

Westchester Center for Natural Health
Dr. Angelica Lemke, ND

Patient Information

Last Name: _____ First Name: _____ Preferred Name: _____

Date of Birth: _____ Sex: _____

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

Home Ph:(_____) _____ Work Ph:(_____) _____ Cell Ph:(_____) _____

May we leave confidential voice-mail messages for you at any of the above numbers? No Yes (specify): Home Work Cell

Address: _____ City: _____ State: _____ Zip Code: _____

e-mail address: _____ Is e-mail a good way to correspond with you? No Yes

Emergency Contact: _____ Relationship to Emergency Contact: _____

Contact's Phone #: (_____) _____ Home Work Cell Do you have special needs?: No Yes (see front desk)

Do you have a primary care provider? Yes No If so, what is the name of your primary doctor? _____

How did you hear about us? Magazine Ad Mailer/Flyer Website Workshop/Event Friend/Family
 Yellow Pages Other _____ Medical Referral from: _____

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____) _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____
Guarantor's Signature Date

Terms of Admission

Financial Terms: I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. The Westchester Center for Natural Health is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please call us at (914) 747-1647.

I hereby acknowledge that I have received a copy of The Westchester Center for Natural Health's Notice of Privacy Practices. Should I refuse or fail to sign this form, I acknowledge that The Westchester Center for Natural Health has made a good faith effort to obtain my acknowledgement.

X _____
Patient's Signature Date

X _____
Guardian/Representative's Signature Date

Relationship to Patient/Representative Authority

(version 9-22-09)

CONSENT FOR TREATMENT

I hereby authorize all private practitioners at [the Westchester Center for Natural Health](#) to perform the following specific procedures as necessary to facilitate my treatment:

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions

Herbs/Homeopathy/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, highly dilute quantities of a naturally occurring substance, may also be used.)

Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)

Soft Tissue Therapy (use of hydrotherapy and craniosacral therapy)

Potential Risks: Pain, discomfort, allergic reactions to prescribed herbs or supplements; soft tissue aggravations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional 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 doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the private practitioners at the Westchester Center for Natural Health. 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 me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

Guardian/Personal Representative's Name (PRINT)

Patient's Name (PRINT)

Guardian/Personal Representative's Signature

Patient's Signature

Relationship/Representative's Authority

Date

Date

WESTCHESTER CENTER FOR NATURAL HEALTH
DR. ANGELICA LEMKE, ND& CLASSICAL HOMEOPATH

ADULT INTAKE FORM

Name:	Age:	Date of 1 st Visit :
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Main reasons for visit (list in order of importance):

How long have you had this condition:

What other medical diagnoses have you received?

What type of therapies have you tried in the past for these concern(s)?

- Pharmaceuticals Diet Modification Vitamins/minerals Detoxification Herbs Homeopathy
 Chiropractic Acupuncture Other _____

Current prescription(s) and/or over the counter medication(s):

Current supplements and/or vitamins:

Major Hospitalizations, Surgeries, and Injuries: please indicate dates and complications (if any)

Year Illness, Surgery, Injury, Major Medical Diagnosis

_____	_____
_____	_____
_____	_____

How would you rate your general current STATE of HEALTH on the following scale (1 being the least):

1 2 3 4 5 6 7 8 9 10

Please rate your current STRESS level on the following scale (1 being the least):

1 2 3 4 5 6 7 8 9 10

Please rate your ENERGY level (1 being the least):

1 2 3 4 5 6 7 8 9 10

WESTCHESTER CENTER FOR NATURAL HEALTH

DR. ANGELICA LEMKE, ND& CLASSICAL HOMEOPATH

SYMPTOM CHECKLIST: Do you have or have you had:

UPPER GASTROINTESTINAL

- bloating or burping
- GERD or burning in stomach
- excessive appetite
- lack of appetite
- sleepy after meals
- stomach pain or cramps
- stomach ulcers

LIVER/GALLBLADDER

- nausea or motion sickness
- gall stones
- pain between shoulder blades
- pain on right side of rib cage
- chemical/medication sensitive
- easily hungover
- headache that's right sided or over eyes

INTESTINES

- constipation
- diarrhea or loose stool
- hemorrhoids
- blood or mucous in stool
- excessive gas or foul gas
- food cravings _____
- food allergies _____

SKIN

- rashes or hives
- easy bruising
- itchiness
- acne
- perspiration issues

IMMUNE

- frequent colds/flu/sore throat
- cough or bronchitis
- sinus infections
- enlarged lymph nodes
- asthma or hay fever

HEENT

- headaches/migraines/head pain
- dizziness/vertigo
- eye pain, blurring, or discharge
- > 5 mercury teeth fillings
- ear itching, infections or hearing loss

THYROID/ADRENAL

- heat or cold intolerance
- fatigue or big energy drops
- feel overstressed/overworked
- dizzy from lying to standing

BONES/JOINT/MUSCLES

- joint/muscle pain or aching
- joint/muscle swelling
- joint/muscle stiffness
- history of trauma

CONSTITUTIONAL

- sleep issues or insomnia
- prefer HOT or COLD weather
- body temp is WARM or COLD
- prefer WARM or COLD drinks

MENTAL/EMOTIONAL

- depression/sadness
- anxiety/phobia issues
- anger/frustration
- memory loss

CARDIOVASCULAR

- high blood pressure
- high cholesterol
- varicose veins
- easy bleeding

MEN ONLY

- prostate or urination problems
- weight issues
- venereal disease/STD
- libido issues

WOMEN ONLY

- age of onset menses ____
- age of onset menopause ____
- length of cycle ___days
- duration of flow ___days
- Is your flow: light med heavy
- irregular periods or no period
- cramps or pain with period
- PMS or emotional with period

- breast tenderness
- breast discharge
- fibroids or endometriosis
- ovarian cysts or pain
- vaginal discharge with itching
- yeast infection
- issues with libido
- currently trying to conceive

- problems getting pregnant
- currently on birth control
- urinary tract infections
- number of children
- difficult pregnancies
- difficult childbirths
- menopausal issues
- weight issues

OTHER _____