Living Natural
Naturopathy & Ayurveda

Margrit Mikulis, ND, AD
Living Natural Inc.
147 Orchard Street, Brattleboro, VT 05301
info@livingnaturalinc.com

Name: _____Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (h): _____ (w): _____ (c): _____

Email: _____

PC: _____

Height: _____Weight: _____Occupation: _____ How long: _____

Marital/Relationship status: _____# of Children/Dependents: _____

Name of Emergency contact: _____ Relationship to you: _____

Phone: _____ Or:

_____ How did you first hear about

Naturopathic Medicine/Living Natural Inc.?_____

Please describe your present health concerns and their duration:

What would you like to accomplish on your first visit?

Describe your top 3 stressors:

Describe how you support yourself (or who supports you) when these stressors are active:

Tell me about 3 things you absolutely LOVE to do, and why?

Medical History

Are you currently under the care of a family physician or other health professionals? If no please explain.

Are you currently taking any medications and/or receiving any medical treatment for your health condition? Please list medications and dosage.

Do you take or use any of the following?

Y = presently use N = never have used P = have used in the past

Appetite Suppressants	Y	N	P	Pain Relievers	Y	N	P	Cortisone	Y	N	P
Thyroid Medication	Y	N	P	Sleeping Pills	Y	N	P	Antacids	Y	N	P
Antidepressants	Y	N	P	Tranquilizers	Y	N	P	Laxatives	Y	N	P

Have you had any of the following in the last five years?

Test	When	For What reason	Results/Outcome

Bone density_____

CT Scan_____

Colonoscopy_____

EEG _____

Endoscopy_____

MRI_____

Ultra Sound_____

X-Ray_____

Have you had any past hospitalizations? If so, what for and when?

Are you allergic to any substances? Please specify, including foods, pollens, dust, etc. Any other allergic reactions?

Do you have any past medical history? If yes, please specify the age of occurrence, duration and treatment.

Health as a child: ☐ Good ☐ Fair ☐ Poor

Please rate your energy level: ☐ Very high ☐ High ☐ Moderate ☐ Low ☐ Very Low

What time of day do you feel best? _____

What time of day do you feel worse? _____

Family History

	If living		*If deceased*
Age	Health	Age	Cause of death

Mother : _____

Father: _____

Siblings:_____

_____

_____

Children:_____

_____

_____

Do you have a family history of any of the following?

Condition	Yes	Family Member(s)	Age of Onset	Description
Heart Disease	☐			
High Blood Pressure	☐			
Stroke	☐			
Diabetes	☐			
Cancer	☐			
Overweight	☐			
Food Intolerance	☐			
Autoimmune Disease	☐			
Asthma/ Hay Fever	☐			
Kidney Disease	☐			
Osteoporosis	☐			
Suicide	☐			
Thyroid Disease	☐			
Tuberculosis	☐			

Nutrition History

Have you changed your eating habits for a health reason?

Do you avoid any particular foods?

Are you currently following a particular diet or nutrition plan? If yes, please explain

Have you recently lost or gained weight? Yes No If yes, please describe.

Do you have or have you had an eating disorder? Yes No If yes, please describe.

How many meals do you eat each day?	How many snacks do you eat each day?
How many meals do you buy from a restaurant or fast food **per week?** 0-1 2-3 4-6 > 6	
Do you drink alcohol? Yes No If yes, how many drinks **per week?**	
Do you drink caffeinated beverages? Yes No If yes, how many cups **per day?**	
Do you use any natural or artificial sweeteners? Yes No If yes, which ones?	
What is your favorite meal?	

Check all of the factors that apply to your eating habits and current lifestyle:

☐ Love to eat	☐ Fast eater	☐ Live alone or eat alone often
☐ Love to cook	☐ Erratic eating patterns	☐ Do not plan meals or menus
☐ Emotional eater	☐ Eat too much	☐ Time constraints
☐ Late night eater	☐ Rely on convenience foods	☐ Travel frequently
☐ Struggle with eating issues	☐ Eat fast food frequently	☐ Eat only because I have to
☐ Family members have	☐ Make poor snackchoices	☐ Negative relationship with food
	☐ Confused	☐ Dislike healthy food
☐ Dislike cooking	about	☐ Don't know how to cook
	food/nutrition	

Do you eat between meals: ☐ yes ☐ no

Do you eat your meals at the same time each day: ☐ yes ☐ no

Which is your main meal? ☐ Breakfast ☐ Lunch ☐ Dinner

Rate your digestion: ☐ Good ☐ Fair ☐ Poor

How much water do you drink per day? ☐ Never ☐ 1-2 glasses ☐ 3-4 glasses ☐ 5-6 glasses ☐ 7+

My eating habits include: ☐ Eat w full attention on food ☐ Talk while eating ☐ Eat fast
☐ Watch television while eating ☐ Eat while reading/working ☐ Eat on the go

What tastes do you like or crave? ☐ Sweet ☐ Sour ☐ Salty ☐ Hot/Spicy ☐ Bitter ☐ Starches ☐ Oily

Are there any particular foods that create discomfort when you eat them? Please list:

Digestion

Do you experience any of the following: ☐ Gas ☐ Bloating ☐ Constipation ☐ Heartburn
☐ Sour burps ☐ Diarrhea ☐Heavy feeling in the stomach ☐ Low appetite ☐ Nausea

Bowel Movements

☐ Once per week ☐ Once every 2-3 days ☐ Once daily ☐ 2-3 times per day ☐ 4+ times daily
☐ First thing in the morning ☐ Late in daytime ☐ Immediately after meals ☐ Immediately after dinner
☐ Need laxatives daily ☐ Other, please specify: _____

Bowel nature: ☐ Soft ☐ Medium ☐ Hard

Are your bowel movements associated with: ☐ Pain ☐ Gas ☐ Blood ☐ Mucous ☐ Foul Smell

☐ Other, please specify: _____

Urination

Do you experience any of the following: ☐ Pain ☐ Burning sensation ☐ Discoloration
☐ Frequent urination during the day ☐ Urination several times during the night
☐ Other, please specify: _____

Natural Urges

Do you delay or suppress any of the following: ☐ Bowel movements ☐ Gas ☐ Urination
☐ Sleep ☐ Yawning ☐ Burping ☐ Breathing ☐ Sneezing ☐ Hunger ☐ Semen ☐ Tears

Emotions

What is your present state of mind and emotions? ☐ Good ☐ Fair ☐ Poor

Do you often experience any of the following? ☐ Worry ☐ Depression ☐ Lack of energy
☐ Anxiety ☐ High stress levels ☐ Fear or Panic ☐ Lack of memory
☐ Anger ☐ Irritation ☐ Loneliness ☐ Light headedness

How are your family relationships? ☐ Good ☐ Fair ☐ Poor

How is your social life? ☐ Good ☐ Fair ☐ Poor

How is your mental state? ☐ Good ☐ Fair ☐ Poor

How is your career? ☐ Love it ☐ Like it ☐ Unhappy with it

How purposeful is your life? ☐ Completely ☐ Neutral ☐ Not happy

Rate your spiritual life: ☐ Satisfying ☐ Neutral ☐ Empty

Daily Routine

How regular is your daily routine? ☐ Very regular ☐ Somewhat regular ☐ Irregular

Do you practice any type of meditation? Please explain.

Do you practice any type of yoga? Please explain.

Do you travel a lot? ☐ yes ☐ no

How often do you smoke cigarettes?
☐ Never ☐ less than once per week ☐ several times a week ☐ more than once per day ||
How many: ____

Which type of weather makes you feel most uncomfortable? ☐ Cold ☐ Hot ☐ Cold and damp

☐ How often do you exercise?
☐ Never ☐ Weekly once ☐ Weekly twice ☐ 3-4 days weekly ☐ 5-6 days weekly ☐ daily

How long do you exercise? _____ What type of exercise?_____

Is your exercise: ☐ Vigorous ☐ Moderate ☐ Light or Gentle

What is your body build? ☐ Thin ☐ Large ☐ Average ☐ Muscular
Are you overweight? ☐ yes ☐ no
If yes, by how much? ☐ Less than 15 lbs ☐ 15-30 lbs ☐ 30-50 lbs ☐ More than 50 lbs

Are you underweight? ☐ yes ☐ no
If yes, by how much? ☐ Less than 10 lbs ☐ 10-20 lbs ☐ More than 20 lbs

What time do you wake up? _____

What time do you go to bed? _____

Do you sleep in the daytime? ☐ yes ☐ no

How do you generally feel on arising in the morning? ☐ Fresh & rested ☐ Little tired ☐ Very tired

How is your sleep?
☐ Too heavy and too long
☐ Awaken too early
☐ Sound, normal duration ☐ Light, interrupted
☐ Difficulty falling asleep ☐ Difficulty waking up
☐ Too little sleep ☐ Frequent Nightmares

Do you experience pain during intercourse? ☐ yes ☐ no

Do you have any sexual difficulties? ☐ yes ☐ no
If yes, please explain:

~For Women:

Age menses began: _____ years

Which of the following describes your menstruation: ☐ Regular ☐ Irregular ☐ Too frequent ☐ Absent
☐ Ceased due to menopause

How many days does your menstrual period last? ☐ 0-4 days ☐ 5-7 days ☐ +7 days
☐ Spotty irregularity throughout the month ☐ Other, please specify:
_____

How is your menstrual flow? ☐ Heavy ☐ Light ☐ Normal

Associated symptoms (before or during menstruation):

☐ Fluid Retention ☐ Migraine ☐ Depression ☐ Acne ☐ Tension ☐ Anger ☐ Food cravings
☐ Cramping ☐ Frustration ☐ Breast tenderness ☐ Nightmares ☐ Other

Are you pregnant now? ☐ yes ☐ no ☐ don't know

Do you take contraceptive pills or devices? ☐ yes ☐ no If yes, please explain:
_____

Number of previous pregnancies: _____

How many children do you have? _____ Children's ages: _____

Do you self-examine your breasts regularly? ☐ yes ☐ no
Do you experience any problems in your breasts? ☐ Lumps ☐ Pain or tenderness ☐ Nipple discharge
☐ Other, please explain:

Review of Personal history:

Y= presently have N= have never had P= have had in the past 10 years

Skin

Rashes	Y	N	P
Eczema/Hives	Y	N	P
Acne/Boils	Y	N	P
Color Changes	Y	N	P
Itching	Y	N	P
Lumps	Y	N	P
Night Sweats	Y	N	P

Nose and Sinuses

Frequent Colds	Y	N	P
Nose Bleeds	Y	N	P
Stuffiness	Y	N	P
Hay Fever	Y	N	P
Sinus Problems	Y	N	P

Neck

Lumps	Y	N	P
Swollen Glands	Y	N	P
Goiter	Y	N	P
Pain/Stiffness	Y	N	P

Respiratory

Cough	Y	N	P
Sputum	Y	N	P
Spitting up blood	Y	N	P
Bronchitis	Y	N	P
Pleurisy	Y	N	P
Emphysema	Y	N	P
Wheezing	Y	N	P
Asthma	Y	N	P
Shortness of Breath	Y	N	P
At night	Y	N	P
Lying down	Y	N	P
On exertion	Y	N	P
Difficult breathing	Y	N	P
Pain on breathing	Y	N	P
Tuberculosis	Y	N	P
Pneumonia	Y	N	P

Head

Headaches	Y	N	P
Migraines	Y	N	P
Head Injury	Y	N	P

Ears

Impaired Hearing	Y	N	P
Ringing	Y	N	P
Earache	Y	N	P
Dizziness	Y	N	P

Eyes

Glasses or contacts	Y	N	P
Eye Pain	Y	N	P
Tearing or dryness	Y	N	P
Glaucoma	Y	N	P
Cataracts	Y	N	P

Mouth and Throat

Frequent Sore Throat	Y	N	P
Sore Tongue	Y	N	P
Gum problems	Y	N	P
Teeth Problems	Y	N	P

Gastrointestinal

Nausea	Y	N	P
Vomiting	Y	N	P
How many bowel movements Per day			
Is this a change	Y	N	P
Blood in stool	Y	N	P
Gallbladder disease	Y	N	P
Liver disease	Y	N	P
Jaundice	Y	N	P
Change in thirst	Y	N	P
Trouble swallowing	Y	N	P
Belching/gas	Y	N	P
Ulcer	Y	N	P
Hemorrhoids	Y	N	P
Bloating	Y	N	P

Cardiovascular

Heart Disease	Y	N	P
Chest Pain	Y	N	P
Angina	Y	N	P
Palpitations	Y	N	P
Fluttering	Y	N	P
High Blood Pressure	Y	N	P
Murmurs	Y	N	P
Swelling in ankles	Y	N	P

Blood

Anemia	Y	N	P
Easy bleeding	Y	N	P
Easy bruising	Y	N	P

Neurological

Fainting	Y	N	P
Seizures	Y	N	P
Paralysis	Y	N	P
Muscle weakness	Y	N	P
Numbness/tingling	Y	N	P
Loss of memory	Y	N	P

Female Reproductive

Age at onset of period			
Length of monthly cycle			
Are cycles regular	Y	N	P
Painful menses	Y	N	P
Excessive flow	Y	N	P
PMS	Y	N	P
Birth Control	Y	N	P
What type			
Number of pregnancies			
Number of live births			
Number of miscarriages			
Difficulty of conceiving	Y	N	P
Sexual Difficulties	Y	N	P
Venereal Disease	Y	N	P

Urinary

Pain on urination	Y	N	P
Increased frequency	Y	N	P
Frequency at night	Y	N	P
Inability to hold	Y	N	P
Frequent infections	Y	N	P
Kidney stones	Y	N	P
Kidney Disease	Y	N	P

Peripheral Vascular

Deep leg pain	Y	N	P
Cold Hands/feet	Y	N	P
Varicose veins	Y	N	P

Mental/Emotional

Depression	Y	N	P
Mood Swings	Y	N	P
Anxiety/nervousness	Y	N	P
Panic attacks	Y	N	P
Tension	Y	N	P
Sense of doom	Y	N	P

Hair

Thinning	Y	N	P
Falling out	Y	N	P
Balding/Alopecia	Y	N	P
Hirsutism	Y	N	P
Scalp problems	Y	N	P

Male Reproductive

Hernias	Y	N	P
Testicular masses	Y	N	P
Testicular pain	Y	N	P
Sexual difficulties	Y	N	P
Prostate disease	Y	N	P
Venereal disease	Y	N	P
Discharge or sores	Y	N	P
Erectile dysfunction	Y	N	P

Daily Habits

Exercise	Y	N	P
What form			
How often			
Use recreational drugs	Y	N	P
Use tobacco	Y	N	P
Use alcohol	Y	N	P
Sleep well	Y	N	P
Awake rested?	Y	N	P
Average 7 hours?	Y	N	P

How to determine your current state of being

When answering the following questions, evaluate your current state of being. Circle one description for each row, or two if there are the answers are close.

Mental Profile

	Vata		Pitta		Kapha	
Mental activity	Quick, active, restless		Sharp, critical, aggressive		Calm, steady, slow, stable	
Memory	Short term		Generally good		Good long term	
Concentration	Weak		Generally good		Very good	
Ability to learn	Quick to grasp concepts		Moderate ability to grasp new information		Slow to grasp new information	
Dreams	Fearful, very active, flying,		Aggressive, fiery, adventurous		Watery, romance, relationships	
Sleep	Light, interrupted		Sound, medium		Sound, heavy, long	
Speech	Quick, can miss words		Sharp, direct, strong		Slower, clear, melodious	
Voice	High pitched		Medium pitched		Low pitched	
Sub-total						

Behavioral Profile

	Vata		Pitta		Kapha	
Eating Speed	Fast		Medium		Slow	
Hunger level	Irregular		Sharp, can be strong		Can easily miss meals	
Food/Drink	Prefers warm		Prefers cold		Prefers dry and warm	
Achieving goals	Easily distracted		Focused and driven		Slow and steady	
Giving/donations	Gives small amounts		Gives nothing or large amounts infrequently		Gives regularly and generously	
Relationships	Many casual		Intense		Long and deep	
Sex drive	Variable, low		Moderate		Strong	
Works best	Supervised		Alone		In groups	
Weather preference	Warm and moist		Cool and dry		Warm and dry	
Reaction to stress	Excites quickly		Medium		Slow to get excited	
Financial	Doesn't save, spends quickly		Saves but big spender		Saves regularly, accumulates wealth	
Routine	Dislikes routine		Likes planning and organizing		Works well with routine	

Sub-total						

Emotional Profile

	Vata		Pitta		Kapha	
Moods	Changes quickly		Changes slowly		Steady, unchanging	
Reacts to stress with	Fear		Anger		Indifference	
More sensitive to	Own feelings		Not sensitive		Others feelings	
When threatened tends to	Run		Fight		Make peace	
Relations with spouse/partner	Clingy		Jealous		Secure	
Expresses affections	With words		With gifts		With touch	
When feeling hurt	Cries		Argues		Withdraws	
Emotional trauma causes	Anxiety		Denial		Depression	
Confidence level	Timid		Outwardly self-confident		Inner confidence	
Sub-total						

Physical Profile

	Vata		Pitta		Kapha	
Amount of hair	Average		Thinning		Thick	
Hair type	Dry, frizzy, thin, dark		Straight, fine, premature graying		Oily, wavy, thick	
Hair color	Light brown, blond		Auburn, reddish		Dark brown, black	
Skin	Dry, rough or both, dark/sallow, tans easily, cold		Soft, normal to oily, light, sunburns easily, warm		Oily, moist, fair, thic, cool	
Complexion	Darker		Pink, red		Pale-White	
Eyes	Small, brown, gray, violet, unusual color		Medium, Green, hazel, almond-shaped		Large, dark, blue	
Whites of eyes	Blue/brown		Yellow or red		Glossy/white	
Teeth	Very large or very small		Small -medium		Medium-large	
Weight	Thin, hard to gain		Medium		Heavy, easy to gain	

Elimination	Dry, hard, thin, easily constipated		Many during day, soft to normal		Heavy, slow, thick, regular	
Sweat	Scanty		Profuse		Moderate	
Sub-total						

TOTAL	*Vata*		*Pitta*		*Kapha*	

Living Natural Payment Policies

Pay at service

All payments are due at the time of service. This includes initial visits, follow-up visits, and any product purchased from Living Natural.

Insurance detail

Although Dr. Mikulis does not bill for insurance she will provide procedural and diagnostic codes on each "paid" invoice, so her clients can submit directly to their insurance. While we do not process insurance, please be aware that many insurance companies will cover "out-of-network providers" and we can help guide you in the billing process. Additionally, Health Savings Accounts are optional accounts that can be utilized for payment.

Rates

All in-office visits and phone consultations are charged at a $300-per-hour rate. All initial office visits are typically one hour or more, and follow-up visits are typically 45 minutes. Because some visits can be longer and some visits can be shorter, changes to the allotted time are prorated at the $300-per-hour rate and Dr. Mikulis keeps time on her phone. Please note that very often Dr. Mikulis only needs a brief amount of time for a focused visit and this will be priced accordingly, based on the structure described above.

Card on file

Please be aware that we request a current credit card to be kept on file for all of our clients. We will ask you to provide this when scheduling your initial visit. Because we care so much about keeping your personal information in a secure HIPAA Protected environment, we only maintain password-protected records of your payment information. If you have any questions or concerns, please raise them prior to your initial visit. We encourage open communication and transparency with our clients regarding our policies.

By signing below, I certify that I have read and agree to abide by all of the above policies.

Signed:_____Print:_____Date:_____

Living Natural Inc. Consent Form

Please read the following document carefully. If you have questions, please ask before signing it. Living Natural Inc. wishes to provide you with the highest quality health care possible, and in order to do so, it is necessary that you understand the following.

Consent to Treatment: Treatment at this practice requires an agreement between you the patient, and the practitioner. Any therapy will proceed by mutual consent between the practitioner and you, the patient. You agree to discuss any problems with the practitioner so that they may have a clear picture of your health at the time of service. If you refuse to sign, treatment will be denied.

Naturopathic medicine: Because of the possibility of drug interaction with herbs and nutritional supplements, we require our patients to inform your practitioner of any medications they may be taking, including any dietary supplements and herbs. **Patients must inform the practitioner of any possibility of pregnancy.**

Lateness and billing policies:

- Respect your practitioner and the patients who are scheduled after you, and arrive on time for your appointment. You will be charged the full fee, even if you arrive late. The practitioner is waiting for you, and will not be able to make up the lost time. If you are more than 15 minutes late, your appointment will be rescheduled and you will still be charged for the appointment you were late for.
- We do not bill for insurance, so full payment is required at time of service. However, we encourage you to submit for reimbursement from your insurance company and we will provide you with an appropriately coded invoice, if needed.
- Lengthy emails, lab interpretation from other doctors, or phone messages with more than a follow up question from your last visit will be billed in 10 minute increments, at the appointment rate, and cannot be billed to insurance.
- Please make note of the date and time of your upcoming appointment. **Missed appointments will be charged the full appointment fee at the hourly rate of $300-per-hour.**

Cancellation Policy: This office requires at least 24 hours notice of cancellation in advance of the scheduled appointment with Dr. Margrit Mikulis. You will be charged half of the appointment fee the first time you cancel, and the full appointment fee for any subsequent short-notice missed visits, if less than a 24 hour notice is given. You must pay this fee out of pocket as insurance cannot be billed for this fee. Additionally, if you reschedule more than two consecutive appointments, the third appointment will need to be paid in advance.

YOUR SAFETY IS IMPORTANT TO US, SO INCLEMENT WEATHER CANCELLATIONS WILL NOT BE CHARGED.

EMERGENCY CARE: Our clinic does not administer emergency medical care. In the case of an emergency, please contact your family physician/primary care provider or go to the nearest emergency room or urgent care. We do not answer calls, have an answering service or always check emails after hours.

I HEREBY,

- CERTIFY THAT I HAVE RECEIVED AND READ THE HIPAA NOTICE REGARDING PRIVACY PRACTICES.
- CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME INCLUDING SUPPLEMENTS/PRODUCT SOLD TO ME AND I WILL PAY LIVING NATURAL INC. IN FULL AT THE TIME OF MY VISIT.
- I CERTIFY THAT I AM RESPONSIBLE FOR ANY MISSED APPOINTMENT FEES DUE TO NON-CANCELLATION IN THE STATED TIME PERIOD.
- I CERTIFY THAT I HAVE READ ALL THE ABOVE PATIENT POLICIES CAREFULLY.

Signed:_____Print:_____Date:_____