Dr. Kristina Taylor Lewis, ND
Dr. Eric Lewis, ND

16 Sterling Street
Asheville, NC 28803
828-298-4800
LewisNaturalHealth.com

Dear Patient,

We want to thank you for choosing us as your naturopathic healthcare provider. In order to give you the best possible care, please review the following information before your first appointment.

Your First Appointment(s) with Eric Lewis, ND

- **Patient name:** _____
- **Part I appointment:** _____
- **Part II appointment:** _____

Please fill out the following form and provide it to our office at least 2 days *BEFORE* your first appointment. You may fax (866-400-9118), mail, or personally deliver this form to our office.

- A completed New Patient Information Form

Please bring to your first appointment:

- Any forms not yet completed
- A completed 5-Day Diet Diary
- All current medications, supplements, and/or vitamins (in their original bottles, if possible)
- Copies of any previous medical records (including lab work). To request records from another physician, please use the "Records Release" form included in this packet. If you do not have records to share, you can leave this form blank.

To change your appointment, please contact us **48-hours in advance**, and we will be happy to reschedule you to a more convenient time. In order to reserve your first appointment, we require a **$100 deposit**. This deposit is refundable minus a $15 processing fee with a 48-hour cancellation notice. ***Missed appointments with no notice given in person or by phone are subject to a charge for the full amount of the scheduled visit.*** Please review our office policies and the end of this packet for more details.

If you have any questions before your appointment, please do not hesitate to call us at **828-298-4800**. Thank you!

We are looking forward to providing you with excellence in naturopathic healthcare!

LEWIS FAMILY
NATURAL HEALTH

Confidential New Patient Information

PLEASE PRINT **Today's Date** _____

Patient's Name: _____

Gender: _____ **Birthdate**: ___/___/___ **Age**: _____

Mailing Address:_____
Street City State Zip

Primary Phone: _____ **Alternate Phone**: _____

Email address: _____ **Alternate Email**: _____

Relationship Status: Single Married Partnership Separated Divorced Widow(er)

Spouse/Partner's Name _____

Children (Names/Ages)_____

Parent/Guardian Name (if patient under 18): _____

Occupation _____ **Employer:** _____

Hobbies/Interests: _____

Emergency Contact: Name _____ Relationship _____ Phone _____

Primary Care Physician: Name: _____ Office: _____

How did you hear about us?

☐ Referral from an existing patient: (who?) _____

☐ Referral from another health care provider: (who?) _____

(If you were referred, may we have your permission to thank the individual?)
Yes, please! *Yes, but please keep my name anonymous* *No*

☐ Internet search ☐ Other (please specify): _____

What made you decide to make an appointment with Lewis Family Natural Health?

_____

_____

_____

_____

List, in order of importance, your major health concerns/what you wish us to address today:

1. _____
2. _____
3. _____
4. _____
5. _____

What treatments have you already tried?

☐ Conventional Medicines ☐ Surgery ☐ Diet/Nutrition ☐ Chiropractic ☐ Massage

☐ Herbal Medicines ☐ Homeopathy ☐ Acupuncture ☐ Vitamins ☐ Fasting/Detoxification

☐ Other: _____

Current Medications: (include all prescription and over-the-counter medications; don't forget birth control, hormones, etc.)

Medication	*Dose/Frequency*	*For how long?*	*For what reason?*

Current Supplements: (include all vitamins, herbs, homeopathy, or other supplements)

Supplement	*Brand*	*Dose/Frequency*	*For how long?*	*For what reason?*

Please list your current health care professionals:

Doctor/Practitioner	*Specialty*	*Office Name*	*Office Phone Number*

Please write down a general timeline of your health history. Starting from childhood, include all major illnesses, injuries, operations, hospitalizations, and other medical diagnoses.

Illness/Operation/Hospitalization/Injury/Diagnoses:	*Year*	*Details/Notes*

Have you had any recent lab tests or blood work? What kind, when, and what were the results?

_____

Family History: Has anyone in your immediate family (parents, siblings, children) ever had heart disease, cancer, autoimmune disease, thyroid problems, or any other notable medical conditions? If so, please describe.

_____

_____

Please list any known allergies (Medications, Foods, Environmental, Chemical):

_____

Review of Systems: Please indicate if you have had problems with any of the following:
Circle P for Past or C for Current

HEAD:		
Headache	P	C
Migraine	P	C
Head injury	P	C
Dizziness/Vertigo	P	C
EYES/EARS/NOSE/THROAT:		
Seasonal allergies	P	C
Blurry vision	P	C
Double vision	P	C
Cataracts	P	C
Glaucoma	P	C
Other eye disorder	P	C
Ear aches/infections	P	C
Hearing disorder	P	C
Tinnitus (ringing in ears)	P	C
Sinus pain/infection	P	C
Nasal congestion	P	C
Nose bleeds	P	C
Frequent colds	P	C
Sore throat	P	C
Voice hoarseness	P	C
RESPIRATORY:		
Asthma	P	C
Bronchitis	P	C
Coughing	P	C
Shortness of breath	P	C
Wheezing	P	C
CARDIOVASCULAR:		
Heart disease	P	C
High blood pressure	P	C
Low blood pressure	P	C
Chest pain	P	C
Palpitations	P	C
Murmurs	P	C
Edema (swelling)	P	C
Rheumatic fever	P	C
Stroke	P	C
Vascular disease	P	C
URINARY TRACT:		
Frequent urinary infections	P	C
Pain with urination	P	C
Discharge/blood in urine	P	C
Frequent urination/urgency	P	C
Kidney stones	P	C
Urinary incontinence	P	C
GASTROINTESTINAL:		
Heartburn/Acid reflux/GERD	P	C
Ulcer	P	C
Bloating	P	C
Excessive flatulence	P	C
Nausea/Vomiting	P	C
Constipation	P	C
Diarrhea	P	C

IBS	P	C
Crohn's/Ulcerative Colitis	P	C
Hemorrhoids	P	C
Gall stones	P	C
Gall bladder disease	P	C
Hepatitis	P	C
Cirrhosis	P	C
Pancreatitis	P	C
SKIN:		
Dry skin	P	C
Acne	P	C
Rash	P	C
Hives	P	C
Eczema	P	C
Psoriasis	P	C
Moles	P	C
Recent skin changes	P	C
Skin cancer	P	C
MUSCULOSKELETAL:		
Arthritis	P	C
Joint pains	P	C
Joint stiffness	P	C
Gout	P	C
Muscle aches/pains	P	C
Back pain	P	C
Neck pain	P	C
Weakness	P	C
Tremors	P	C
NERVOUS SYSTEM:		
Tingling/numbness	P	C
Paralysis	P	C
Seizures	P	C
Sciatica	P	C
Carpel tunnel syndrome	P	C
Insomnia	P	C
ENDOCRINE:		
Diabetes (Type I or II)	P	C
Thyroid disease	P	C
Hormonal problems	P	C
MENTAL/EMOTIONAL:		
Anxiety	P	C
Depression	P	C
Bipolar disorder	P	C
Suicidal	P	C
Anger	P	C
Fearful	P	C
Panic attacks	P	C
Mood swings	P	C
Poor memory	P	C

MEN ONLY:

Have you experienced any of the following? Circle P for Past or C for Current.

Frequent urination (Day/Night)	P	C
Incomplete urination	P	C
Trouble starting urination	P	C
Discharge from urethra	P	C

Testicular pain/swelling	P	C
Hernia	P	C
Change in sex drive	P	C
Erectile difficulty	P	C
Rectal burning/itching	P	C
BPH	P	C

Prostate Cancer	P	C
Testicular Cancer	P	C
Infertility	P	C
Sexually Transmitted Disease	P	C

Do you have a history of sexual/mental/emotional/physical abuse? What age? _____

When was your last:

Rectal/Prostate Exam: _____ PSA blood test: _____ Stool check for blood: _____

Any irregular results from any of these tests?: _____

WOMEN ONLY: Gynecological and Obstetrical History

Circle which best describes your current menstrual status?

- Premenopause (before menopause; having periods)
- Amenorrhea (before menopause, but not having periods)
- Perimenopause/transition towards menopause (I have seen changes in my period and think menopause is coming soon, but I have not gone 12 months in a row without a period)
- Postmenopause (I have not had a period in 12 months)

Age of first menstrual period: _____ Date of last menstrual period: _____

Are your periods (or were your periods) usually: ☐ Regular ☐ Irregular

How many days between periods?: _____ How many days does your period last?: _____

Are your periods painful? _____ Do you have spotting or bleeding between periods? _____

Have you experienced any recent changes in your menstrual cycle?

_____

Have your periods stopped? _____ Age at onset of Menopause: _____

Was your menopause: *Spontaneous/Natural* *Surgical/After a hysterectomy*

Do you use or have you used Hormone Replacement Therapy? Please describe your experience:

_____

Do you have a uterus? Y N Do you have your ovaries? Y N

Have you experienced any of the following? Circle P for Past or C for Current.

Menstrual Irregularities	P	C
Prolonged bleeding	P	C
Painful periods	P	C
Heavy flow	P	C
Light flow	P	C
Change in menses (duration, regularity, flow, pain)	P	C
Pelvic pain	P	C
Discharge	P	C
Yeast infections	P	C
Hot flashes	P	C
Hormone use	P	C
Breast pain (with cycle/constantly)	P	C
Fibrocystic breasts	P	C

Difficulty conceiving/carrying pregnancy to term	P	C
Hair growth on face	P	C
Pain with intercourse	P	C
Change in sex drive	P	C
Endometriosis	P	C
Uterine fibroids	P	C
Ovarian cysts	P	C
Female Cancer	P	C
Pelvic inflammatory disease	P	C
Sexually transmitted disease	P	C
Osteoporosis	P	C
Osteopenia	P	C

Obstetrical History

Please indicate the method of birth control you are currently using or have used previously. Circle P for Past or C for Current.

Birth control pill, patch, or ring	P	C
Injectable or implanted hormone	P	C
Condoms	P	C
Diaphragm, cervical cap, foam/gel	P	C
Sterilization ("Tubes tied")	P	C
Male partner had vasectomy	P	C

IUD	P	C
Natural family planning/rhythm method	P	C
Other	P	C

How many children do you have? _____ How many times have you been pregnant? _____

# of Births: _____ # of Miscarriages: ____ # of Abortions: _____ # of Adoptions: _____

Have you had difficulty conceiving or carrying a pregnancy to term? _____

Any complications during pregnancy, delivery, or postpartum? _____

Sexual History

Are you currently sexually active? *Yes* *No*

Are you sexually active with: ☐ *A man (or men)* ☐ *A woman (or women)* ☐ *Both men & women*

Are you currently in a mutually monogamous relationship? _____

Do you have concerns about your sex life? _____

Do you have a loss of interest in sexual activities (libido, desire)? _____

Do you have any concerns with the physical sensations of sex (vaginal dryness, pain, orgasm, etc.)?

_____

If you have pain, please describe the pain: ☐ *Pain with penetration* ☐ *Pain inside* ☐ *Feels dry*

Do you have a history of (please circle) sexual, mental, emotional, and/or physical abuse? At what age(s)? _____

Health Habits:

Do you regularly use any of the following?:

☐ Antacids ☐Pain medicines (Prescription or Over-the-counter, i.e. Advil, Tylenol)

☐ Steroids (Prednisone, Cortisone, etc.) ☐Laxatives ☐ Antibiotics

☐ Tobacco: Current? _____ Past? _____ Amount per day: _____ Since when?:_____

Does anyone smoke in your household?_____

☐ Alcohol: Number of drinks per day: _____ ☐ Recreational Drugs _____

Have you ever had addiction for alcohol or drugs? _____ Did you receive treatment? _____

What special diet do you follow, if any? (Vegetarian, Vegan, Paleo, Gluten Free, etc.)_____

Eating Habits:

☐Skip breakfast
☐3 meals a day
☐2 meals a day

☐Graze (small, frequent meals)
☐Food rotation
☐Eat constantly whether hungry or not

☐Generally eat on the run
☐Crave sweets
☐Crave salt

What do you drink during the day and how much? (Coffee, tea, soda, water, juice, etc.)

_____

Exercise:

Do you exercise? _____ What type of exercise do you do? _____

How often do you exercise? _____ For how long do you exercise? _____

Weight:

Your weight today: _____ Your height: _____ Your ideal weight: _____

Do you consider yourself: ☐ Overweight ☐ Underweight ☐ Just right

Sleep:

How long do you sleep each night? _____ Do you have difficulty falling asleep? _____

Do you wake during the night? If so, why? _____ Do you wake feeling refreshed?_____

General Energy level (1=low, 10=high): 1 2 3 4 5 6 7 8 9 10

Do you experience fatigue? If so, when?: ☐ Morning ☐ Afternoon ☐ Evening

Stress:

Stress level (1=low, 10=high): 1 2 3 4 5 6 7 8 9 10

What are your major sources of stress? _____

Do you enjoy your work? _____ How many hours a week? _____

Is your home or job associated with potentially harmful chemicals (pesticides, etc.)?: _____

How may we best be of service to you? Do you have any specific wishes or requests regarding your treatment that you would like us to know about? Are there religious, spiritual, or cultural considerations you would like to share with us?

_____

_____

_____

_____

LEWIS FAMILY
NATURAL HEALTH

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LewisNaturalHealth.com

Diet Diary for: _____ **Beginning Date:** _____

The purpose of this diary is to provide us with an unbiased record of your normal eating habits. Simply eat your typical diet for 5 days in succession and record it. Under breakfast, lunch, dinner and snack columns, list what you ate and drank. Under Notes, list anything you noticed during the day such as mood swings, bowel movements, indigestion, headaches, fatigue, etc. and after which meal they occurred.

BREAKFAST	LUNCH	DINNER	SNACKS	NOTES
Day 1				
Day 2				

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Breakfast	Lunch	Dinner	Snacks	Notes
Day 3				
Day 4				
Day 5				

LEWIS FAMILY
NATURAL HEALTH

Records Release Authorization

To: _____
(Doctor/Hospital)

Address: _____

Phone: _____ Fax: _____

I hereby authorize and request you to release to:
Lewis Family Natural Health
16 Sterling Street
Asheville, NC 28803
Phone: 828-298-4800 Fax: 866-400-9118

The following information:

_____ Lab only

_____ Complete Medical Records

I authorize the release of photocopies of the following medical records. Records or files shall include all confidential communicable disease-related information, confidential alcohol or drug abuse-related information and confidential mental health diagnosis/treatment information.

Concerning my illness and/or treatment from _____ to _____.

Name: _____

Address: _____

SS# or DOB: _____

Signature: _____ Date: _____

LEWIS FAMILY NATURAL HEALTH 16 Sterling Street * Asheville, NC 28803 * 828-298-4800 * LewisNaturalHealth.com

Dear Patient: Please read the following office policies and let us know if you have any questions.
YOUR SIGNATURE IS NEEDED ON THE LAST PAGE. THANK YOU!

FINANCIAL POLICIES:

Lewis Family Natural Health, Inc., is a fee-for-service office and does not accept or submit health insurance claims for payment. Therefore, payment for services and nutritional supplements is due in full at the time of service. Please let us know if you need to discuss other payment options. We accept cash, personal checks, and all major credit cards. There is a minimum $25 fee for returned checks and no further personal checks will be accepted.

Every effort has been made to ensure an easy-to-understand schedule of fees. For a more detailed description of our fees for services, please ask us for additional information. Fees as listed below are for office visits only, and do not include the cost, if any, of nutritional supplements or lab work.

New Patient Series (Adult):	$250 Part I (90 min), $145 Part II (60 min)*
New Patient Series (Child 12 and under):	$225 Part I (90 min), $145 Part II (60 min)*
Established Patient Follow-up/Acute Visits:	$85 (regular), $125 (intermediate), $145 (extensive)
New Patient Acute Illness Visits:	$250
90-minute Wellness Consultations:	$250

*Payment of both Part I and Part II visits at the first visit receives a $20 discount. We also have options for payment plans (please ask for more details.)

We also wish to make every effort to answer your questions. Any brief phone or e-mail conversation that serves to **clarify instructions** from a previous visit is free of charge. A phone call or e-mail that **covers new material, requires new information, or takes an extensive amount of time, or results in a change in the naturopathic plan** is considered to be a substitute for an office visit, and will be billed according to the schedule above.

CANCELLATION, RESCHEDULING, AND MISSED APPOINTMENT POLICIES:

- Our doctors only see one patient at a time to give each patient their full attention, and only see a limited number of patients per day. Each doctor reserves 90 minutes for all Part I visits, 60 minutes for all Part II visits, and 30-60 minutes for future follow up visits. When you make an appointment, that scheduled time is reserved for your exclusive use.
- Our doctors also meticulously prepare for each appointment by reviewing your paperwork and treatment plan prior to your appointment to help provide you with the best care possible.
- For these reasons, if you are not able to make your appointment as scheduled, we need to know in advance so that we can contact other patients who are waiting for an appointment.

Appointment and Cancellation Policies:

- We have a **48-hour (2 business days) cancellation policy**.
- Our office will confirm your appointment at least two business days in advance. If you are unable to keep your appointment as scheduled, please let us know 48-hours in advance in order to avoid a missed appointment charge.
- If you have a Monday appointment, we need to hear from you by 4:30 on the Thursday before your appointment.
- To cancel an appointment, please call 828-298-4800. Our regular office hours are Monday-Thursday, 9:30-4:30. If you cannot reach us in person by phone, you may leave a detailed voicemail message with your name, date and time of your scheduled appointment, and your request to cancel or reschedule.

Policies for a New Patient Visit:

- A **$100 deposit** is required to reserve your first 90-minute appointment. You may use a credit card, cash, or personal check (local address only). Please note that we cannot reserve your appointment until we receive this deposit.

- This deposit will be applied to the charge for your first appointment.
- This deposit is fully refundable (minus a $15 processing fee) if you cancel or reschedule 48-hours (2 business days) before your scheduled appointment time.
- If you need to reschedule your appointment to a later date, this deposit can be used to secure this next appointment as long as we have had 48-hours notice.
- Cancellations made with less than 48-hours notice forfeit the $100 deposit.

Policies for a Follow up Visit:

- We do not require a deposit for follow up visits.
- However, the same 48-hour cancellation policy does still apply. For cancellations made less than 48-hours (2 business days) before your scheduled follow up appointment, we reserve the right to charge a $50 fee.

PLEASE NOTE: ***Missed appointments with no notice given in person or by phone are subject to a charge for the full amount of the scheduled visit.***

In the case of a true emergency, this cancellation policy does not apply. Please let us know as soon as possible if this is the case. However, we ask that this only be used in the case of a real emergency and that you otherwise make every attempt to keep your appointment.

HEALTH INSURANCE POLICIES:

We have many questions from patients about insurance coverage for naturopathic care. The following describes our office policy based on our understanding of the laws in North Carolina.

Traditional Health Insurance:

- At this time, there is no license for naturopathic physicians available in the state of North Carolina.
- This means that by law we are not able to diagnose and treat disease, and by extension, our services are not covered by traditional health insurance plans.
- If we were to file a claim for insurance reimbursement, this could be considered insurance fraud.
- Because of this, we are not able to provide documentation, diagnosis codes, or treatment plans to your insurance company. Any form that asks for this information is, unfortunately, not a form our office is able to fill out.
- In the future, when our profession is fully recognized by the state of NC, we will be able to amend this policy as appropriate.

Health Savings Accounts (HSA) and Flex Spending Plans:

- Naturopathic services and supplements are sometimes covered under HSA and Flex plans. Not all plans cover all naturopathic care. The specifics of what is and is not covered depends on the rules of each specific plan. We recommend that you contact your plan administrator or tax advisor before using your HSA or Flex card at our office to determine what is covered and how it should be used.
- We are able to provide documentation to your HSA or Flex plan with the following information: Patient's name and birth date, date(s) of visit(s) to our office, supplements and other recommendations by our naturopathic doctors, and medical diagnosis that another doctor has given you. We are not able to diagnose disease in the state of NC, and therefore cannot list conditions or diagnoses that are not coming to us second-hand through another practitioner.

EMAIL POLICY AND PROCEDURES:

We appreciate that email can be a great way to ask a quick question or clarify something from your last visit, or share with us how you are doing. We have found through experience, however, that email is often not the best way to deal with more treatment-oriented questions and decisions such as questions regarding your medical issues, changes in your symptoms, or complex requests. Instead, in these cases please schedule an appointment so your naturopathic doctor will have time set aside to directly hear and address your concerns.

When using email, please keep the following in mind:

- Never use email for an urgent or emergency problem. The telephone is a much better way to reach us quickly. Typical turn around time for an email sent to our office is 1-2 days.
- If you have sent us an email and have not heard back from us after several days, please follow up with a phone call. Spam and other filters may have caused your email or our reply email to be lost in cyberspace.
- Please know that email is not confidential and is inherently not secure. Do not use email to communicate anything that you wouldn't want someone else to read. If you send an email from your work email address, your employer has a legal right to read what has been written. Likewise, we may forward your email to a member of our staff if appropriate (i.e. for requests to reschedule an appointment or for a supplement refill order). Reserve more confidential requests for a telephone or in-person visit with your naturopathic doctor.
- All electronic communication with LFNH becomes a part of your medical record. This means if you request that we send your records to another healthcare provider, they will receive copies of your email as well as our appointment notes.
- Email is never a substitute for seeing your naturopathic doctor. If you think that you need to be seen, please call and schedule an appointment!

SUMMARY OF POLICIES:

By signing below, I agree that I have read and understand these policies. I have been given the opportunity to ask questions and clarify the information listed above. I guarantee payment of all charges incurred as a patient of Dr. Eric Lewis, ND, Dr. Kristina Lewis, ND and Lewis Family Natural Health, Inc. I understand that insurance does not routinely cover naturopathic services in the state of North Carolina. I also understand that there is a 48-hour cancellation policy for all appointments. I understand the inherent risks in electronic communication and may choose whether or not I wish to use email to communicate with Lewis Family Natural Health.

Patient or Responsible Party's Signature:_____

Printed name: _____ Date: _____

INFORMED CONSENT:

Drs. Eric and Kristina Lewis are Naturopathic Doctors. They are co-owners of Lewis Family Natural Health, Inc.

Both doctors graduated from the Southwest College of Naturopathic Medicine in Tempe, Arizona, a 4-year post-graduate medical school accredited by the US Department of Education. They carry licenses to practice medicine in the state of Vermont. In the state of Vermont, Naturopathic Medicine is regulated by the Vermont Secretary of State's Office of Professional Regulation of Naturopathic Physicians under Vermont Statutes, Title 21, Chapter 81, Section 4121 through 4132.

Dr. Eric Lewis and Dr. Kristina Lewis are licensable in all states licensing Naturopathic Physicians. At this time, there is no such license available in the state of North Carolina. They are therefore not licensed to diagnose or treat disease in North Carolina. As a result, they do not intend to nor imply to diagnose and treat disease. The advice provided by the doctors is educational and intended to complement, not replace, any treatment prescribed by a licensed physician.

I understand the above statement. I further understand that Lewis Family Natural Health, Inc., and its associates, Dr. Eric Lewis and Dr. Kristina Lewis, are not medical doctors and are not attempting to conduct the activities of medical doctors.

Patient or Responsible Party's Signature:_____

Printed name: _____ Date: _____