Patient Contact Information

Name of Patient _____ Date of First Visit _____

Name of Parent(s)/Guardian(s) (if applicable) _____

Relationship to patient _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (cell) _____

(home) _____

(work) _____

Email address_____

Would you like to receive our email newsletter/updates? ___ Yes ___ No

Age _____ Date of Birth _____ Gender: Female _____ Male _____

Married _____ Separated _____ Divorced___ Widowed ___ Single _____ Partnership _____

Live with: Spouse _____ Partner____ Parents _____ Children ___ Friends _____ Alone _____

Occupation _____ Hours per week _____ Retired _____

Employer _____

(Work address) _____

How did you hear about Dr Vreeland? Friend _____ (name)
Doctor/health provider _____ (name)
Lecture _____ (please specify)
Flyer _____ (please specify)
Internet _____ (website)
Other _____ (please specify)

Next of Kin or other to reach in an emergency _____

Relationship _____ Phone _____

Address _____

Important Patient Information

APPOINTMENTS

- There is a 24-hour cancellation policy.
- There is a $25.00 fee for missed appointments with less than 24-hours notice.
- As a courtesy to our patients, appointments will be confirmed prior to the appointed time. It is however, the patient's responsibility to keep the scheduled appointment or reschedule.
- Initial consultation with Dr Vreeland - $275 for 60 minutes
- Follow-up appointments to review lab results or treatment programs in person or by phone - $135 for 30 minutes.
- There is no charge for reasonable e-mails or phone calls. For non-urgent matters that would be best attended to during an appointment Dr Vreeland will request you either a) schedule an appointment or b) hold your question until your next appointment (this generally applies to questions that change the course of care or take longer than 5 minutes to respond to either by phone or email).

LAB TESTS

- Dr Vreeland offers phlebotomy services through Primex at Newport Integrative Health. Patients may choose blood draws be performed at NIH or at an outside lab facility.
- After your initial or follow–up consultations, lab tests and/or diagnostic tests may be ordered.
- Testing recommendations and cost(s) per test will be reviewed.
- Fees for such tests are billed directly by the lab to the patient. In many cases, the lab will work directly with the patient's insurance care provider.
- Some lab tests take up to 5 weeks to be finalized and sent to the office, Dr Vreeland cannot guarantee turn-around time on laboratory testing.
- You will receive a copy of your lab test in the mail or via email.
- Dr Vreeland does not mark up or profit in any way from the sale of lab testing kits that she orders for her patients.

BILLING/ISURANCE

- Payment for the office visit or phone appointment is expected at time of service and can be in the form of check, cash or credit card payments. All credit card payments will be processed the same day of the visit or phone call.
- You will receive an invoice at the completion of your visit.
- Dr Vreeland does not accept insurance or Medicare. You can request a bill of services rendered that you can submit to your insurance provider who may reimburse you for some or the entire fee at their discretion. Please note that phone visits may not be reimbursed by your insurance carrier.

PATIENT INITIALS _____

After signing, you are entitled to a copy of this consent.
Please request this copy from the staff.

Important Patient Information

SUPPLEMENTS

- Nutritional supplements are available for patient convenience at Newport Integrative Health.
- Patients are under no obligation to purchase their supplements at the office.
- Newport Integrative Health will ship supplements to your home at standard shipping fees (most typically $3-8).
- Return policy; we are able to return unopened supplements within 30 days of purchase. We are unable to return any opened supplements.

PATIENT AWARENESS AND RESPIONSIBILITY

- Any therapy, no matter how well appointed, may fail to resolve your symptoms and improve your health.
- Dr Vreeland will inform you of the therapies most relevant to your condition both conventional and alternative.
- You have the choice to accept, refuse or terminate these therapies at any time.
- By agreeing to make every effort to implement an agreed upon program, you will receive the full benefit of your visits with Dr. Vreeland.
- You are responsible for seeking professional medical attention from Dr. Vreeland or another facility for a worsening of your condition.
- You are aware that many medical conditions require additional treatment and that follow-up visits are often necessary.
- You are aware that you may be referred to another physician for treatment when needed.

EVENING AND WEEKEND CALLS

- Dr Vreeland does not maintain regular call on the evenings and weekends.
- If you have a non-urgent question please call during clinic hours or feel free to email Dr Vreeland directly or call and leave a message at the office and she will respond to your question during the work week.

EMERGENCIES

- In the event of an emergency you are responsible to obtain medical attention, call 911 or go to the nearest emergency room.

PATIENT SIGNATURE _____ Date_____
(or Patient Representative)

Indicate relationship if signing for patient_____

After signing, you are entitled to a copy of this consent.
Please request this copy from the staff.

Consent for Naturopathic Treatment

Dr. Lauren Vreeland ND
1831 Orange Ave., #A
Costa Mesa, CA 92627
Tel: (949) 574-4978
Fax: (949) 574-9854

I, _____ (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not. I have also read and understand the attached NOTICE OF PRIVACY PRACTICES**,** which discusses my rights under the Health Insurance Portability and Accountability Act of 1996**.**

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act,[1] which may include but are not limited to nutritional counseling, western herbs, homeopathy, nutritional supplements, pharmaceuticals, oral chelation, hydrotherapy, intramuscular injections, and IV therapy.

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements because they may be toxic when taken in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat the medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, **if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1**.

I have read, or have had read to me, the above information and I consent. I have also had an opportunity to ask questions about the consents content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME, (printed) _____

PATIENT SIGNATURE _____ **Date:** _____
(or Patient Representative)
Indicate relationship if signing on behalf of patient _____

_____

After signing, you are entitled to a copy of this consent.
Please request this copy from the staff.

Doctor-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered at any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services. _____ Patient Initials

If any provision if this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____

Signature **Authorized Provider Representative**

_____ _____

Date **Date**

If this consent is signed by a personal representative on behalf of the patient complete the following:

Personal representative's name: _____

Relationship to patient: _____

After signing, you are entitled to a copy of this consent.
Please request this copy from the staff.

Consent for Use or Disclosure of Health Information (HIPPA form)

Our Privacy Pledge

Patient giving consent

Name: _____for_____

To the Patient- please read the following statement carefully
Purpose of Consent: By signing this form you will consent to the use and disclosure of your protected health information to carry out your treatment, payment, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent.
Our Notice provides a description of our treatment, payment, and healthcare operations, the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available upon request. We encourage you to read it carefully before signing this consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices at any time by contacting:

Lauren Vreeland, ND
1831 Orange Ave., #A
Costa Mesa, CA 92627
Tel: (949) 574-4978 Fax: (949) 574-9854

Right to Revoke: You have the right to revoke this consent at any time by giving written notice of your revocation submitted to the contact above. Please understand that revocation of this consent will not affect action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment and healthcare operations

_____ _____
Signature Authorized Personal Representative

_____ _____
Date Date

If this consent is signed by a personal representative on behalf of the patient complete the following:
Personal representative's name: _____
Relationship to patient: _____

After signing, you are entitled to a copy of this consent.
Please request this copy from the staff.

Consent Regarding E-mail Use or Disclosure of Health Information

Lauren Vreeland**,** ND provides patients with the opportunity to communicate by e-mail. Transmitting confidential health information by e-mail however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
    a. General e-mail risks are the following; e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress and e-mail; e-mail is easier to falsify than hand written or signed documents; backup copies may exist even after the sender or the recipient has deleted his/her copy.
    b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer reading their e-mail.
2. It is the policy of Lauren Vreeland, ND that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of that's patients protected personal health information and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. Lauren Vreeland, ND will use reasonable means to protect the security and confidentiality of e-mail communication. Because of the risks outlined above, we cannot, however guarantee the security and confidentiality of e-mail or internet communication.
3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
    a. All e-mails to or from patients concerning diagnosis and/or treatment will be made part of the protected personal health information. As a part of the protected personal health information, other individuals, such as Newport Integrative Health staff, insurance coordinators and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
    b. Lauren Vreeland, ND will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore e-mail must not be used in a medical emergency.
    c. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmittable or communicable diseases such as syphilis, gonorrhea and the like; behavioral health, mental health; or alcohol and drug abuse.
    d. Lauren Vreeland, ND cannot guarantee that electronic communications will be private. However, she will take reasonable steps to protect the confidentiality of the e-mail or internet communication but Lauren Vreeland, ND is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.
    e. If consent is given for the use of e-mail, it is the responsibility oft the patient's to inform Lauren Vreeland, ND of any types of information you do not want to be sent by e-mail
    f. Lauren Vreeland, ND is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to Lauren Vreeland, ND

I have read this form carefully and understand the risks and responsibility associated with the use of e-mail.

I agree to assume all risks associated with the use of e-mail

PATIENT SIGNATURE _____ Date_____

After signing, you are entitled to a copy of this consent.
Please request this copy from the staff.

Lauren Vreeland, N.D.

HEALTH HISTORY QUESTIONNAIRE

Successful health care and preventive medicine are made possible when Dr. Vreeland has a comprehensive understanding of her patients. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything you don't understand with a question mark. If a section or question does not apply to you or your child skip it and proceed to the next question.

Are you currently receiving healthcare? Y N

If yes, where and from whom?_____
If no, when and where did you last receive medical or health care?
_____

What was the reason? _____
What are your most important health problems? List as many as you can in order of importance.

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

Do you have any known contagious diseases at this time? Y N If yes, what?_____
Current Medications
Please list any **prescription** or **over-the-counter medications** you are taking, with dosages.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please list any **vitamins** or other **supplements** you are taking, with dosages.

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Allergies - Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental? _____

Lauren Vreeland, N.D.

Patient name (Last, First)

HOSPITALIZATION AND SURGERY

List hospitalizations or surgeries you have had:

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

X-RAYS AND SPECIAL STUDIES

X-rays, CT scans, or other studies you have had:

_____

_____

_____

FAMILY HISTORY

	FATHER	MOTHER	CHILD	SPOUSE	SISTERS	BROTHERS
Age (if living)						
Health (G=good P=poor)						
Age at death (if deceased)						
Check (√) those applicable						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hayfever/Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Cause of Death						

GENERAL

When during the day is your energy the best? _____ Worst? _____

Main interests and hobbies?_____

Do you exercise? ☐

If yes, what kind? _____ How often? _____

Average 6-8 hrs. sleep? ☐

Sleep well? ☐

Awaken rested? ☐

Spend time outside? ☐

Do you use tobacco? ☐

Smoked previously? ☐

How many years? _____ How many packs per day? _____

Lauren Vreeland, N.D.

Patient name (Last, First)

MENTAL/ EMOTIONAL

Treated for emotional problems?	☐	Depression?	☐
Mood Swings?	☐	Anxiety or nervousness?	☐
Memory problems?	☐	Poor concentration?	☐

ENDOCRINE

Hypothyroid?	☐	Heat or cold intolerance?	☐
Hyperthyroid?	☐	Diabetes?	☐
Excessive thirst?	☐	Excessive hunger?	☐
Fatigue?	☐	Hypoglycemia	☐

IMMUNE

Chronic Fatigue Syndrome?	☐	Chronic/recurrent infections?	☐
Chronically swollen glands?	☐	Slow wound healing?	☐

NEUROLOGIC

Seizures?	☐	Paralysis?	☐
Numbness or tingling?	☐	Vertigo or dizziness?	☐

SKIN

Rashes or Itching?	☐	Eczema, Hives?	☐
Acne, Boils?	☐	Lumps?	☐
Color Change?	☐	Perpetual Hair Loss?	☐

HEAD

Headaches?	☐	Head Injury?	☐
Migraines?	☐	Jaw/TMJ problems	☐

EYES

Spots in Eyes?	☐	Cataracts?	☐
Impaired vision?	☐	Glasses or contacts?	☐
Tearing or dryness?	☐	Glaucoma?	☐

EARS

Impaired hearing?	☐	Ringing?	☐
Earaches?	☐	Dizziness?	☐

NOSE AND SINUSES

Frequent colds?	☐	Nose Bleeds?	☐
Stuffiness?	☐	Hayfever?	☐
Sinus problems?	☐	Loss of smell?	☐

MOUTH AND THROAT

Frequent sore throat?	☐	Teeth grinding?	☐
Gum problems?	☐	Hoarseness?	☐

NECK

Lumps?	☐	Swollen glands?	☐
Goiter (enlarged thyroid)?	☐	Pain or stiffness?	☐

Lauren Vreeland, N.D.

Patient name (Last, First)

MUSCULOSKELETAL

Joint pain/stiffness/arthritis?	☐	Broken bones?	☐
Weakness?	☐	Muscle spasms or cramps?	☐

BLOOD / PERIPHERAL VASCULAR

Easy bleeding or bruising?	☐	Anemia?	☐
Deep leg pain?	☐	Cold hands/feet?	☐

RESPIRATORY

Cough?	☐	Spitting up blood?	☐
Asthma?	☐	Bronchitis?	☐
Pneumonia or Tuberculosis?	☐	Emphysema?	☐
Pain or Difficulty breathing?	☐	Shortness of breath?	☐

CARDIOVASCULAR

Heart disease?	☐	High/Low Blood Pressure?	☐
Murmurs?	☐	Palpitations/Fluttering?	☐
Blood clots?	☐	Fainting?	☐
Chest pain/angina?	☐	Swelling in ankles?	☐

GASTROINTESTINAL

Trouble swallowing?	☐	Heartburn?	☐
Change in appetite?	☐	Nausea/vomiting?	☐
Vomiting blood?	☐	Bowel Movements: How often? _____	
Blood in stool?	☐	Is this a change?_____	
Pain or cramps?	☐	Constipation?	☐
Belching or passing gas?	☐	Diarrhea?	☐
Gall Bladder disease?	☐	Ulcer?	☐
Jaundice (yellow skin) or liver disease?	☐	Hemorrhoids?	☐

URINARY

Pain on urination?	☐	Frequency at night?	☐
Incontinence?	☐	Frequent infections?	☐
Kidney stones?	☐		

Lauren Vreeland, N.D.

Patient name (Last, First)

FEMALE REPRODUCTION / BREASTS

Age of first menses? _____
First day of last menses? _____
# of days in between menses? _____ days
# of days your menses lasts? _____ days

Painful menses? ☐
Heavy or excessive flow? ☐
Are you sexually active? ☐
Pain during intercourse? ☐
PMS? ☐
If yes, what are your symptoms?
_____
_____

Endometriosis? ☐
Menopausal symptoms? ☐
Sexually transmitted infection? ☐
Herpes? ☐
Do you do breast self exams? ☐
Breast pain/tenderness? ☐

Are cycles regular? ☐
Bleeding between cycles? ☐

Clotting? ☐
Discharge? ☐
Sexual difficulties? ☐
Birth control? ☐
What type?_____
Difficulty conceiving? ☐
Number of pregnancies _____
Number of live births _____

Ovarian cysts? ☐
Abnormal PAP? ☐
Genital warts? ☐

Breast lumps? ☐
Nipple discharge? ☐

MALE REPRODUCTION

Hernias? ☐
Testicular pain? ☐
Discharge or sores? ☐
Are you sexually active? ☐
Impotence? ☐
Premature ejaculation? ☐

Testicular masses? ☐
Prostate disease? ☐
Sexually transmitted infections? ☐
Birth control? Type?_____
Genital warts? ☐
Herpes? ☐

DIETARY

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To drink: _____

Weight:_____ lbs. Weight 1 year ago:_____ lbs.

Maximum Weight: _____ When? _____Height: _____

Lauren Vreeland, N.D.

Patient name (Last, First)

CONTEXT OF CARE

What three expectations do you have from this visit?

What long-term expectations do you have from working with this clinic?

What expectations do you have of me personally as your naturopathic doctor?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do?

Please write any additional information (use back if necessary)