

**NEW PATIENT REGISTRATION-ADULT****Dr. Sean Ceaser, N.D.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (Prov./State) (Postal/Zip code)

Tel#: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M / F Date of Birth: \_\_\_\_\_ email: \_\_\_\_\_

Single/ Married/ Other \_\_\_\_\_ Partner's name: \_\_\_\_\_

Your medical doctor: \_\_\_\_\_

Other health practitioners involved in care: \_\_\_\_\_

Emergency phone contact: \_\_\_\_\_ Phone # \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of work: \_\_\_\_\_ # of years : \_\_\_\_\_

Do you have private insurance that covers Naturopathic Medicine? Yes No  
Insurance provider \_\_\_\_\_ Limit of coverage \$ \_\_\_\_\_

How did you hear about the clinic? \_\_\_\_\_

If online, please give how you specifically found the website: \_\_\_\_\_

**INFORMED CONSENT FOR TREATMENT for Dr. Sean Ceaser, N.D.**

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This notice is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment.

*If you refuse any specific procedure this will not affect your receiving other care or future treatments.*

I voluntarily request Dr. Ceaser as my Naturopathic Doctor to examine and treat me and my health conditions. I understand that the course of care therapy may include the use of multiple modalities of Naturopathic medicine including nutritional supplements, injection therapies, OncoTherm hyperthermia, prolotherapy, Platelet Rich Plasma, intravenous nutrients, chelation, ozone, acupuncture and other therapies offered by Dr. Ceaser. I understand that my verbal consent to a specific treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive treatment. I waive the option of signing a consent to treat for each and every specific procedure at each treatment date.

I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time. I understand that I have the right and the opportunity to ask questions about my condition, discuss naturopathic and conventional options at any time. I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.

I understand that payment is due in full at the time of service.

I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.

All information given now or at any point in the future is confidential. It is Naturopathic Physicians Group's policy to require a medical release form before releasing medical records to anyone other than the patient. I certify that I have read this form or have had it read to me and that I understand its content and meaning. I have sufficient information to give this informed consent.

Patient Name \_\_\_\_\_ Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY QUESTIONNAIRE**

Please list the reasons for your visit in order of importance & how long you've had the problem:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please indicate your expectations and what you hope to accomplish with your Naturopathic visit:

4. \_\_\_\_\_

Please circle all that apply. Note beside the symptom if you need. If it is a past issue please indicate "P" beside the symptoms.

Fatigue AM/after lunch/PM Weight gain/loss Cancer: Type & stage: Pain: Swelling: Stiffness Depression Anxiety Memory loss/foggy thinking Behavioral problems Dizziness Insomnia. I sleep _____ hours/night Numbness/tingling Bone loss Weakness Restless legs Cold hands/feet Varicose veins	Skin problems: Hair loss: Headaches: Eye problems: Ear problems: Sinus problems: Metal taste Frequent sore throats Thyroid problems: Heat/cold intolerant Difficulty breathing: Wheezing Cough Toxic exposure: Heart disease: Hypertension Palpitations Digestive problems:	Diarrhea/Constipation Nausea/vomiting Liver problems: Gallbladder problems: Urinary difficulties: Kidney stones Period begins every _____ days Irregular cycles Infertility Period cramping Clotting Breast tenderness Menopausal Hot flashes/night sweats Testicular pain Prostate problems Sexual difficulties: Other:
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**CURRENT MEDICATIONS.** Include medications, chemo & cancer drugs, vitamins, supplements, herbs, OTC rx

Medicine:	Dose:	Began on:	Stopped on:
1.			
2.			
3.			
4.			
5.			
6.			
7.			

List more on back if needed. **Allergies:** \_\_\_\_\_

**Hospitalizations (& year):** \_\_\_\_\_

**Diseases in family history:** \_\_\_\_\_