

ARIANNE KOVEN, C.N.H.P.
TRADITIONAL NATUROPATH

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When returning this form to my office please include a photograph of you by yourself (it can be recent or older) and sign your name on the back. Thank you!

Client In-Take Form

Client Name: _____		Spouse Name _____	
Street Address: _____			
City/State/Zip: _____			
Phone #: HOME _____		FAX _____	
CELL _____		WORK _____	
Place of Birth (City & State): _____			
Date of Birth: _____		Time of Birth: _____	
Blood Type: _____		Eye Color: _____	
Who referred you to us? _____			

Number of organs removed: _____

Number of Synthetic drugs used currently: _____

Amount of times you smoke per day
(Number of cigarettes, cigars etc.) _____

Number of steroid type drugs used
in the last year: _____

Number of metal amalgam fillings currently
or present during last year: _____

Number of street drugs used in the last month: _____

Number of known FOOD and ENVIRONMENTAL
allergies: _____
Please List: _____

Responsibility for your disease
(0 minimum - 10 maximum): _____

Personal stress (0- 10 max): _____

Amount of fat in diet, as percent/10
(include processed foods): _____

Number of sugar type products/day:
(includes soft drinks, ice cream etc.): _____

Number of exercise sessions per week : _____
(20 min. or more, not work)

Number of alcoholic drinks per day: _____
(on average)

Number of cups of coffee, tea per day: _____
(or any caffeine products)

Number of any known extreme toxic
exposures : _____ (radiation, insecticide, chemicals)

Number of major injuries in past: _____

Number of major Infections: _____
(past and present)

Number of glasses of water per day: _____

How many kilos overweight: _____
(2.2lb = 1 kilo)

Number of head injuries _____

Describe your stress, if any, regarding the following areas: *Job, family, home, relatives:*

Check all that apply:

Miscellaneous Stress:

- Endocrine disturbance (hormonal or glandular)
- Emotional
- Mental Stress
- Sensory-eyes, ears, taste, feeling, smell problem
- Perverse energy-excess humidity, heat, cold, dryness, wind, radiation

Possible Toxic Exposures to:

- Beauty Shop Toxins or similar
- Asbestos from shipping industry, insulation etc.
- Industrial Toxins
- Insecticides, Herbicides, Industrial Farm Chemicals
- Heavy Metals
- Food Additives
- Radiation
- Chlorine or Fluorine sensitivity
- Environmental toxins of water and air pollution
- Infectious exposure

General Health:

- Do you catch colds easily and frequently?
- Do they last longer than 3 days on the average?
- Do you have a persistent cough or hoarseness?
- Do you have difficulty in swallowing?
- Are you losing weight without trying to?
- Have you recently lost consciousness or had double vision?

Have you ever been diagnosed as having any of the following?

- Viral Infection (eg., Mono, EBV, Herpes)
- Yeast Infections (eg., Candidiasis)
- Diabetes
- Anemia
- Hair loss
- Skin Problems
- Bursitis
- Arthritis
- Other _____

Additional Disorders:

- Vascular or circulatory disease
- Cold extremities
- History of infections
- Degenerative disease
- Dietary problems
- Congenital disorder, hereditary or from birth
- Allergy-tendency or prevalence of allergic symptoms in history.
- Trauma-injury in the past or present

Does your family history include any of the following conditions?

- Depression/Schizophrenia
- Diabetes
- High blood pressure
- Heart Disease
- Cancer
- (Specify) _____
- Other _____

Energy/Mood Levels:

- Do you experience frequent mood swings during the day, for example, happy to depressed?
- Do you have trouble relaxing in the evening?
- Do you experience difficulty in falling asleep, taking more than 15 minutes?
- Do you wake up feeling sluggish and fatigued?
- Do you experience difficulty concentrating or remembering daily events or things to do?
- Do you become impatient and anxious over trivial matters easily?
- Are you easily fatigued by your daily routine?

Exercise Habits:

- When exercising, is it difficult to get into the workout and maintain energy levels?
- Do you have any joint or connective tissue problems? (Pain, inflammation, grinding, swelling...)

Are your strength levels:

- Improving? Staying the same? Decreasing?

Drug Types Currently Used**Drug Names:**

- Angina Medication _____
- Antacids _____
- Antibiotics _____
- Anticonvulsants _____
- Anti-Depressants _____
- Antifungal _____
- Antihistamines _____
- Anti-Inflammatory _____
- Anxiety Medication _____
- Aspirin/Tylenol _____
- Birth Control _____
- Blood Pressure _____
- Blood Thinner _____
- Cancer drugs, _____
Chemotherapy _____
- Cholesterol reducer _____

Drug Types Currently Used**Drug Names:**

- Diabetic Medications _____
- Digestion Medications _____
- Diuretics _____
- Heart Medications _____
- High Blood Pressure _____
- High Cholesterol _____
- Hormones Replacements _____
- Hydrocortisone Cream _____
- Kidney Medications _____
- Muscle Relaxants _____
- Pain Medications _____
- Parkinson Drugs _____
- Steroids _____
- Thyroid Medications _____
- Other _____

Check the box if you have recently suffered from any of these symptoms:

- | | | |
|--|--|--|
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Tremors/trembling of hands, feet, lips, eyelids or tongue | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Anxiety/nervousness | <input type="checkbox"/> Burning sensation of lips, face | <input type="checkbox"/> Hearing difficulties |
| <input type="checkbox"/> Difficulty breathing when anxious | <input type="checkbox"/> Burning in throat | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Inflammation of lining of the mouth | <input type="checkbox"/> Sensitivity to light |
| <input type="checkbox"/> Exaggerated response to stimulation | <input type="checkbox"/> Ulcers in mouth or on tongue | <input type="checkbox"/> Chronic headaches |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Twitching or jerking of muscles | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Emotional instability | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Lack of self-control | <input type="checkbox"/> Difficulty talking | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Fits of anger with violent, irrational conduct | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Excessive itching |
| <input type="checkbox"/> Loss of self-confidence | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Skin irritation |
| <input type="checkbox"/> Constant death wish | <input type="checkbox"/> Food sensitivity to eggs or milk | <input type="checkbox"/> Low body temperature |
| <input type="checkbox"/> Shyness of timidity | <input type="checkbox"/> General food sensitivities | <input type="checkbox"/> Cold, clammy skin especially hands and feet |
| <input type="checkbox"/> Being easily embarrassed | <input type="checkbox"/> Bloating feeling most of the time | <input type="checkbox"/> Excessive perspiration with frequent night sweats |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Constant or frequent pain in joints |
| <input type="checkbox"/> Inability to concentrate | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Unexplained numbness or burning sensations |
| <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Frequent or recurring heartburn | <input type="checkbox"/> General fatigue |
| <input type="checkbox"/> Lethargy/drowsiness | <input type="checkbox"/> Frequent urination during the night | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Chronic diarrhea or constipation | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Mental depression /despondency | <input type="checkbox"/> Increased heart rate | <input type="checkbox"/> Loss of weight |
| <input type="checkbox"/> Rocking movements | <input type="checkbox"/> Menstrual pains | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> Frequent leg cramps | <input type="checkbox"/> Disturbances in menstrual cycle | <input type="checkbox"/> Speech disorders |
| <input type="checkbox"/> Diminished touch sensation | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Slurred speech |
| <input type="checkbox"/> Numbness and tingling of hands, feet, fingers, toes or lips | <input type="checkbox"/> Bone loss around teeth | <input type="checkbox"/> Unintelligible speech |
| <input type="checkbox"/> Aversion to touch | <input type="checkbox"/> Loosening of teeth | <input type="checkbox"/> Slow reaction time |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Excessive salivation | <input type="checkbox"/> Poor performance with timed tests |
| <input type="checkbox"/> Loss of coordination | <input type="checkbox"/> Metallic taste | |
| | <input type="checkbox"/> Ringing in ears | |

EATING HABITS

Do you experience indigestion? Yes No
 Do you have other digestive disorders? Yes No

List: _____

After a meal high in Protein do you feel:
 (High Protein Foods: meats, fish, egg, chicken, dairy)
 No Change ___ Relaxed ___ Tense ___

Does a carbohydrate meal leave you feeling:
 (High Carb. Foods: pasta, potato, rice, vegetables)
 No Change ___ Relaxed ___ Tense ___ Sleepy ___

Do you tend to snack:

When you are nervous?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
When you are depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In the evening?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
On foods high in salt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
On foods high in sugar?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

How often do you eat the following?

Dairy products:
 Daily ___ 2-3x/week ___ 2-3x/mo. or less ___ Never ___

Red meat:
 Daily ___ 2-3x/week ___ 2-3x/mo. or less ___ Never ___

Major source of protein you consume:

Estimate the percentage in your diet of the following types of food: Protein _____% Carbs. _____% Fat _____%

DIETARY RECALL

Please indicate (**and be honest**) all the food and drink you've consumed in the last 24 hours.

BREAKFAST	LUNCH	DINNER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
SNACK	SNACK	SNACK
_____	_____	_____
_____	_____	_____
_____	_____	_____

METABOLIC ASSESSMENT FORM

PART I

Please list the 5 major health concern in order of importance:

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

PART II

Please circle the appropriate number "0 - 3" on all questions below.

0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard dry or small stool	0	1	2	3
Coated tongue of "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Do you use laxatives frequently	0	1	2	3

Category II

Excessive belching burping or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3

Category III

Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0	1	2	3

Category IV

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-7 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage bloated	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Excessive passage of gas	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Difficulty losing weight 0 1 2 3

Category V

Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates for clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	0	1	2	3

Category VI

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category VII

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3

Category VIII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category IX	
Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under high amounts of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3

Category X	
Tired, sluggish	0 1 2 3
Feel cold - hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight gain even with low-calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression, lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on scalp, face or genitals or excessive falling hair	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category XI	
Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervousness and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category XII	
Diminished sex drive	0 1 2 3
Menstrual disorders or lack of menstruation	0 1 2 3
Increased ability to eat sugars without symptoms	0 1 2 3

Category XIII	
Increased sex drive	0 1 2 3
Tolerance to sugars reduced	0 1 2 3
“Splitting” type headaches	0 1 2 3

Category XIV (Male Only)	0 1 2 3
Urination difficulty or dribbling	0 1 2 3
Urination frequent	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel evacuation	0 1 2 3
Leg nervousness at night	0 1 2 3

Category XV (Males Only)	
Decrease in libido	0 1 2 3
Decrease in spontaneous morning erections	0 1 2 3
Decrease in fullness of erections	0 1 2 3
Difficulty in maintaining morning erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decrease in physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional then in the past	0 1 2 3

Category XVI (Menstruation Females Only)	
Are you menopausal	0 1 2 3
Alternation menstrual cycle lengths	0 1 2 3
Extended menstrual cycle, greater than 32 days	0 1 2 3
Shortened menses, less than every 24 days	0 1 2 3
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne break outs	0 1 2 3

Category XVII (Menopausal Females Only)	
How many years have you been menopausal?	0 1 2 3
Do you ever have uterine bleeding since menopause?	0 1 2 3
Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Mood swings	0 1 2 3
Depression	0 1 2 3
Painful intercourse	0 1 2 3
Shrinking breast	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3
Increased vaginal pain, dryness or itching	0 1 2 3

PART III

How many alcohol beverages do you consume per week?_____

How many caffeinated beverages do you consume per day?_____

How many times do you eat out per week?_____

How many times a week do you eat raw nuts or seeds?_____

How many times a week do you eat fish?_____

How many times a week do you schedule for work outs?_____

List the three worst foods you eat during the average week?_____, _____, _____

List he three healthiest foods you eat during the average week?_____, _____, _____

Rate your stress levels on a scale of 1 - 10 during the average week._____

Welcome to our practice. Arianne Koven is a practitioner of Traditional Naturopathy. She is not a licensed physician, nor is she licensed as a naturopathic medical doctor who uses prescription drugs, invasive procedures, and allopathic treatments. The idea behind traditional naturopathy is outlined in the accompanying literature.

Dr. Koven has been practicing traditional naturopathy for 25 years. Her education and training consists of:

- Naturopathy
- Enzyme Therapy
- Nutrition
- Bio-Terrain Evaluation
- Nambudripad's Allergy Elimination Techniques
- Emotional Counseling

In order to receive her services, California state law requires that you acknowledge receipt of the information provided in this form and that you sign it. You will receive a copy. We will keep the original in our records for at least three years.

Her method of treatment, traditional naturopathy, is alternative or complementary to healing arts that are licensed by the State of California under Sections 2053.5 and 2053.6 of California's Business and Professions Code.

If you ever have any concerns about the nature of your treatment, please feel free to discuss them with Dr. Koven. We recommend that you inform your medical doctor that you are receiving traditional naturopathic services.

Acknowledgment and Consent to Receive Services:

I have read and understand the above disclosure about the naturopathic services offered by Arianne Koven and her education and training. I have discussed with Dr. Koven the nature of the services to be provided. I understand that Dr. Koven is not a licensed physician or a licensed naturopathic medical doctor who uses prescription drugs, invasive procedures, and allopathic treatments. Therefore, Dr. Koven's traditional naturopathic services are not licensed by the state. I understand it is my responsibility to maintain a relationship for myself/my child with a medical doctor. Any controversy or claim which cannot be amicably resolved between the parties shall be settled by binding arbitration in accordance with the Uniform Rules for Better Business Bureau Arbitration, and the judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. I have consented to use the services offered by Dr. Koven, and agree to be personally responsible for the fees in connection with the services provided to me.

Signed: _____
(Client/parent/conservator/guardian)

Date: _____

Indicate capacity to sign if other than client _____

WELLNESS & BIO-FEEDBACK CONSULTATION WAIVER

1. I fully understand that the attending technicians are not allopathic doctors (MD's) and do not portray themselves to be, but are wellness consultants and Bio-feedback technicians.
2. I fully understand the difference between the practice of allopathic medicine, nutritional wellness consulting, and Bio-feedback.
3. I fully understand that the services provided by the attending technicians are not allopathic, but are strictly behavioral or Bio-feedback in nature.
4. I fully understand that the attending technicians perform their services within the parameters of natural health care and wellness system using Bio-feedback and stress reduction.
5. I fully understand that the attending technicians do not offer allopathic drugs, surgery, chemical stimulants, radiation therapy, or any other conventional treatments. In addition they do not diagnose, treat or otherwise prescribe for my disease, conditions, or illness and that my wellness and stress parameters are being measured.
6. I have solicited the attending Bio-feedback technician's services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health.
7. If I desire any services not provided by the attending Bio-feedback technicians, which is my prerogative, I fully understand that I should seek them elsewhere. A referral for such services can be arranged.
8. I presently seek counsel, advice, opinions, Bio-feedback, or points of view and/or programs within the scope of attending technicians wellness and stress reduction practice. I am fully aware and release the Bio-feedback technician to do Bio-feedback tests and stress counseling reduction.
9. I fully understand that the services provided by the attending technicians are not generally accepted and/or recommended by allopathic doctors or other conventional health professionals. I realize that insurance payment is possible but unlikely.
10. By signing below I acknowledge that I have read and understand all parts of this waiver and that I had the opportunity to ask any questions with regard to such procedure.

Signature _____ Date _____

**When returning this form to my office please include a photograph of you by yourself (it can be recent or older) and sign your name on the back
Thank you!**

***We would appreciate a 24 hour cancellation notice of your intended appointment.
A missed appointment will incur a \$25 charge.***

These recommendations are for the reduction of stress only.
They are not intended as treatment or prescription for any disease, or as a substitute for medical care.