches Y P N
Head Injury Y P N

Eyes

Impaired Vision Y P N
Glasses or Contacts Y P N
Eye Pain Y P N
Tearing Y P N
Dryness Y P N
Double Vision Y P N
Glaucoma Y P N
Cataracts Y P N

Ears

Impaired hearing Y P N
Ringing Y P N
Earaches Y P N
Dizziness Y P N

Nose and Mouth

Frequent Colds Y P N
Sore Tongue Y P N
Gum Problems Y P N
Hoarseness Y P N
Teeth Problems Y P N
Sinus Problems Y P N

Neck

Lumps Y P N
Swollen Glands Y P N
Goiter Y P N
Pain or Stiffness Y P N

Respiratory

Cough Y P N
Sputum Y P N
Spitting up Blood Y P N
Wheezing Y P N
Asthma Y P N
Bronchitis Y P N
Pneumonia Y P N
Pleurisy Y P N
Emphysema Y P N
Difficulty Breathing Y P N
Pain when Breathing Y P N
Shortness of Breath Y P N
At night Y P N
Lying down Y P N
Tuberculosis Y P N

Cardiovascular

Heart Disease Y P N
Angina Y P N
High Blood Pressure Y P N
Murmurs Y P N
Rheumatic Fever Y P N
Chest Pain Y P N
Swelling in ankles Y P N
Palpitations, Fluttering Y P N

Gastrointestinal

Trouble Swallowing Y P N
Heartburn Y P N
Change in Thirst Y P N
Change in Appetite Y P N
Nausea Y P N
Vomiting Y P N
Vomiting Blood Y P N
Bowel Movements
How Often _____
Blood in Stool Y P N
Belching or passing gas Y P N
Jaundice (yellow skin) Y P N
Liver Disease Y P N
Gall Bladder Disease Y P N
Ulcer Y P N
Hemorrhoids Y P N
Date of last colon cancer screen?

Urinary

Pain on Urination Y P N
Increased Frequency Y P N
Frequency at Night Y P N
Inability to hold urine Y P N
Frequent Infections Y P N
Kidney Stones Y P N

Female Reproduction

Age Menses Began _____
Average Number of days _____
Length of Cycle _____
Bleeding Between Periods Y P N
Are Cycles Regular Y P N
Pain during intercourse Y P N
Painful Menses Y P N
Vaginal problems Y P N
Excessive Flow Y P N
Birth Control Y P N
What Type? _____
Number of Pregnancies _____
Number of Live Births _____
Number of Miscarriages _____
Number of Abortions _____
Difficulty Conceiving Y P N
Menopausal Symptoms Y P N
Are you Sexually Active Y P N
Sexual Difficulties Y P N
Venereal Disease Y P N

Breasts

Do You Self Exam Y P N
Lumps Y P N
Pain (or tenderness) Y P N
Nipple discharge Y P N
Date of Last Breast Exam/mammogram?

Male Reproductive

Hernias Y P N
Testicular Masses Y P N
Testicular Pain Y P N
Penis problems Y P N
Are you sexually Active Y P N
Sexual Difficulties Y P N
Prostate Disease Y P N
Venereal Disease Y P N
Discharge or Sores Y P N

Musculoskeletal

Joint Pain or Stiffness Y P N
Arthritis Y P N
Broken Bones Y P N
Muscle Spasms Y P N
Weakness Y P N

Peripheral Vascular

Deep Leg Pain Y P N
Cold Hands and Feet Y P N
Varicose Veins Y P N
Thrombophlebitis Y P N

Neurologic

Fainting Y P N
Seizures Y P N
Paralysis Y P N
Muscle Weakness Y P N
Numbness or Tingling Y P N
Loss of Memory Y P N

Emotional

Depression Y P N
Mood Swings Y P N
Anxiety Y P N
Tension Y P N

Endocrine

Hypothyroid Y P N
Heat or Cold Intolerance Y P N
Excessive Thirst Y P N
Excessive Hunger Y P N

Blood

Anemia Y P N
Easy Bleeding or Bruising Y P N

Have you noticed a change in any of the following in the last five years?

Mood
Sex drive
Overall Drive
Endurance/Stamina
Workout Recovery
Sleep
Metabolism/Weight
Please Elaborate:

Family History

How many children do you have?

What are their ages?

(Check those applicable)	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)	_____	_____	_____	_____	_____	_____
Health G:good F:fair P:poor	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma, Hayfever, Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

Please include anything else you find relevant for the Doctor to understand your case: