



PATIENT INFORMATION

Today's Date: _____

Name: _____

Age: _____ Birthdate: _____ Gender: _____

Address: _____

City: _____ Zip: _____

Phone: _____

Email: _____

Occupation: _____

Are you: Single Married Separated/Divorced

Live with: Alone Spouse/Partner Parents

Children Friends Siblings

Emergency Contact? _____

Relationship: _____

Phone: _____

How did hear about Dreaming Tree Medicine?
Anyone I can thank for referring you?

CURRENT HEALTH CONDITIONS

What health concerns brought you here today? Please list in order of importance:

1 _____

2 _____

3 _____

Has anything recently changed or worsened?

What do you believe is your body's weakest organ/body area (heart, lungs, skin, bones, etc)?

On a scale 0-10 (10 being the highest) rate your satisfaction in the following areas of your life: (be honest! No one else will see your answers)

Health ____ Exercise ____ Nutrition ____

Water ____ Energy ____ Sleep ____

Career ____ Quiet Time ____ Hobbies ____

Mental/Emotional ____ Marriage/Relationship ____

Upbringing ____ Spirituality ____ Overall Attitude ____

PERSONAL HEALTH HISTORY

Height _____ Weight _____ Max. weight _____ Min. weight _____

Habits: Coffee/Tea ____ Cola ____ Cigarettes/Tobacco ____ Alcohol/Drugs ____

Salt ____ Spicy ____ Sugar/Carbs ____ Dairy/Milk/Cheese ____

Exercise ____ Screen Time (TV, movies, iPhone) ____ Others ____

Are there any foods that you avoid? _____ Foods you crave? _____

Typical meals? B _____ L _____ D _____

How would you describe the environment/emotional climate of your home during meals?

MEDICAL HISTORY – Please circle any conditions that pertains to you currently or in the past.

- | | | |
|-------------------------|-----------------------------|------------------------------|
| • Alcohol/Drug Abuse | • Edema | • Infertility |
| • Allergies | • Epilepsy/Seizures | • Jaundice |
| • Anemia | • Exposure Toxic Substances | • Joint Pain/Inflam |
| • Anxiety | • Eyes | • Kidney |
| • Arthritis | • Fatigue, Chronic | • Mononucleosis |
| • Asthma/Lung | • Female/Gyn Problems | • Muscle Spasms |
| • Bleeding/Bruising | • Fever (chronic) | • Parasites |
| • Blood Pressure/Stroke | • Gall Bladder/Liver | • Prostate |
| • Cancer | • Gums/Teeth/Mouth | • PTSD |
| • Frequent colds/flu | • Hay Fever | • Sexually Transmitted Infxn |
| • Depression | • Headaches/Migraines | • Skin/Derm |
| • Diabetes | • Head Injury | • Thyroid |
| • Digestive/IBS/Colitis | • Heart Pain/Disease | • Ulcers |
| • Ear | • Hepatitis | • Urinary (UTI) |
| • Eating Disorders | • Hypoglycemia | • Other _____ |

Medications?

Vitamins/Supplements/Herbs?

Allergies?

Significant Traumas/Surgeries/Auto Accidents/etc? _____

WOMEN

Are you currently pregnant? _____ Last Menstrual Period? _____ Age menses began? _____

Menstrual history/PMS? _____

Types of birth control used: _____ Number pregnancies? _____ Births? _____

Last PAP Exam? _____ Results? _____ Blood work/Labs? _____

MEN

Last Physical Exam? _____ Blood work/Labs _____ Pertinent Findings? _____

Any health concerns, symptomology or general questions regarding any of the following?

- | | | |
|-----------------|---------------------------------|--------------------------------|
| Pain in the: | Infertility | Ejaculation Issues |
| -Penis | Fatigue | Urination Issues |
| -Testicles | Erectile Dysfunction/Low Libido | Stress/Mood Swings/Anger |
| -Scrotum | Tantric Practices | Sex/Porn addiction |
| Prostate Health | Weight/Fitness Issues | Sexually Transmitted Infection |



INFORMED CONSENT

Even the gentlest therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important, therefore, that you inform Dr. Hubbs immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your doctor immediately.

Health risks associated with Naturopathic/Chinese Medicine include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process.
- Allergic reactions to supplements or herbs.
- Pain, bruising or injury from acupuncture.
- Fainting or puncturing of an organ with acupuncture needles.

_____ Initials

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law.

_____ Initials

I understand that the Dr. Hubbs will answer any questions that I have to the best of his ability. I understand that the results are not guaranteed. I do not expect Dr. Hubbs to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures determined necessary by Dr. Hubbs.

_____ Initials

I understand that lab fees and supplements are to be paid for at the time of the service.

_____ Initials

I understand that I will be charged a \$50 late fee for any missed appointments or cancellations with less than 24 hours notice.

As the patient, you are responsible for the total charges incurred for each visit. I accept cash and all major credit cards. If you have coverage for Naturopathic/Chinese Medicine, you are responsible for any amount not covered by your insurance company.

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print): _____

Signature of Patient or Parent/Guardian: _____ Date: _____



DREAMING TREE medicine

Welcome to Dreaming Tree Medicine! Congratulations for putting yourself first and investing in your health and wellness. By making the choice to utilize Naturopathic and Chinese Medicine, you have taken a major step on the path toward improving your health now and for years to come. I am honored and excited to be your doctor and I'm certain you will find your experience working with me a positive and rewarding one, as I help you find or reset a direction towards optimal, holistic health.

Thank you for taking the time to fill out the important questionnaire contained within this packet. The responses you provide will greatly assist me to understand you, your goals and ideas for your health so that I can formulate an individualized health care plan tailored to your needs. Rest assured that all the information you share on these forms and in our interactions will be held with the utmost confidentiality. As your doctor, I am the only person who reviews these forms and I hold the doctor-patient relationship sacred and confidential. I work really hard to create a space that is comfortable, safe and secure, so that you may be yourself and as honest as possible. Please remember to bring the "intake form" and the signed "informed consent form" when you come for your initial visit.

Typically, your first visit is one and a half hours long and will include a thorough discussion of your health history, pertinent physical examinations, tongue and pulse diagnosis, and an acupuncture treatment. Once your condition is further assessed a treatment plan will be designed specifically for you and will be discussed in detail at your second/follow-up visit. It is also important that if you have had any laboratory testing done within the past year to bring a copy of these results with you on your first visit. If you have any difficulty gaining access to these documents I can provide a "Release of Records" form to assist you. Please remember to give 24 hours notice for any cancellations or rescheduling of appointments to avoid a late cancellation fee.

At present, naturopathic and Chinese medicine/Acupuncture is covered by many insurance companies and your eligibility will need to be determined prior to first visit. Any services and labs not covered, along with supplement items are due at time of service.

Dr. Aaron Hubbs ~ Dreaming Tree Medicine

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*Thank you for taking the time to fill out these forms.
I look forward to working with you on your journey to living your dreams!*