Name:

Date of Birth:

Today I am here for:

If you can't remember what you are scheduled for, we are happy to let you know

Please circle "yes" only to the services for which you are scheduled. Circle "**no**" to services for which you are not scheduled and ***do not wish to receive***. Circle "If Possible" for which you are not scheduled yet wish to receive. If you mark anything other than what you are scheduled, please explain below.

Naturopathy	Yes	No	If Possible
Acupuncture	Yes	No	If Possible
Massage/Manual Therapy	Yes	No	If Possible
Nutritional Counseling	Yes	No	If Possible
Medical/Emotional Counseling	Yes	No	If Possible
Spiritual Counseling	Yes	No	If Possible

Please explain any new or continuing issues/ concerns you would like to discuss with the doctor. Include any changes in your medications or supplements as well as a brief explanation for any service requests that were not scheduled for today.

_____

_____

_____

_____

_____

Signature:_____ Date:_____

By signing this form, you agree to the ***services and the fee associated with those services*. Whereas most services are billable to insurance, some are not. It is up to your insurance company to determine which of these services are covered and any remaining balance due is the patient's responsibility.**