

Dr. Jafer, N.D. (USA), B.H.M.S. (India)
Holistic, Alternative & Integrative Healthcare
Naturopathy, Homeopathy, Ayurveda, Unani & Siddha
www.drjafer.com Cell: 310 689 6599, Ph/Fax: 470 7231 drjafernd@gmail.com, homnat2@yahoo.com

Patient Information

Name: _____ **Gender:** _____

Date of Birth: _____ **Social Security Number:** _____

Circle One: Minor Single Married/Partnered Divorced Widowed

Name of Parent/Guardian (if minor): _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone:() _____ **Work Phone:**() _____

Patient or Parent's Employer: _____

E-mail Address: _____

Emergency Contact: _____ **Phone:**() _____

How did you hear about me? _____

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Patient Health History – First Office Visit

Today's Date: _____
Name: _____ Gender: _____ Date of Birth: _____
Occupation: _____
Marital Status (please circle): Single Married/Partnered Divorced Widowed
Do you have children? _____ Ages: _____

Please list your present health concerns in order of importance:

- 1) _____ Date of onset: _____
- 2) _____ Date of onset: _____
- 3) _____ Date of onset: _____
- 4) _____ Date of onset: _____
- 5) _____ Date of onset: _____

Is there any other information regarding your health which you would like to add? _____

What other health care are you presently receiving? _____

When was your last physical exam? _____ Name of Doctor: _____

Have you been vaccinated? _____

Please list any surgeries or hospitalizations including dates: _____

Please briefly describe all serious accidents, severe injuries, head injuries, and broken bones including dates: _____

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Please list all prescription and over the counter medications you are currently taking, including dosages: _____

Please list all nutritional and herbal supplements you are currently taking including dosages: _____

Please list any known allergies (food, chemical, environmental, pharmaceutical):

Are any of them life-threatening? _____ If so, which one(s)? _____

Lifestyle

Smoking (type and amount per day)? _____

If former smoker, date quit _____

Alcohol (type and amount per week)? _____

If former drinker, date quit _____

Caffeine (type and amount per week)? _____

Recreational drugs (type and amount per week)? _____

How much sleep do you get per night? _____

Quality of sleep? _____

Exercise (type and amount per week)? _____

Stress level? (check one) _____ None _____ Mild _____ Moderate _____ Severe

Do you enjoy your work? _____

Do you always wear a seat belt while in a vehicle? _____

Do you always wear a helmet while on a bicycle or motorcycle? _____

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Are you sexually involved with _____ men _____ women _____ both? Do you always practice safe sex? _____

Primary emotional state/mood? _____

Family Health History

Please mark with the appropriate letter if any of your blood relatives have had any of the following conditions:

(M=mother, F=father, S=sibling, G=grandparent, C=child)

- | | |
|---|--------------------------|
| ____ Allergies | ____ Hayfever |
| ____ Anemia | ____ Hemophilia |
| ____ Arthritis | ____ High blood pressure |
| ____ Asthma | ____ High cholesterol |
| ____ Cancer | ____ Kidney disease |
| ____ Depression | ____ Migraines |
| ____ Diabetes | ____ Obesity |
| ____ Drug or alcohol problem | ____ Psoriasis |
| ____ Eczema | ____ Stroke/Heart Attack |
| ____ Epilepsy | ____ Skin disorders |
| ____ Glaucoma | ____ Syphilis |
| ____ Gonorrhea | ____ Thyroid Disease |
| ____ Gout | ____ Tuberculosis |
| ____ Other disease (please list): _____ | |

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Past Medical History

Do you know of any chemical exposure, past or present, to any of the following toxic substances:

Mercury Lead Arsenic Herbicides/Pesticides
Formaldehyde _____Other

Please check spaces for conditions that you have been diagnosed:

<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Chickenpox
<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Migraines	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Bladder infections
<input type="checkbox"/> Hernia	<input type="checkbox"/> Back/Neck Pain	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Hives or Eczema	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Infectious Mono
<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Bleeding disorders
<input type="checkbox"/> Whooping cough	<input type="checkbox"/> Strep throat	<input type="checkbox"/> STD's
<input type="checkbox"/> Polio	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> IBS	<input type="checkbox"/> Lupus	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Other disease (please list): _____		

Consent for Complementary and Alternative Services

California law requires that this information be provided and that the person receiving the information acknowledge receipt of that information, before services in complementary and alternative healthcare are provided. This document provides important information regarding the services being provided and should be carefully reviewed. You should ask any questions before signing this document.

Our Philosophy

Dr Jafer is dedicated to assisting patients in attaining a vibrant level of health and well-being in their lives by providing quality alternative & holistic healthcare to the entire family. We are dedicated to the following principles of Naturopathic Medicine:

- To find and treat the cause of illness and not only want alleviation of symptoms.
- To treat the whole person, not isolated body parts or systems.
- To regard the client as a unique and incredible individual.
- To use natural therapies to help the body restore itself to a state of healthy balance.
- To value the role of mind, emotions and spirit in creating good health.
- To encourage the client's full and active participation in their health.
- To identify and support behaviors that create the kind of life the client wants.
- To take all the time needed to fully understand the client's life story, concerns and goals.
- To recognize that dietary & lifestyle behaviors are key to healing the whole person.

Educational History

Dr. Jafer, N.D. (USA), B.H.M.S. (India)

Jafer's full name is Mohammed "Jafer" A. Gulam-Hussain. He is a Naturopathic & Homeopathic doctor with a specialty in Ayurveda, Unani & Siddha with training and experience since 1988. He has two doctorate degrees, one in Naturopathic Medicine (N.D.) from Bastyr University (www.bastyr.edu), a 4-year post-graduate program in naturopathic medicine, in the USA, and the other in Homeopathic Medicine (B.H.M.S.) from Father Muller's Homeopathic Medical College and Hospital, a 5 ½-year homeopathic medical program in India.

What is a Naturopathic Doctor and what does their training entail?

Naturopathic doctors are distinct from acupuncturists, chiropractors or medical doctors. They are uniquely trained to find and treat the true cause of illness. The Naturopathic approach provides the best possible care by addressing the physical, mental, emotional, and spiritual well-being of each individual.

A Naturopathic doctor has completed a 4-5 year intensive, postgraduate, didactic program at an accredited naturopathic college. This training includes 2-3 years of clinical training where the student manages patients under the supervision of an experienced, licensed physician. Entrance is highly competitive and requires the completion of a 4-year undergraduate degree at an accredited college or university that includes all premedical prerequisites. Currently, there are only few accredited Naturopathic institutions in the United States. To learn more about the field of Naturopathic Medicine or to research the colleges, please visit the American Association of Naturopathic Physicians at www.naturopathic.org. To learn more about our specific college, please visit Bastyr University at www.bastyr.edu.

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Licensure

Naturopathic doctors are licensed in several states and act as primary care practitioners, under the law. In California, the law to license Naturopathic doctors as primary care doctors (SB 907) went into effect on January 1, 2004. The licensure of Naturopathic doctors should be in full effect soon. This does not, in any way, limit us from the treatment of any specific disease. **Dr. Jafer is currently practicing legally (under the Medical Practice Act & the provisions provided by SB 577) as a Naturopathic Health Practitioner in the State of California until state licensure is secured.** To learn more about licensing efforts in the State of California, please visit our state association websites at www.canp.org and www.naturopathicmedicinnow.com.

Services Provided

Naturopathic Medicine	Mind/Body Medicine
Homeopathic Medicine	Nutritional Supplements
Ayurvedic Medicine	Diet Therapy
Unani Medicine	Cell Salt Therapy
Siddha Medicine	Anti-Aging Consultation
Counseling & Lifestyle Modification	Natural Health Consultation

I, _____ (Client’s Name), consent to naturopathic and/or homeopathic (complementary & alternative / holistic) care based on the theories described above and provided by Dr. Mohammed “Jafer” Gulam-Hussain, ND, BHMS. I understand and acknowledge that:

1. Jafer is not a licensed physician in the State of California.
2. The treatment offered is alternative or complementary to services that are licensed by the State of California.
3. The services offered are not licensed by the State of California.
4. I have received written information regarding the nature of services to be offered and the theory of treatment upon which the services offered are based.
5. I have received written information regarding the provider’s education, training, experience and qualifications to provide the services described above.

I have received and read all of the information described above. In addition, I have had an opportunity to discuss the above services with my provider. I understand that at any time I can discontinue treatment or ask additional questions regarding the services. These disclosures will remain on file with the provider for three years.

Client’s Signature

Date

Client’s Printed Name: _____

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CLIENT FEES & PAYMENT POLICIES

We make every effort to minimize the cost of your medical care. Full payment is required at the time of service. We accept payment by cash or check only. Checks or charges that are denied for lack of funds will incur a fee of \$35.00 per transaction. Prices & fees subject to change.⁵¹ We are committed to providing economical, quality health care. Thank you for your patronage.

Consultations

First Office Call (FOC):	\$200.00	60 minutes
Return Office Call (ROC):	\$100.00	30 minutes

Telephone Consultations / House Calls

Telephone consultations are available for patients who have had a prior, in-person, FOC. ROC fees apply to all telephone consultations. House calls are also available for patients who are physically unable to come to the clinic. Standard office visit fees apply plus travel time and expenses. After hours emergency phone calls will be billed a \$50.00 minimum charge.

Cancellation Policies

Appointments cancelled with greater than 24 hours notice will incur no charge. There will be a \$50.00 fee for appointments cancelled with less than 24 hours notice. A full office visit fee will be charged for failure to provide any notice of cancellation.

I agree to payment according to the policies provided above.

Client Signature

Date

Client's Printed Name