Patient Registration Form

Last Name:	First Name:	M.I.
Address:		
City:	State:	Zip:
Cell phone:	Home phone:	Join our mailing list? Y/N
Phone # where we may leave private medical information? (Circle one) Cell or Home or Both		Date of Birth:
Email Address:		
Primary Care Physician:		Phone #:
Employer:		Occupation:
Emergency Contact:	Relation:	Phone #:
Allergies:		
HEALTH INSURANCE COMPANY:		
How did you hear about W Clinic? ☐ Radio ☐ Newspaper ☐ Yelp ☐ Groupon ☐ Magazine ☐ Internet Search ☐ Direct Mail ☐ Physician Referral ☐ Friend/Family (please list person) ☐ Facebook other:		

_____ _____

Patient Signature Date

W Clinic of Integrative Medicine
3231 S. Country Club Way SUITE 106♦ Tempe, AZ 85282 ♦ www.wclinicaz.com♦ 480-820-5026

Patient Intake Form

Date:_____

Patient Name: _____ **Birthdate:** _____

List your health concerns in order of importance:

1) _____
2) _____
3) _____

Current Diagnosed Health conditions:

1) _____
2) _____
3) _____
4) _____
5) _____

Past diagnosed health condition:

1) _____
2) _____
3) _____
4) _____
5) _____

List All Surgeries & Hospitalizations, including date occurred:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Current Medications (indicate name of drug, dose, and how often you take it. If None, write None):

_____
_____
_____
_____

Current supplements (Vitamins, minerals, herbs, fish oil, etc):

_____
_____
_____
_____

W CLINIC of INTEGRATIVE MEDICINE

Allergies: Any known drug allergies, food allergies, or environmental allergies?

_____

_____

_____

_____

Family history:

Please circle any of the following illnesses/diseases if you have had an immediate family member (Mother, father, sibling, child, grandparents) with that/those condition(s):

Cancer	Diabetes mellitus	Mental illness
High blood pressure	Allergies	Osteoporosis
Heart attack	Asthma	Lung Disease
Stroke	Autoimmune disease	Other

NEXT place an abbreviation next to the disease listed above indicating the family member who suffers or suffered from this:

Mother= M	Brother=B	maternal grandmother=MGM
Father=F	Sister= S	maternal grandfather= MGF
	child=C	Paternal Grandmother= PGM
		Paternal Grandfather=PGF

Social history

Smoking? Yes No Past **How many packs per day?** _____ **How many years?**_____

alcohol? Yes No Past **How much and how often if yes/past?** _____

Soda/Pop? Yes No Past **Ounces per day if Yes/Past:** _____

Illegal drugs? Yes No Past **What drug if yes/past?** _____

Treated for substance abuse of any kind ? Yes No Past **when?** _____

Review of Systems:

Do you have low energy or fatigue? Yes No

Present Weight: _____ **Weight one year ago:** _____ **Height:** _____

Ideal Weight:_____

# of Bowel Movements Per Day? _____

# of Hours of Sleep Per Night? _____

Dental History:

Root canals? Yes No # of Root canals: _____

Mercury Amalgam tooth filings? Yes No # of mercury fillings: _____

Dental crowns? Yes No # of dental crowns: _____

Please list issues you may have regarding each category or leave blank if not applicable:

Skin:	
Head/Neck:	
Respiratory (Lungs):	
Cardiovascular (Heart/Blood Vessels):	
Gastrointestinal/Digestion:	
Urinary:	
Female Reproductive:	
Male Reproductive:	
Musculoskeletal (Muscles/Skeleton/Joints):	
Neurologic (Nervous system):	
Psychiatric (Mental Health):	

MALE GENITALIA

Testicular pain/swelling Hernia Impotence/erectile dysfunction Prostate disease Prostate cancer BPH (Benign prostatic hypertrophy)	Discharge from penis Frequent urination at night Difficulty starting or stopping urinary stream Difficulty establishing or maintaining an erection Decrease in early morning erections	Changes in sleeping patterns Decreased mental sharpness/acuity Difficulty concentrating Difficulty losing weight	Decreased muscle mass Decreased muscle strength Increase in waist size Loss of height Sexually active
Any history of STDs (Sexually transmitted diseases)? Yes No If yes, what disease?			
I AM _____ YEARS OLD. I FEEL _____ YEARS OLD.			

Welcome to W Clinic of Integrative Medicine. We look forward to helping you achieve your health goals. This document contains important policy information that pertains to your treatment. Please read over the entire document, initial each area and sign at the bottom; if you have any questions please feel free to ask us.

Appointments
Kindly provide 24 hours notice if you need to cancel or reschedule an appointment. Canceled or rescheduled appointments without appropriate notice will be assessed a fee of $100 for new patient consultations, $50 for established patient visits and $25 for all other services. Following the first missed appointment we will be asking you for a credit card to hold your future appointment(s). Please note that insurance companies do not reimburse for missed appointments.

Payment
W Clinic of Integrative Medicine requires payment in full at the time services are rendered. I also understand that upon my request the cost of all procedures and services will be told to me before they are performed. For your convenience we accept Check, Cash, Visa, Mastercard or American Express payments. There will be a $25.00 fee for all returned checks.

Retail Return Policy
All supplement and other retail sales are final.

Refunds and Credits
Payment for services rendered is non-refundable. Payment for pre-paid services may be returned as a credit to your patient account at W Clinic. Patient account balances may be used for any service or products offered at W Clinic. Any credit issued has no cash value.

Emergencies
If you have a true medical emergency or serious medical concern please call 911 immediately. If you an a non-emergency health concern please call our office at 480-820-5026 between 8 am and 5 pm M-F, 9 am and 4 pm Sat. and we will schedule you as soon as possible to speak with/be seen for a medical visit by Dr. Weirick, Dr. Williamson(s), Dr. Thoreson, or Dr. Slovak.

I have read this document completely and I understand and agree with all of its contents demonstrated by my signature below and my initials above.

Signature of Patient or Patient Representative Date

CLINIC
of INTEGRATIVE MEDICINE

Informed Consent to Treat

Consent: I voluntarily consent to outpatient care provided by Dr. Susan Williamson Weirick NMD and/or Dr. John Williamson NMD and/or Dr. Phillip Williamson NMD and/or Dr. Kaylee Thoreson NMD and/or Emil Slovak Jr. MD encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies including imaging studies), Intravenous therapies, injections, acupuncture, and administration of medications prescribed by the doctor.
I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.
I understand that not ALL of the treatment suggestions provided are accepted by the United States FDA and therefore should not be taken as such.

Type of Care: I understand that this medical practice uses some diagnostic and treatment methods that are variously known as, but not limited to: Naturopathic, environmental, complementary, alternative, integrative or nutritionally oriented. I agree to treatment using, but not limited to, nutrition, lifestyle, homeopathy, ozone therapy, manipulation, herbs, chelation therapy, acupuncture, pharmaceuticals, and intravenous and injection therapies.

Recital of Risks:
I understand and am informed that, as in the practice of naturopathic medicine/medicine, there are some risks to treatment, including, but not limited to: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness, allergic reactions to prescribed herbs, supplements, medications, aggravations of pre-existing symptoms.

Notice to all pregnant women: All female patients must alert their physician if they have a confirmed or suspected pregnancy as some of the therapies prescribed could present a risk to the pregnancy.

Notice to individuals with bleeding disorders, pace maker and /or cancer, for your safety it is vital to alert your physician of these conditions.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

No Guarantee: I understand that results are not guaranteed.

Agreement and Continuous Effect: I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I understand that this consent form will be valid and remain in effect as long as I receive medical care provided by Dr. Susan Williamson Weirick NMD and/or Dr. John Williamson NMD and/or Dr. Phillip Williamson NMD and/or Dr. Kaylee Thoreson NMD and/or Emil Slovak Jr. MD

Patient or patient representative signature Date

Dr. Susan Williamson Weirick NMD
Dr. John Williamson NMD
Dr. Phillip Williamson NMD
Dr. Kaylee Thoreson NMD
Dr. Emil Slovak Jr MD

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to view it.

Name: _____Birthdate: _____

Signature: _____Date: _____