Welcome to Ancient Traditions Natural Medicine, LLC, the office of Dr. Angela P. Lambert. In order to provide you with the best possible care, I ask you to complete this entire form. Please provide me with all possible information regarding your health so that we may form a successful, long term working relationship.

Thank you and I look forward to working with you.
Dr. Angela Lambert

ADULT INTAKE FORM

Basic Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # (home): _____ (cell):_____ (work): _____

May we leave a message with phone numbers listed? Yes ☐ No ☐

Email address: _____ Skype name: _____

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

☐Married ☐Separated ☐Divorced ☐Single ☐Partnership ☐Widowed

Live with: ☐Spouse ☐Partner ☐Parents ☐Children ☐Friends ☐Alone

Occupation: _____ Hours per week: _____

Employer Name and Address: _____

Employer City: _____ State: _____

Have you ever seen a Naturopathic doctor or Licensed Acupuncturist before? Yes ☐ No ☐

Which one(s)? _____

How did you hear about Dr. Angela? ☐Another practitioner _____ ☐Friend/family member

☐Google search ☐Facebook ad ☐SWN ☐NHAND Website ☐Public health talk ☐Other_____

Has any other family member already been a patient at our clinic? _____

Emergency contact: _____ Relationship: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____

Context of Care Review

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

_____

What do you know about our approach?

_____

What *three* expectations do you have from *this* visit to our clinic?

_____

_____

What *long term* expectations do you have from working with our clinic?

_____

What expectations do you have of me personally as your health care provider?

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ 100%

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

_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

_____

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

_____

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

_____

What do you love to do?

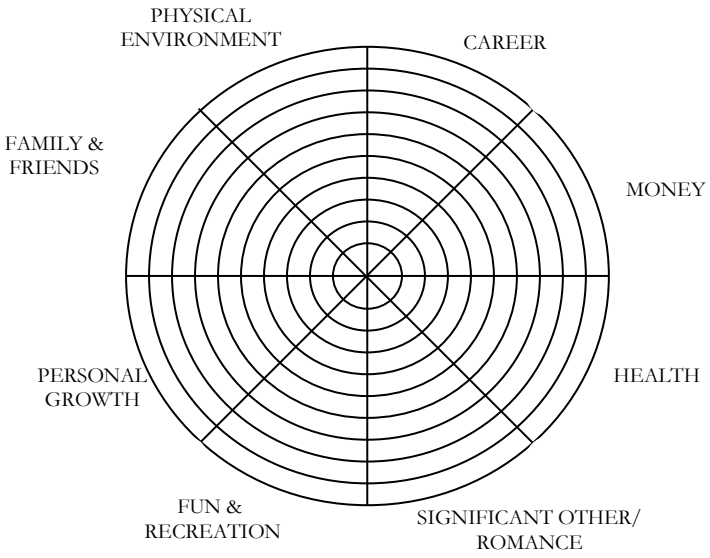
_____

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



Are you currently receiving healthcare? Yes☐ No☐

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) _____
7) _____

Do you have any known contagious diseases at this time? Yes☐ No☐

If yes, what?_____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please check and say who)

☐Cancer	☐Diabetes	☐Heart Disease	☐High Blood Pressure
☐Kidney disease	☐Epilepsy	☐Arthritis	☐Glaucoma
☐Tuberculosis	☐Stroke	☐Anemia	☐Mental Illness
☐Asthma	☐Hay fever	☐Hives	

Any other relevant family history?_____

What is your family heritage?_____

CHILDHOOD ILLNESSES

Birth city & state: _____ Birth time: _____ Birth weight: _____

Please check whether you had any of the following as a child:

☐Rheumatic fever	☐Diphtheria	☐Scarlet fever	☐Chicken pox
☐German Measles	☐Measles	☐Mumps	

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

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

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmentals or chemicals? _____

CURRENT MEDICATIONS

Do you take or use any of the following (please check):

☐ Laxatives	☐ Pain relievers	☐ Antacids	☐ Cortisone
☐ Antibiotics	☐ Tranquilizers	☐ Sleeping Pills	☐ Thyroid Medication
☐ Birth Control Pills	☐ Hormone Replacement		

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

GENERAL

Height: _____ Weight: _____ Weight one year ago: _____

Maximum Weight: _____ When:_____

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

Main interests and hobbies: _____

Exercise: ☐ Yes ☐ No If so, what kind and how often: _____

Watch TV: ☐ Yes ☐ No If so, how many hours? _____ Read: ☐ Yes ☐ No If so, how many hours? _____

Do you have a religious or spiritual practice ☐ Yes ☐ No If so, what kind? _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

DENTAL HEALTH

Do you have or have you had Cavities? ☐ Yes ☐ No

How many?

- Amalgam fillings? _____
- Composites? _____
- Gold? _____

Dental health habits:

- Brushing: how often? _____
- Flossing: how often? _____
- How often see dentist? _____

FOR THE FOLLOWING, PLEASE CHECK:

Y= yes/condition you have now **N**= no/never had P= problem in the past **S**= sometimes a problem now

GENERAL

Do you sleep well? Y☐N☐P☐S☐
Average 6-8 hours? Y☐N☐P☐S☐
Awake rested? Y☐N☐P☐S☐
Have a supportive relationship? Y☐N☐P☐S☐
Have a history of abuse? Y☐N☐P☐S☐
Experienced a major trauma? Y☐N☐P☐S☐
Use recreational drugs? Y☐N☐P☐S☐
Treated for drug dependence? Y☐N☐P☐S☐
Use alcoholic beverages? Y☐N☐P☐S☐
Use tobacco? Y☐N☐P☐S☐
If in the past, how many years? _____
How many packs per day? _____
Do you enjoy your work? Y☐N☐P☐S☐
Take vacations? Y☐N☐P☐S☐
Spend time outside? Y☐N☐P☐S☐
Eat three meals a day? Y☐N☐P☐S☐
Do you go on diets often? Y☐N☐P☐S☐
Do you eat out often? Y☐N☐P☐S☐
Do you drink coffee? Y☐N☐P☐S☐
Drink black/green tea? Y☐N☐P☐S☐
Drink soda? Y☐N☐P☐S☐
Do you eat refined sugar? Y☐N☐P☐S☐
Do you add salt to your food? Y☐N☐P☐S☐

NEUROLOGIC

Seizures? Y☐N☐P☐S☐
Muscle weakness? Y☐N☐P☐S☐
Loss of memory? Y☐N☐P☐S☐
Vertigo or dizziness? Y☐N☐P☐S☐
Paralysis? Y☐N☐P☐S☐
Numbness or tingling? Y☐N☐P☐S☐
Easily stressed? Y☐N☐P☐S☐
Loss of balance? Y☐N☐P☐S☐

ENDOCRINE

Hypothyroid? Y☐N☐P☐S☐
Hypoglycemia? Y☐N☐P☐S☐
Excessive thirst? Y☐N☐P☐S☐
Fatigue? Y☐N☐P☐S☐
Heat or cold intolerance? Y☐N☐P☐S☐
Hyperthyroid? Y☐N☐P☐S☐
Diabetes? Y☐N☐P☐S☐
Excessive hunger? Y☐N☐P☐S☐
Seasonal depression? Y☐N☐P☐S☐
Difficulty exercising? Y☐N☐P☐S☐

IMMUNE

Reactions to immunizations? Y☐N☐P☐S☐
Chronically swollen glands? Y☐N☐P☐S☐
Slow wound healing? Y☐N☐P☐S☐
Chronic fatigue syndrome? Y☐N☐P☐S☐
Chronic infections? Y☐N☐P☐S☐
Night sweats? Y☐N☐P☐S☐

EARS

Impaired hearing? Y☐N☐P☐S☐
Ringing in ears? Y☐N☐P☐S☐
Dizziness? Y☐N☐P☐S☐
Ear aches? Y☐N☐P☐S☐

EYES

Impaired vision? Y☐N☐P☐S☐
Cataracts? Y☐N☐P☐S☐
Glaucoma? Y☐N☐P☐S☐
Spots in vision? Y☐N☐P☐S☐
Color blindness? Y☐N☐P☐S☐
Tearing or dryness? Y☐N☐P☐S☐
Eye pain or strain? Y☐N☐P☐S☐

HEAD

Headaches? Y☐N☐P☐S☐
Migraines? Y☐N☐P☐S☐
Head injury? Y☐N☐P☐S☐
Jaw or TMJ problems? Y☐N☐P☐S☐

NOSE AND SINUS

Frequent colds? Y☐N☐P☐S☐
Stuffiness? Y☐N☐P☐S☐
Sinus problems? Y☐N☐P☐S☐
Nose bleeds? Y☐N☐P☐S☐
Hay fever? Y☐N☐P☐S☐
Loss of smell? Y☐N☐P☐S☐

NECK

Lumps in neck? Y☐N☐P☐S☐
Goiter? Y☐N☐P☐S☐
Difficulty swallowing? Y☐N☐P☐S☐
Pain or stiffness in neck? Y☐N☐P☐S☐

MOUTH AND THROAT

Frequent sore throat? Y☐N☐P☐S☐
Copious saliva? Y☐N☐P☐S☐
Sore tongue or lips? Y☐N☐P☐S☐
Hoarseness? Y☐N☐P☐S☐
Jaw clicks? Y☐N☐P☐S☐
Teeth grinding? Y☐N☐P☐S☐
Gum problems? Y☐N☐P☐S☐
Dental cavities? Y☐N☐P☐S☐

SKIN

Rashes? Y☐N☐P☐S☐
Acne/boils? Y☐N☐P☐S☐
Change in skin color? Y☐N☐P☐S☐
Lumps or bumps on skin? Y☐N☐P☐S☐
Eczema or hives? Y☐N☐P☐S☐
Itching? Y☐N☐P☐S☐
Perpetual hair loss? Y☐N☐P☐S☐

RESPIRATORY

Cough? Y☐N☐P☐S☐
Sputum? Y☐N☐P☐S☐
Asthma? Y☐N☐P☐S☐
Wheezing? Y☐N☐P☐S☐
Bronchitis? Coughing Y☐N☐P☐S☐
up blood? Y☐N☐P☐S☐
Shortness of breath? Y☐N☐P☐S☐
Shortness of breath when lying down? Y☐N☐P☐S☐
Pain with breathing? Y☐N☐P☐S☐
Emphysema? Y☐N☐P☐S☐
Tuberculosis? Y☐N☐P☐S☐

GASTROINTESTINAL

Trouble swallowing? Y☐N☐P☐S☐
Change in thirst? Y☐N☐P☐S☐
Change in appetite? Y☐N☐P☐S☐
Nausea/vomiting? Y☐N☐P☐S☐
Ulcer? Y☐N☐P☐S☐
Jaundice (yellow skin color)? Y☐N☐P☐S☐
Gall bladder disease? Y☐N☐P☐S☐
Liver disease? Y☐N☐P☐S☐
Hemorrhoids? Pancreatitis? Y☐N☐P☐S☐
Heartburn? Y☐N☐P☐S☐
Abdominal pain or cramps? Y☐N☐P☐S☐
Belching or passing gas? Y☐N☐P☐S☐
Constipation? Y☐N☐P☐S☐
Y☐N☐P☐S☐

Bowel movements: how often? _____
Is this a change?_____
Black stools? Y☐N☐P☐S☐
Blood in stools? Y☐N☐P☐S☐

MENTAL/EMOTIONAL

Treated for emotional problem? Y☐N☐P☐S☐
Depression? Y☐N☐P☐S☐
Anxiety or nervousness? Y☐N☐P☐S☐
Poor concentration? Y☐N☐P☐S☐
Do you have mood swings? Y☐N☐P☐S☐
Considered suicide? Y☐N☐P☐S☐
Attempted suicide? Y☐N☐P☐S☐
Tension? Y☐N☐P☐S☐
Memory problems? Y☐N☐P☐S☐

URINARY

Increased frequency of urination? Y☐N☐P☐S☐
Inability to hold urine? Y☐N☐P☐S☐
Pain in urination? Y☐N☐P☐S☐
Frequency at night? Y☐N☐P☐S☐
Frequent UTI's? Y☐N☐P☐S☐
Kidney stones? Y☐N☐P☐S☐

MUSCULOSKELETAL

Joint pain or stiffness? Y☐N☐P☐S☐
Arthritis? Y☐N☐P☐S☐
Broken bones? Y☐N☐P☐S☐
Weakness? Y☐N☐P☐S☐
Muscle spasms or cramps? Y☐N☐P☐S☐
Sciatica? Y☐N☐P☐S☐

BLOOD

Anemia? Y☐N☐P☐S☐
Easy bleeding or bruising? Y☐N☐P☐S☐
Cold hands/feet? Y☐N☐P☐S☐
Deep leg pain? Y☐N☐P☐S☐
Thrombophlebitis? Y☐N☐P☐S☐
Varicose veins? Y☐N☐P☐S☐

FEMALE REPRODUCTIVE

Age of first menses:_____
Age of last menses (if menopausal):_____
Length of cycle:_____days
Duration of menses:_____days
Are your cycles regular? Y☐N☐P☐S☐
Painful menses? Heavy or Y☐N☐P☐S☐
excessive flow? PMS? Y☐N☐P☐S☐
Y☐N☐P☐S☐

Symptoms:_____
_____
Bleeding between cycles? Y☐N☐P☐S☐
Clotting? Y☐N☐P☐S☐
Endometriosis? Y☐N☐P☐S☐
Ovarian cysts? Y☐N☐P☐S☐
Vaginal odor? Y☐N☐P☐S☐
Vaginal discharge? Y☐N☐P☐S☐
Date of last pap smear: _____
Abnormal PAP? Y☐N☐P☐S☐
Cervical dysplasia? Y☐N☐P☐S☐
Are you sexually active? Y☐N☐P☐S☐
Sexual orientation: _____
Birth control? Type: _____
Pain during intercourse? Y☐N☐P☐S☐
Gonorrhea? Y☐N☐P☐S☐
Herpes? Y☐N☐P☐S☐
Chlamydia? Y☐N☐P☐S☐
Genital warts? Y☐N☐P☐S☐
Syphilis? Y☐N☐P☐S☐
Difficulty conceiving? Y☐N☐P☐S☐
Number of pregnancies:_____
Number of live births:_____
Number of miscarriages:_____
Number of abortions:_____
Do you do self breast exams? Y☐N☐P☐S☐
Breast pain/tenderness? Y☐N☐P☐S☐
Breast lumps? Y☐N☐P☐S☐
Nipple discharge? Y☐N☐P☐S☐
Menopausal symptoms? Y☐N☐P☐S☐

MALE REPRODUCTIVE

Are you sexually active? Y☐N☐P☐S☐
Sexual orientation: _____
Birth control? Type: _____
Discharge or sores? Y☐N☐P☐S☐
Chlamydia? Y☐N☐P☐S☐
Gonorrhea? Y☐N☐P☐S☐
Genital warts? Y☐N☐P☐S☐
Herpes? Y☐N☐P☐S☐
Syphilis? Y☐N☐P☐S☐
Hernias? Y☐N☐P☐S☐
Testicular masses? Y☐N☐P☐S☐
Testicular pain? Y☐N☐P☐S☐
Prostate disease? Y☐N☐P☐S☐
Impotence? Y☐N☐P☐S☐
Premature ejaculation? Y☐N☐P☐S☐

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us if there are any ways you **do not** want us to attempt to reach you. Please check all that apply:

☐ Please do not phone me at home. Use this alternate phone number: _____

☐ Please do not phone me at work. Use this alternate phone number: _____

☐ Please do not leave messages on my answering machine.

☐ Please do not contact me by email.

☐ Please send mail, including my bills, to this alternate address:

Address: _____

City: _____ State: _____ Zip: _____

Other request (please describe):

_____

_____

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____ /_____ /_____

Patient Signature (Parent/guardian signature if minor) Date

FEE SCHEDULE

Dear New Patient,

Welcome to Ancient Traditions Natural Medicine, LLC. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read and initial the following statements:

New Patient Office Visit, Acupuncture or Naturopathic (60 - 75 minutes) $525.00
Routine Return Visit (45-60 minutes) $205.00
Routine Return Visit (30+ minutes) $155.00
Routine Return Patient (15 Minutes) $110.00
Return Acupuncture Visit (60-90 minutes) $155.00
Well Woman Exam including Pap smear (lab fees not included) $195.00
Physical Exam including prostate exam (male) $195.00
New Patient Acute Visit (15 minutes) $110.00
New Patient Acute Visit (30 minutes) $175.00

Phone consultation AND email fees same as Return Visit Fees.
These prices include discounts for fees paid in full on the Day of Service.
If your account is not paid in full on the Day of Service, additional charges may be added.
Email fees: 1-2 question emails about CURRENT TREATMENT PLANS: no charge.
Email questions requiring discussion, a FOLLOW-UP visit is required.

_____ Payment for all services and medicinary items is due at the time of the visit. We accept cash, checks, Visa, MasterCard, Amex. Returned checks will be subject to a $35.00 NSF fee.

_____ Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention from your physician will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Your physician will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment.

_____ You will be charged a CANCELLATION FEE of $75.00 for any missed appointments or late cancellations (less than 48 hours' notice).

_____ I understand that I am expected to have a local primary care physician if I am conducting my appointments with Dr. Lambert by phone, Skype, or any other electronic means.

I have read and understand the above-stated payment policies of Ancient Traditions Natural Medicine, LLC and will comply with them in all respects.

_____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____
Patient Signature (Parent/guardian signature if minor) Date

Informed Consent and Request for Naturopathic Medical Care, Classical Chinese Medicine Treatment and Acupuncture

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Angela P. Lambert, ND, L.Ac, MSOM, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I,_____ , hereby request and consent to examination and treatment with Naturopathic Medicine, Classical Chinese Medicine (CCM) by Dr. Angela P. Lambert, ND, L.Ac, MSOM, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists or licensed massage therapists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Angela P. Lambert, ND, L.Ac, MSOM, and/ or with the allied health care provider providing backup:

1.) my suspected diagnosis(es) or condition(s)
2.) the nature, purpose, goals and potential benefits of the proposed care
3.) the inherent risks, complications, potential hazards or side effects of treatment or procedure
4.) the probability or likelihood of success
5.) reasonable available alternatives to the proposed treatment procedure
6.) potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, pregnancy massage (to relieve muscular discomfort associated with pregnancy), muscle energy technique and cranio-sacral therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Trigger point injection therapy with vitamin substances
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians)

The scope of practice of acupuncture is outlined below. I understand that Classical Chinese medicine and Acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Use of electrical, mechanical and magnetic devices
- Moxa (indirect or direct burning of herbal material in the form of a loosely compacted herb or stick
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Gua sha (rubbing on an area of the body with a blunt or round instrument)
- Dietary advice (based on traditional Chinese medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials)

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies; allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor- stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider, Dr. Angela P. Lambert, ND, L.Ac, MSOM, LMT, of these conditions. Please Initial:

- ☐ I understand that Dr. Angela P. Lambert, ND, L.Ac, MSOM is not licensed to prescribe any controlled substances.
- ☐ I understand that Dr. Angela P. Lambert, ND, L.Ac, MSOM will only prescribe medications if she believes that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescriptive medication needs.
- ☐ I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.
- ☐ I understand that Dr. Angela P. Lambert, ND, L.Ac, MSOM is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Dr. Angela P. Lambert, ND, L.Ac, MSOM and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Lambert explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

_____ _____

Printed Name of Patient Signature of Patient

_____ _____

Printed Name of Guardian Signature of Guardian

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Date Signed