The Vital Life

Michael Lang, ND

Welcome to my office!

The goal of this clinic is to help you find joy in the process of your own healing, health education, and personal growth. Since this takes time, money and energy, please consider what you are willing to invest in yourself. Allow me to investigate what it takes to develop the personal habits of health and healing, and the therapeutic possibilities to support that healing. Then together we will assess when you should notice the fruits of your efforts.

If your treatment is for a chronic challenge, please remember that your condition did not develop overnight. There are no magic bullets – only the miracle of the body's capacity to heal itself! It requires time to make an evaluation and then proceed with your program. You may be under my care for several months or longer. Please dedicate the time it takes for your healing.

I encourage you to ask questions to make sure you understand what I do and what I ask of you. This is a team effort!

Patient fees are as follows:

- **Bio-identical Hormones/Vital Life Program, $900 for 1st year of service; subsequent years$300.**
- **Adult visits are $165.00 for the initial consultation (90 minutes). The same fee applies for a consult and physical exam for children less than 12 years old.**
- **Follow up and acute visits are billed by time, complexity and procedures. Usually $90.00**
- **Procedures, intravenous therapy, supplies, house calls, and medications are charged separately.**
- **Medically assisted weight loss, $450 plus cost of medication (60 day supervision)**

Payment is expected at the time of service. Most insurance companies, but not Medicare, cover my services. Therefore, consult your insurance company before the initial visit. At the time of your visit you will receive a superbill to submit to your insurance company. If payment is not possible at the time of services, please discuss payment options *before* the initial consultation. Should the need arise that your account be referred to an outside collection agency, you agree to pay all collection costs, attorney fees and court costs.

My desire is that you find our time together rewarding. I play to win and hope you do also! I welcome your suggestions as to how I may serve you better.

Please sign below, indicating that you have read and understand the above statements.

_____ _____

Name Date

_____

Childs' name (if parent or guardian signs to give permission for treatment)

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Patient Profile Intake Form

By completing this profile of your health history, I can offer you more complete naturopathic care. Please be assured that I keep this information confidential.

Name _____ **Age** _____ **Birth Date**_____

Address _____ **City** _____ **State** _____ **Zip**_____

Home Phone _____ **Work Phone** _____

Email address _____

Married Partnered Separated Divorced Widowed Single Children? Yes / No

How did you hear about us? _____

Where, when, from whom, and for what reason did you last receive any health care? _____

_____

_____

Please list, in order of importance, your health concerns and/or goals.

1. _____

2. _____

3. _____

4. _____

Family Health History: Y = Yes N = No D = Caused Death (age of death) P = In the past

Please indicate if a family member has had any of the following. If yes, specify who.

Anemia Y N D P _____

Arthritis Y N D P _____

Asthma / Hay fever Y N D P _____

Cancer (type?) Y N D P _____

Cystic Fibrosis Y N D P _____

Diabetes Y N D P _____

Eating Disorder Y N D P _____

Epilepsy Y N D P _____

Fibromyalgia Y N D P _____

Glaucoma Y N D P _____

Heart Disease (incl heart attacks) Y N D P _____

Hypertension (high blood pressure) Y N D P _____

Kidney Disease Y N D P _____

Mental Illness Y N D P _____

Lung Disease Y N D P _____

Stroke Y N D P _____

Substance Abuse (drugs, alcohol) Y N D P _____

Venereal Disease Y N D P _____

Blood Type (please circle) A B AB 0

Childhood Illnesses **Please circle if you have had any of the following:**

Scarlet fever Measles Diphtheria Rubella (German measles) Chicken pox

Rheumatic fever Mumps

Others_____

Date of last Tetanus shot _____

Allergies:

Drugs? _____

Foods? _____

Environmental? _____

Have you ever been hospitalized? Please list when and why.

Illnesses: _____

Surgeries:_____

Other:

_____

Medications: Please indicate if you have used any of the following.

Appetite suppressants	**Y N P**	**Sleeping pills**	**Y N P**
Antacids	**Y N P**	**Pain relievers**	**Y N P**
Birth Control Pill or Implant	**Y N P**	**Other Hormones**	**Y N P**
Thyroid Medicine	**Y N P**	**Tranquilizers**	**Y N P**
Laxatives	**Y N P**	**Cortisone**	**Y N P**

Please list current prescription drugs, over-the-counter drugs, vitamins, herbs, or other supplements and the reason for taking them.

_____

_____

_____

Health Conditions **Y = Yes** **N = No** **P = A condition you've had in the past**

Skin

Acne	**Y**	**N**	**P**	**Boils**	**Y**	**N**	**P**
Color Changes	**Y**	**N**	**P**	**Eczema**	**Y**	**N**	**P**
Hives	**Y**	**N**	**P**	**Itching**	**Y**	**N**	**P**
Lumps	**Y**	**N**	**P**	**Moles**	**Y**	**N**	**P**
Rashes	**Y**	**N**	**P**	**Psoriasis**	**Y**	**N**	**P**

Head

Hair loss	**Y**	**N**	**P**	**Headaches**	**Y**	**N**	**P**
Head injury	**Y**	**N**	**P**	**Skull fracture**	**Y**	**N**	**P**

Eyes

Eye pain	**Y**	**N**	**P**	**Cataracts**	**Y**	**N**	**P**
Double vision	**Y**	**N**	**P**	**Dryness**	**Y**	**N**	**P**
Glasses/Contacts	**Y**	**N**	**P**	**Glaucoma**	**Y**	**N**	**P**
Impaired vision	**Y**	**N**	**P**	**Tearing**	**Y**	**N**	**P**
Injuries	**Y**	**N**	**P**	**Date of last eye exam _____**			

Ears

Discharge	**Y**	**N**	**P**	**Earaches**	**Y**	**N**	**P**
Dizziness	**Y**	**N**	**P**	**Impaired hearing**	**Y**	**N**	**P**
Ringing	**Y**	**N**	**P**	**Injuries**	**Y**	**N**	**P**

Nose and Sinuses

Frequent colds	**Y**	**N**	**P**	**Hay fever**	**Y**	**N**	**P**
Nose bleeds	**Y**	**N**	**P**	**Sinus pain**	**Y**	**N**	**P**
Stuffiness	**Y**	**N**	**P**	**Persistent runny nose**	**Y**	**N**	**P**

Mouth and Throat

Bleeding gums	**Y**	**N**	**P**	**Difficulty swallowing**	**Y**	**N**	**P**
Dental cavities	**Y**	**N**	**P**	**Sore throats**	**Y**	**N**	**P**
Hoarseness	**Y**	**N**	**P**	**Sore tongue**	**Y**	**N**	**P**
Dentures	**Y**	**N**	**P**	**Ulcerations**	**Y**	**N**	**P**
Difficulty speaking	**Y**	**N**	**P**	**Chewing tobacco**	**Y**	**N**	**P**

Neck

Goiter	**Y**	**N**	**P**	**Pain/Stiffness**	**Y**	**N**	**P**
Swollen glands	**Y**	**N**	**P**	**Injuries**	**Y**	**N**	**P**

Respiratory

Asthma/Wheezing	**Y**	**N**	**P**	**Bronchitis**	**Y**	**N**	**P**
Emphysema	**Y**	**N**	**P**	**Pneumonia**	**Y**	**N**	**P**
Tuberculosis	**Y**	**N**	**P**				
Short of breath	**Y**	**N**	**P**	**with exertion**	**Y**	**N**	**P**
				while lying down	**Y**	**N**	**P**

Spitting up blood Y N P

Difficult/Painful breathing Y N P

Cardiovascular

Angina	Y	N	P	**Dizziness after standing**	Y	N	P
Chest pain	Y	N	P	**High blood pressure**	Y	N	P
Heart disease	Y	N	P	**Swollen ankles**	Y	N	P
Murmurs	Y	N	P	**Rheumatic fever**	Y	N	P
Palpitations	Y	N	P	**Fluttering**	Y	N	P

Gastrointestinal

Blood in stool	Y	N	P	**Belching/Passing gas**	Y	N	P
Change in thirst	Y	N	P	**Change in appetite**	Y	N	P
Heartburn	Y	N	P	**Vomiting**	Y	N	P
Hemorrhoids	Y	N	P	**Jaundice/Yellow skin**	Y	N	P
Ulcers	Y	N	P	**Liver disease**	Y	N	P
Hernia	Y	N	P	**Constipation**	Y	N	P
Diarrhea	Y	N	P	**Abdominal pain**	Y	N	P

Bowel movements: How often? _____ Is this a change? Y N

Consistency & Color _____ Foul odor? Y N

Urinary

Kidney stones	Y	N	P	**Frequent infections**	Y	N	P
Kidney pain	Y	N	P	**Increased frequency**	Y	N	P
Nighttime frequency	Y	N	P	**Incontinence**	Y	N	P

Pain with urination Y N P **Urethral discharge Y N P**

Hesitancy Y N P **Dribbling Y N P**

Female Reproductive

Date and results of last pap smear _____

History of abnormal pap smears: Y / N_____

Age menses began _____ **Birth Control Y N P**

Age menopause began _____ **Type _____**

Average # of days of flow _____ **Days between periods _____**

Irregular cycles Y N P **Painful menses Y N P**

Number of pregnancies _____ **Number of live births _____**

Number of miscarriages _____ **Number of abortions _____**

Difficulty conceiving Y N P **PMS Y N P**

Pain during intercourse Y N P **Excess flow Y N P**

Menopausal symptoms Y N P **Sexual difficulties Y N P**

Are you sexually active Y N **History of venereal disease Y N P**

Sexual preference: Heterosexual Homosexual Bisexual

Breasts

Do you do self exams Y N **Lumps Y N P**

Pain Y N P **Nipple discharge Y N P**

Last mammogram and findings:_____

Male Reproductive

Do you do testicular self exams? Y N **Hernias Y N P**

Testicular pain Y N P **Sexual difficulties Y N P**

Testicular masses Y N P **Penile discharge Y N P**

Venereal disease Y N P **Difficult urination Y N P**

Prostate pain Y N P **Prostate disease Y N P**

Sexually active Y N **Birth control type _____**

Sexual Preference: Heterosexual Homosexual Bisexual

Last digital prostate exam and findings:

_____

Last Prostate Specific Antigen (PSA) measurement and value:

_____

Musculoskeletal

Joint pain/stiffness Y N P **Broken bones Y N P**

Joint swelling Y N P **Muscle weakness Y N P**

Muscle cramps/spasms Y N P **Arthritis Y N P**

Peripheral vascular

Deep leg pains Y N P **Cold hands & feet Y N P**

Varicose veins Y N P **Numb hands & feet Y N P**

Thrombophlebitis Y N P **Pain in legs while walking Y N P**

Neurological

Dizziness Y N P **Numbness/tingling Y N P**

Fainting Y N P **Memory loss Y N P**

Seizures Y N P **Paralysis Y N P**

Stroke Y N P **Tremors Y N P**

Endocrine and Blood

Anemia Y N P **Excessive thirst Y N P**

Hypothyroid Y N P **Easy bleeding/bruising Y N P**

Excessive hunger Y N P **Heat/cold intolerance Y N P**

Excessive fatigue Y N P **Insomnia Y N P**

Low/altered libido Y N P

Mental and Emotional

Excessive fears Y N P **Anxiety/nervousness Y N P**

Mood swings Y N P **Depression Y N P**

Tension Y N P **Excessive anger Y N P**

Habits

Do you awaken rested Y N **What are your main hobbies/interests?**

Sleep well Y N _____

Ave. hours sleep _____ _____

Enjoy your job? Y N _____

Watch TV? Y N **What forms of exercise do you get and**

Hours per day _____ **how often?** _____

Read? Y N _____

Hours per day _____ **Take vacations? Y N**

Have you ever been treated for alcohol dependency? Y N Drug dependency? Y N

If yes, when and where? _____

Do you use recreational drugs? Y N

Do you consume alcohol? Y N

How much? _____ **How often?** _____

Do you smoke cigarettes? Y N

Age started? _____ How much per day? _____

Have you ever smoked? Y N When did you quit? _____

Do you use chewing (smokeless) tobacco? Y N

Age started? _____ How much per day? _____

Have you ever used chewing tobacco? Y N When did you quit? _____

Thank you for taking the time to fill out this form completely. Don't worry if you were not able to answer some of the questions. During your office visit, we will discuss some of your responses in detail. Please feel free to attach any additional sheets describing your medical history or symptoms in detail.

Neural Therapy History: Please be as accurate as possible and include age of occurrence.

Surgery	Age		Toxic Profession past or present	Age
Injuries, Accidents without Stitches	**Age**		**Major Psychological Trauma**	**Age**
			Serious Infections & Diseases	**Age**
Typical childhood vaccinations? Yes No				

Long Periods of Prescription, Street Drugs,	**Age**		**Injuries or Accidents with Stitches**	**Age**
Alcohol or Cigarettes				
Long Visits or Lived in Foreign Country like	**Age**		**Dental Intervention – root canal, extraction**	**Age**
India, China, Mexico, Africa, etc.				
Treated for Parasites, Infections? Yes No				
Pregnancies, Births, Abortions, IUDs, Birth Control Pill use, etc	**Age**		**Medications & Allergies, past or present**	**Age**

Consent to Naturopathic Treatment Provided by Michael Lang, ND

1. **This is to acknowledge that I have been informed and understand that:**

   a) Any treatment or advice provided to me as a patient of Michael Lang, ND is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider.

   b) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider.

   c) I understand that Michael Lang, ND is not preventing me from seeking or following the advice of another licensed health care provider.

   d) The treatment and therapies provided to me by Michael Lang, ND may be different from those offered by another licensed health care provider.

2. **I agree to pay for any fees for services, costs of supplements and homeopathic remedies, cost of laboratory tests, or other fees at the time of the visit.**

3. **I hereby authorize and consent to treatment.**

_____ _____

Patient Signature Date