PINNACLE OF HEALTH
NATUROPATHIC WELLNESS CENTRE
DR. FARYAL LUHAR, ND / Doctor of Naturopathic Medicine

PATIENT INTAKE AND INFORMED CONSENT FORM - WEIGHT LOSS PROTOCOL

NAME:_____

ADDRESS: _____ PHONE NO.: _____ (H)
_____ _____ (C)
_____ _____ (W)

DATE OF BIRTH: _____ EMAIL: _____

FAMILY PHYSICIAN & PHONE NO.:_____

OCCUPATION: _____

Please answer the following questions to the best of your ability in order to aid in the assessment of your current health status and to facilitate the healing process.

Current Weight: _____ Ideal Weight: _____

What is your most comfortable healthy weight that you have been for most of your adult life?
_____

Have you tried any other weight loss pills or programs? If so, please describe below how effective the program was.
_____
_____

What other chief health concerns would you like to address?

- _____
- _____
- _____

List your current medications – pharmaceutical and natural. Please indicate the dosage, strength and how long you have been taking them.

Prescription/Over-the-counter Medications	Supplements/Vitamins/Herbs/Homeopathics

List all major surgeries and dates:
_____
_____

List any allergies (food, medication)
_____
_____

How many courses of antibiotics have you been on in the past 5 years? _____

Describe your intake of food/beverage on a typical day:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Water/day: _____
Coffee/Tea: _____

Do you drink alcohol? _____ Do you smoke? _____

How many hours do you sleep at night? _____ How many hours do you work each day? ___

How often do you exercise/week? What type of exercise?
_____ _____
_____ _____

When was your last physical exam including blood analysis? _____

How many amalgams or silver fillings do you have on your teeth? _____

Besides cleaning supplies, are you exposed to environmental toxins at work? Please describe:_____

What level of personal stress are you experiencing at the present moment?
minimal average considerable unbearable

What are the main stressors in your life? Please describe briefly how this stressor is affecting you.
○Financial ○Job Related ○ Marriage ○ Health ○ Spiritual ○Family
- Other: _____

INFORMED CONSENT

I, _____ give my full consent to Faryal Luhar, Doctor of Naturopathic Medicine to assess my health and utilize naturopathic modalities for treatment as deemed appropriate in order to provide me with the best naturopathic health care. Laboratory exams and other blood work may be ordered and shared with health professionals as necessary for treatment.

I understand that any information provided will be kept confidential and will not be divulged without my authorization.

I also understand that the weight loss protocol has been devised to address my unique health factors, utilizing natural medicines and treatments and is not a quick fix remedy to loose weight.

I agree to render payment at the time of treatment unless other arrangements have been discussed.

Signature of patient: _____ Date: _____