



## 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? <input type="checkbox"/> RADIO <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> YELP <input type="checkbox"/> GROUPON <input type="checkbox"/> MAGAZINE <input type="checkbox"/> INTERNET SEARCH <input type="checkbox"/> DIRECT MAIL <input type="checkbox"/> PHYSICIAN REFERRAL <input type="checkbox"/> FRIEND/FAMILY (PLEASE LIST PERSON) <input type="checkbox"/> FACEBOOK OTHER:				

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE



**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):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**ALLERGIES: ANY KNOWN DRUG ALLERGIES, FOOD ALLERGIES, OR ENVIRONMENTAL ALLERGIES?**

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**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 fillings? 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	Discharge from penis	Changes in sleeping patterns	Decreased muscle mass
Hernia	Frequent urination at night	Decreased mental sharpness/acuity	Decreased muscle strength
Impotence/erectile dysfunction	Difficulty starting or stopping urinary stream	Difficulty concentrating	Increase in waist size
Prostate disease	Difficulty establishing or maintaining an erection	Difficulty losing weight	Loss of height
Prostate cancer			Sexually active
BPH (Benign prostatic hypertrophy)	Decrease in early morning erections		
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 have 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.

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Signature of Patient or Patient Representative

Date



### 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

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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: \_\_\_\_\_