THE KARLFELDT CENTER

2921 S. Meridian Road
Meridian, Idaho 83642
(208)338-8902 OFFICE
(208)345-3225 FAX
www.TheKarlfeldtCenter.com

New Patient Intake

Name:	Todays Date:	
Address:		
City:	State:	Zip:
Phone:	Occupation:	Work Phone:
Email:		
Date of birth:	Age:	Gender: M F
If patient is a minor, name of parent or guardian:		
How did you hear about us: ____ Ad ____ Provider ____ Patient who:___________________ ____ Radio ____ Internet Other: ___________________		

Primary Care Physician: ____

What is the Primary reason for your visit?

____

____

Medical History:

Diabetes	Cancer	Heart Problems	High Blood Pressure	Thyroid Problems	Gallbladder Problems
Asthma	Allergies	Kidney Problems	Autoimmune Disorder(s)	Acid Reflux/ Heartburn	Digestive Disorders
Parasites	Candidiasis	Chronic UTIs	Head or Neck Injury/ Concussion	Celiac Disease	Hepatitis: ___ (Type)
Anxiety	Depression	Lung Problems	High Cholesterol	IBS	Vein Trouble
HIV/AIDS/STD	Migraines	Nervous Disorders	Fibromyalgia	PTSD	Mononucleosis
Stroke	Neuropathy	Rheumatic Fever	Joint Aches	Muscle Cramps	Psoriasis
Shingles	Acne	Periodontal Disease	Sleep Apnea	Gout	Arthritis
Hypo/Hyperglycemia	Bloating	Low Immunity	Sugar Cravings	Salt Cravings	Adrenal Fatigue
Osteoporosis	Seizures	Blood Clots	Stomach Ulcers	Hormonal Imbalance	ADD/ADHD

Prescriptions:

Please list all prescription drugs you are currently taking (or provide a separate list):

Drug	Purpose	Dose	How Often?	How Long?

Allergies:

Do you have any known drug allergies? YES NO If yes, to what:

____

____

Please list all major surgeries, including year surgery was performed:

____

____

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Family History: Please list any medical conditions that run in your immediate family:

____

____

Please list all additional supplements you are currently taking (or provide a separate list):

Supplement	Purpose	Dose	How often?	How long?

When was your most recent antibiotic? What did you take:

____

Overall Health and Energy:

On a scale of 1-10 (1 being very low and 10 being very high), how would you rate your current health level? 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 (1 being very low and 10 being very high), how would you rate your current stress level? 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 (1 being very low and 10 being very high), how would you rate your current energy level? 1 2 3 4 5 6 7 8 9 10

Depression & Anxiety:

Do you feel depressed at the present time? YES NO

Do you feel anxious at the present time? YES NO

Have you suffered from depression in the past? YES NO

Have you suffered from anxiety in the past? YES NO

Sleep:

Rate the quality of sleep you usually got in the past month : 1 2 3 4 5 6 7 8 9 1O

At what time do you go to bed? ___________ am/pm At what time do you rise in the morning? _____ am/pm
Are you able to sleep through the night? YES NO Are you able to fall asleep easily most nights? YES NO

Do you wake refreshed? YES NO

Toxic Exposure:

Have you worked in an occupation where exposure to chemicals, heavy metals or other toxins? No___ Yes____
If yes, please list chemicals:

____

Bowel Movements:

How often do you have a bowel movement within a: _______ /day _______/ week

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Do you tend toward: ☐Constipation ☐Diarrhea ☐ Neither

Do you ever see the following in your stool? ☐Blood ☐Mucous ☐Undigested Food ☐Grease

Diet:

What type of diet do you currently have? Please describe your diet and eating habits:

____

____

How long have you eaten this way? _______________ How was your diet prior? _______________________________

Social History:

Do you drink alcohol? ___Yes ___No If yes, how much weekly? _________________

Do you use tobacco products? ___Yes ___No If yes, what kind? ________________________

Additional Information:

Please list all current treatments (if any) you are receiving along with the physician or practitioner's name:

____

____

Women Only:

Number of days between your periods: _________ How many days is your average flow? __________

Please check all symptoms you experience related to your cycle:

☐ mood swings ☐ bloating ▫ back pain ☐ water retention ☐ excessive flow ☐ cramps ☐ fatigue

What form (if any) of birth control do you use? ____________

Have you had an irregular pap smear? YES NO If yes, when: ______________

Do you get vaginal yeast infections often? YES NO

Are you currently experiencing symptoms of menopause? YES NO

Is there anything else you would like us to know?

____

____

____

____

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Patient Policies

Cancellation and No Show Policy

24 hour cancellation is required for all services. Same day cancellation or no shows will be assessed a $30.00 charge. Cancellation must either be done in person or by phone.

Emergency Policy

If you need to call after hours, on holidays or weekends, please feel free to call the office number, leave a message, and someone will get back to you at the earliest possible opportunity. If you are in serious emergency, please call the Emergency Response System at 911 or go to the nearest emergency room.

Payment Policy

Payment is due at time of service. We accept cash, check, and credit card. Checks are made out to The Karlfeldt Center. A $20 service charge will be added to all returned checks. Medical and Chiropractic care may be covered by insurance. Please ask front staff for more information. We do not submit to insurance on a patients behalf.

Return, Exchange and Refund Policy – Expired and/or opened products are not eligible for a refund. Unopened product can be returned for an in store credit. The credit, if returned within 90 days, must be used in **6 months** or it will fall off of the account.

Memberships and programs may incur a cancellation fee. Refer to Commitment Agreement when registering for these services.

Prepaid packages are eligible for refund with the services already provided deducted at their full price. Unused promotional packages are refunded in the following manner: 100% for 14 days after day of purchase, 50% for 30 days after day of purchase, no refunds past 30 days after day of purchase. No refund is given if any service included in the package has been provided by the Karlfeldt Center.

Financial Policy

The Karlfeldt Center is not contracted with any insurance companies and is not allowed to submit any claims on patients' behalves.

I understand that I am financially responsible for any charges incurred and must pay the Karlfeldt Center up front and in full the same day that I receive treatment.

I understand that it is my responsibility to contact my insurance carrier directly regarding any claims I would like to make and that I must submit these claims myself.

I understand that any payments or reimbursements from my insurance company will come directly to me. I hereby authorize the Karlfeldt Center to release any medical information necessary to process claims I may have submitted for services/treatments in the office.

In the event that full payment is not made for services rendered, I understand that the Karlfeldt Center may be forced to take collection or legal action. I agree I will be liable for additional expenses, such as legal fees, interest on the unpaid portion of my account balance, and collection fees.

Print Name: ____________________ Signature: __________________________ Date: _________

Acknowledgment of Receipt of Privacy Practices

Client Name: _______________________________ Date of Birth: _________________

I hereby acknowledge that I have received and read a copy of The Karlfeldt Center's Notice of Privacy Practices.

Client's Signature: ____________________________ Date: ________________

If not the client, please print and state legal authority to sign for client.

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Name: ________________________________ Relationship: __________________________

Consent to Care

I voluntarily consent to care at The Karlfeldt Center, encompassing routine diagnostic procedures and examination. I understand The Karlfeldt Center uses an integrative approach and provides naturopathic, nutritional and supplement consulting as part of the recommendations/suggestions provided to the patient by the care provider. The Karlfeldt Center's consulting is not intended as a diagnosis, treatment, prescription, or cure for any disease, mental or physical, and is not intended as a substitute for regular medical care.

Such services are commonly referred to as integrative, complementary/alternative medicine, or holistic services. This can include naturopathy, nutritional, homeopathy, and mind-body approaches to care as well as nonconventional medical therapies. Many of these services may not be recognized as standard care and while many have long been practiced, may still be considered investigative or experimental. I understand that I will discuss potential therapies with my practitioner that he/she recommends, and that I agree to accept the risks explained to me about these procedures by agreeing to accept these treatments.

I understand that my naturopathic physicians are licensed in their respective professions and will evaluate and advise me from the perspective of their training. I understand that there is a Medical Director on staff who is licensed to diagnose and treat in the scope of his practice. I understand that none of these approaches should replace needed medical treatment recommended by my primary care or specialty physician.

The Karlfeldt Center is not responsible for any negative or adverse reaction to any medication currently prescribed to the patient as a result of any supplement or course of nutrition suggested, nor as a result of any prescription given after the counseling by The Karlfeldt Center. I understand I am responsible for informing my practitioner of any drugs or supplements I am taking so that they can help minimize any potential interactions.

Consultations may include discussions of diet, dietary supplement, herbal and botanical products. While herbs and botanical products are generally available over-the-counter and considered safe based upon research and their long history of use, many of them have not been widely tested. There is some risk that these products could prove harmful, particularly if I am allergic to them which in rare circumstances could lead to serious consequences. I understand that interactions between different types of herbs, and between herbs and drugs, are not yet well known. While unlikely, I could have an adverse reaction or experience a reduction or increase in the effect of other medications. This can have serious consequences for some medications, such as for high blood pressure or blood sugar. I will let my physician know what herbs and medications I am taking.

It is understood that some or all of the supplements that may be suggested may not be approved by the United States Food and Drug Administrative (USFDA). Additionally, some labs may be used that are not USFDA approved, and The Karlfeldt Center may use some research based labs.

I have read and understand the foregoing and that I will have an opportunity to discuss any concerns I have about treatment with my practitioners. I understand the nature of these health care methods, and agree to nutritional counseling or treatment.

Signature of Patient: ____ Date: _______________

If the patient is a minor or is unable to consent, please complete the following:

Patient is a minor and is _______ years of age. Name of: Father ________________ Mother ________________

Patient is unable to consent because ____

____________________________________ ________________ ________________
Signature of Parent//Legal Guardian Please Print Name Relationship

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Authorization to Release Medical Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize The Karlfeldt Center to release my records and any information requested to the following individuals.

1. ________________________________ Relationship: ____________________________

2. ________________________________ Relationship: ____________________________

3. ________________________________ Relationship: ____________________________

4. ________________________________ Relationship: ____________________________

Print Name: __________________________________ Signature:___________________ Date: ____________