

# Duncan Macdonald, L.Ac., Origins Medicine

Phone: 415-902-0771

[www.originsmedicine.com](http://www.originsmedicine.com) [info@originsmedicine.com](mailto:info@originsmedicine.com)

**Dear Patient,**

**Welcome!** And thank you for choosing Duncan Macdonald, L.Ac. as one of your health care providers. **HOW THE PROCESS WORKS:**

**STEP 1:**

During your initial consultation Duncan Macdonald, L.Ac will review your health history and make recommendations for lab tests that are appropriate for your specific health issues.

**STEP 2:**

Once you have completed your lab tests, Duncan Macdonald, L.Ac will explain the meaning of your test results to you in a follow up consultation. He will create an individualized therapeutic program for you including diet changes, nutritional supplements, and exercise, lifestyle and stress management advice.

**STEP 3:**

Subsequent consults are scheduled to monitor your progress. **Duncan Macdonald, L.Ac. will also design an on-going wellness program to be reviewed and updated with our staff at no charge every six months.**

We invite you to contact us via email or phone should you have any questions during the course of your treatment. We may be reached at 415-819-5352 or 415-902-0771

We look forward to assisting you in achieving your current wellness goals, and to guiding you in maintaining wellness throughout your life.

In health,

Duncan Macdonald, L.Ac. and Staff

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## New Patient Paperwork

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Duncan Macdonald, L.Ac. to release my personal medical information to me.

Patient's Signature: _____			Date: _____	
Name:			Date:	
Address:			Country:	
City:		State:	Zip/Postal Code:	
Home Phone:	Work Phone:		Fax:	
E-mail:			Cell Phone:	
Please mark your preference for occasional follow up communication from our office: <input type="checkbox"/> Email <input type="checkbox"/> Phone				
Age:	Birth date:	Sex: M F Pronouns:	Status: M S W D	No. Children:
Occupation:		Employer:		Years Employed:
Spouse's Name:		Occupation:	Employer:	
Person responsible for this account:			Referred by:	
What is your major complaint?				
Other complaints?				
What are your overall health goals once your complaints are resolved?				
How long has it been since you really felt good?				

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Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Pressure (if known) \_\_\_\_\_ % Body Fat (if known) \_\_\_\_\_

1. Are you presently taking any medications, nutritional supplements or vitamins?  
\_\_\_\_\_ please list (attach sheet if necessary)

\_\_\_\_\_ 2. In the past, have you used birth control pills and/or antibiotics? \_\_\_\_\_ a. For how long? \_\_\_\_\_ 3. If you have fillings, please list material(s) used: \_\_\_\_\_ 4.

Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent Headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

5. How much sleep do you get each night on average? \_\_\_\_\_

6. Do you have any food allergies, sensitivities or restrictions

\_\_\_\_\_

\_\_\_\_\_

7. Do you smoke, drink alcohol or use recreational

drugs? \_\_\_\_\_

a. How much, how

often? \_\_\_\_\_

b. How often do you drink caffeinated

beverages? \_\_\_\_\_

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk,

etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Are there foods that you eat on a daily basis, almost daily

basis? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

a. Do you “miss” these foods if you do not eat them? \_\_\_\_\_

10. Write briefly about your weight gain/loss

history: \_\_\_\_\_

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits boredom b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or

obesity: \_\_\_\_\_  
\_\_\_\_\_

12. What methods have you tried to lose/gain

weight \_\_\_\_\_

13. How is your energy

level? \_\_\_\_\_

a. Are there times in the day that you feel

best? \_\_\_\_\_ worst? \_\_\_\_\_

14. Are you happy in your life right

now? \_\_\_\_\_

15. What are your main sources of

stress \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. How do you deal with your

stress? \_\_\_\_\_

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes \_\_\_\_\_ No \_\_\_\_\_

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes \_\_\_\_\_ No \_\_\_\_\_

c. I get tired and/or hungry in the mid-afternoon. Yes \_\_\_\_\_ No \_\_\_\_\_

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert.  
Yes \_\_\_\_\_ No \_\_\_\_\_

e. Now and then I think I am a secret eater. Yes \_\_\_\_\_ No \_\_\_\_\_

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes \_\_\_\_\_  
No \_\_\_\_\_

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes \_\_\_\_\_

No \_\_\_\_\_

h. I experience cravings for sugar, breads, pasta and baked goods. Yes \_\_\_\_\_ No \_\_\_\_\_

i. I feel shaky if I don't eat on time or if I don't snack. Yes \_\_\_\_\_ No \_\_\_\_\_

j. I often find myself irritable or angry. Yes \_\_\_\_\_ No \_\_\_\_\_

**18. Check off any of the following that have applied to you within the last 30 days:**

_____ Do you feel nauseous?	_____ Do you have abdominal/intestinal pain?
_____ Do you have bloating?	_____ Do you get bloated after meals?
_____ Do you get heartburn?	_____ Do you have diarrhea?
_____ Do you have constipation?	_____ Do you travel outside of the U.S.?
_____ Do you have gas?	_____ Are your stools compact/hard to pass?
_____ Do you belch following meals?	_____ Do you have gurgles in your stomach?
_____ Do your bowel movements alternate between constipation and diarrhea?	

**24. In your estimation, how physically fit are you right now?**

Unfit \_\_\_\_\_ Below average \_\_\_\_\_ Average \_\_\_\_\_ Above average \_\_\_\_\_ Very fit \_\_\_\_\_

25. How often do you exercise?

\_\_\_\_\_ a.

What is your

regimen? \_\_\_\_\_

26. If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

\_\_\_\_\_

**27. What are your fitness goals? (circle all that apply)**

_____ General fitness endurance _____	Muscle toning
---------------------------------------	---------------

_____ Weight loss/maintain weight	_____ Muscle strengthening
_____ Osteoporosis prevention	_____ Muscular coordination/balance
_____ Specific sport enhancement _____	Other _____ _____
_____ Flexibility	_____ _____

28. Surgeries, starting with most

recent: \_\_\_\_\_

29. Hospitalizations: \_\_\_\_\_

30. Briefly describe where you have lived since

childhood: \_\_\_\_\_

**32. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.**

Is your life:	Do you often:
Now Past Satisfactory	Now Past Feel depressed
Now Past Boring	Now Past Have anxiety
Now Past Demanding	Do you often:
Now Past Unsatisfactory	Now Past Have irrational fears
Do you worry over:	Now Past Feel upset
Now Past Home life	Now Past Feel things go wrong
Now Past Marriage	Now Past Feel shy
Now Past Children	Now Past Cry
Now Past Job	Now Past Feel inferior
Now Past Income	Have you:
Now Past Money problems	Now Past Seriously considered suicide
	Now Past Attempted suicide

## **POLICIES AND PROCEDURES**

(please retain pgs. 6 &7 for your records)

### **New Patients**

#### First Appointment

Your first consultation will be 45 minutes – 1 hour (\$375). During this time Duncan Macdonald, L.Ac. will determine the appropriate lab tests you should order to address your specific health concerns.

### **Fee Schedule**

New Patient consultation: \$375 (45 minutes - 1 hour)

1 hour: \$400

45 minutes: \$300

30 minutes: \$200

15 minutes: \$100

- Payment is due at time of consultation
- Methods of payment are: Visa, MasterCard or American Express.
- All consultations are timed from the time the appointment begins; you will only be billed for the actual time used.

### **Appointments**

- Follow-up consults may be scheduled in 15, 30, 45, or 60-minute blocks of time. • We encourage you to book your appointments 2 weeks in advance.
- As a courtesy to you, our office will text you to confirm your appointment one day in advance. You may also receive a reminder via email.

### **Lab Tests**

- The results of your lab test(s) will be sent to Duncan Macdonald, L.Ac. 2 to 4 weeks after mailing your specimens to the lab.
- Duncan Macdonald, L.Ac. will evaluate the results. After evaluation you will be contacted to schedule a follow-up appointment.

### **Cancellations**

- We reserve your appointment time for you. If you are unable to keep your scheduled appointment, you must notify our office a minimum of 24 hours before your scheduled time or you may be charged for that appointment.



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- No supplement returns will be accepted after 30 days on all regularly stocked items. Special orders CANNOT be returned!
- Prepaid tests can be returned for credit within one year of purchase.

## Important Notes

- Duncan Macdonald, L.Ac. is not a medical doctor; he does not service medical emergencies. **If you have a medical emergency, you must contact your primary care physician or dial 911!** • Please contact the office if you are not clear on any of our policies or procedures.

I \_\_\_\_\_ have read and understood  
**Duncan Macdonald, L.Ac.'s Policies and Procedures.**  
(please print name)

Date \_\_\_\_\_

Signature \_\_\_\_\_

Please complete this form if you would like us to share information about your progress with another person.



### Authorization to Release Medical Information




To: Duncan Macdonald, L.Ac.


Address: 3862 Piedmont Ave, Oakland, CA \_\_\_\_\_ I,

\_\_\_\_\_ request the following

information:

 Test results  History  Records  Diagnosis  Treatment   
 Reports  Progress

concerning my:  Accident  Injury  Illness

 Other \_\_\_\_\_

To be released to:

\_\_\_\_\_ (Name of  
Practitioner, Doctor, family member etc.)

Address:

\_\_\_\_\_

Fax: \_\_\_\_\_

For the purpose of:

\_\_\_\_\_ (Specify)

\_\_\_\_\_

According to Section 1795 of the California Health and Safety Code, these records must be provided within 15 days of receipt of this notice.

Signed: \_\_\_\_\_ Date:

\_\_\_\_\_  Patient  Spouse  Parent  Guardian