



TRUE ABUNDANCE HEALTH SERVICES  
 DR. SAM SCHIKOWITZ ND. LAC  
 WWW.TRUEABUNDANCEHEALTH.COM  
 (845) 594-6822



## Adult Health Profile

Please answer all questions honestly and with the intent of providing as thorough a picture as possible of your health history.

This form is confidential. This information cannot and will not be given to anyone outside this clinic without your written permission!

Successful health care and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, emotionally, and spiritually. However, if any of these questions are difficult to answer or talk about, please let Dr. Schikowitz know.

The nature of your responses to the following questions will go a long way in assisting my understanding of you. *Your time, thoughtfulness and honesty are greatly appreciated!*

Name: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ How late can you be called? \_\_\_\_\_

Email Address: \_\_\_\_\_ Website: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Blood Type: \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_

Race or ethnic background: \_\_\_\_\_

Education \_\_\_\_\_ Occupation \_\_\_\_\_  Retired

Employer \_\_\_\_\_ Hours per week \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

Has any other family member already been a patient at the clinic? \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

Current Health Care Provider(s):	Type:	Phone:	Fax:
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____

Have you ever consulted:  Naturopathic Physicians  Acupuncturists  Chiropractors  Nutritionists  
 Other \_\_\_\_\_

Describe your ideal doctor or healthcare provider: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

What long term expectations do you have from working with our clinic?

List your major health concerns in order of importance:                      Duration:                      Severity (1 to 10)

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

How did these conditions develop? Are there traumatic events that you can identify as having caused or clearly aggravated your health problems? What happened in your life around this time?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### MEDICATIONS:

Do you take or use the following?

Laxatives	Y N	Cortisol	Y N	Tranquilizers	Y N
Pain relievers	Y N	Antibiotics	Y N	Thyroid medications	Y N
Antacids	Y N	Appetite suppressants	Y N	Sleeping aids	Y N

List all the drugs (prescription and on-prescription pharmaceuticals) including dosages.

1.	_____	6.	_____
2.	_____	7.	_____
3.	_____	8.	_____
4.	_____	9.	_____
5.	_____	10.	_____

Are you sensitive/allergic to any drugs, foods, chemicals, animals, environmental substances?  Yes     No

If yes, please list: \_\_\_\_\_

What happens when you have an "allergy attack"? \_\_\_\_\_

What prior types of allergy testing have you had?: \_\_\_\_\_

### CURRENT SUPPLEMENTS:

List all vitamins, minerals, herbs, homeopathics, with dosages:

1.	_____	6.	_____
2.	_____	7.	_____
3.	_____	8.	_____
4.	_____	9.	_____
5.	_____	10.	_____

## CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from this visit to our clinic?

What long-term expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0%    0    1    2    3    4    5    6    7    8    9    10    100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive?

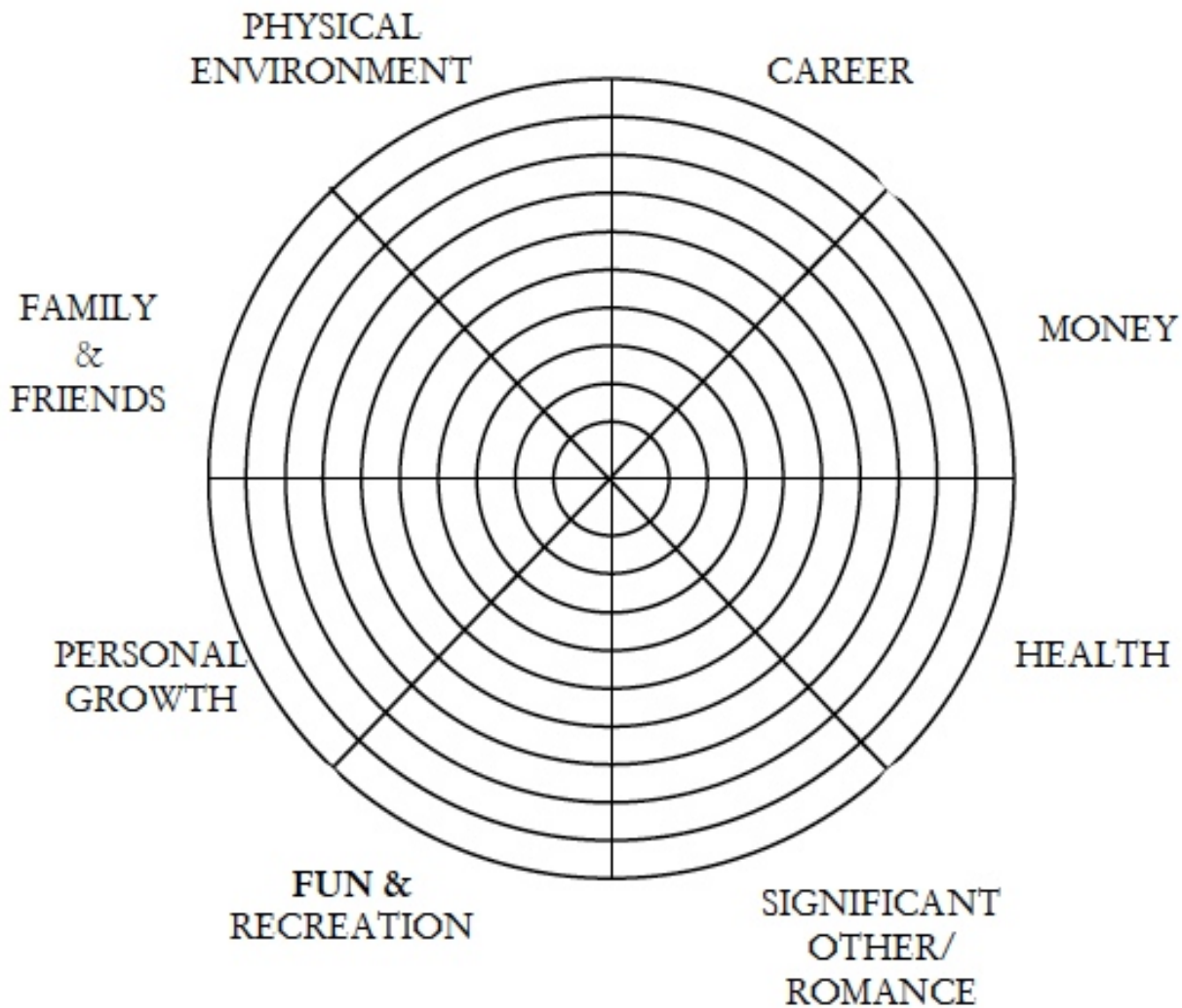
What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and adhering to the therapeutic protocols that we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

## WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you. For example, if you are 60% satisfied in your career, shade the first six levels of the career slice. Do the same for each area, starting from the center point radiating outward.



## PAST MEDICAL HISTORY

### Your Prenatal/birth/feeding history:

Describe your mother's pregnancy with you: Natural Forceps Epidural C-section Trauma

Breast fed? \_\_\_\_\_ how long? \_\_\_\_\_ Formula (kind): \_\_\_\_\_ how long? \_\_\_\_\_

### What childhood illnesses have you had?

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Rubella (German 3 day measles) | <input type="checkbox"/> Measles (2 week) | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Chickenpox    |
| <input type="checkbox"/> Whooping Cough                 | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Polio          | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Roseola                        | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Thrush         | <input type="checkbox"/> Epilepsy      |
| <input type="checkbox"/> Mononucleosis                  | <input type="checkbox"/> Strep Throat     | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Colic         |
| <input type="checkbox"/> Rashes/cradle cap              | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Jaundice       | <input type="checkbox"/> Headaches     |

### Immunizations: Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria

Hepatitis B chicken pox H. influenzae Flu shot Other (for travel) \_\_\_\_\_

### Major Illnesses/emotional or physical trauma/ accidents (not already listed):

Type:	Date:	Treatment received:	Outcome:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Outpatient Procedures / Hospitalizations, surgeries/ special diagnostic studies:

Type (of surgery/study)	Date	Reason for procedure/ admission	Outcome / Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Recent physical exam: Date \_\_\_\_\_ Results: \_\_\_\_\_ normal
- Recent blood work/ urine test: Date \_\_\_\_\_ Results: \_\_\_\_\_ normal
- Recent PAP/ pelvic or prostate exam: Date \_\_\_\_\_ Results: \_\_\_\_\_ normal
- Recent mammogram (females over 40):Date \_\_\_\_\_ Results: \_\_\_\_\_ normal

### LIFESTYLE:

Are you currently: Single Married Partnership Separated Divorced Widowed

Live with: Spouse Partner Parents Children Friends Alone

Are you sexually active? (circle one) Yes No If yes, is it with (circle one): **male** **female** **both**

Do you or your partner(s) use any form of contraception? Yes No If so, what type(s)? \_\_\_\_\_

Are you pregnant? Yes No Trying to get pregnant? Yes No If so, how far along? \_\_\_\_\_

Do you have children? Yes No How many? \_\_\_\_\_ Names/ ages/ and health or wellness issues:

\_\_\_\_\_

\_\_\_\_\_

## PERSONAL

How would you describe your general health? \_\_\_\_\_  
Are you happy in your job or career? Yes No \_\_\_\_\_  
What personal goals do you have? \_\_\_\_\_  
What makes you happy? \_\_\_\_\_  
What are you grateful for? \_\_\_\_\_  
What is your individual & unique purpose in this life? \_\_\_\_\_  
Religious/spiritual affiliation \_\_\_\_\_  
What would you like to change most about your life? \_\_\_\_\_

What behaviors, habits, or thoughts would you like to eliminate? \_\_\_\_\_

Is your present sex life satisfactory? \_\_\_\_\_  
Do you drink alcohol?  Yes  No How often?: wine \_\_\_\_\_ beer \_\_\_\_\_ other alcohol \_\_\_\_\_  
Do you use tobacco or have you in the past?  No  Yes, How long? \_\_\_\_\_ how much daily? \_\_\_\_\_  
Do you now or have you in the past used recreational drugs?  Yes  No \_\_\_\_\_  
Have you ever been exposed to toxic chemicals, solvents or other possible harmful toxins?  Yes  No  
If yes, please explain \_\_\_\_\_

Do you exercise?  Yes  No What form(s)? \_\_\_\_\_

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

Do you make time for rest, relaxation or meditation during the day and/or before bed?  Yes  No

How often? \_\_\_\_\_ How do you relax? \_\_\_\_\_

What are your interests or hobbies? \_\_\_\_\_

Which of the following do you do regularly:  Jogging  Swimming  Walking  Biking  Gardening  
 Yoga  Breathing Exercises  Meditation  Weightlifting  Pilates  Pray  
 Other activities: \_\_\_\_\_

Do you use regularly?  Chemical hair treatments  Electric blanket  Heating pad  Cosmetics, perfumes

Are your home and/or work environments well ventilated?  Yes  No Mold?  Yes  No

Are there unusual/unpleasant smells in your work/living environment?  Yes  No

When were the ducts in your home last cleaned? \_\_\_\_\_

## DIET:

How many meals do you generally eat each day?  One  Two  Three  More than three

Do you: \_\_\_ eat out often \_\_\_ diet frequently \_\_\_ skip meals frequently

Do you have any special diet or eating restrictions?  Yes  No if yes, please explain \_\_\_\_\_

List the primary foods you include in your diet? \_\_\_\_\_

List the foods you exclude from your diet \_\_\_\_\_

Mark which of these you consume regularly.  Coffee  Caffeinated teas  Artificial sweeteners

Processed foods  Preservatives  Refined foods  Margarine  Fast Food  Sugar/sweets

List any other foods you eat which you suspect may be harmful to your health \_\_\_\_\_

List any foods you crave, regardless of their nutritional value (include sweets, chocolate, bread, salty, sour, rich, fatty foods, etc.) \_\_\_\_\_

List any foods to which you have a bad reaction: \_\_\_\_\_

Are you thirsty often?  Yes  No at night?  Yes  No How much water do you drink daily? \_\_\_\_\_

What temperature do you prefer to drink?  Hot  Cold  Room Temp.

Are you satisfied with your diet as it is now?  Yes  No If no, why not? \_\_\_\_\_

### SLEEP:

Do you have trouble falling asleep? Yes No If yes, what keeps you up? \_\_\_\_\_

Do you wake at night and can't fall back to sleep? Yes No \_\_\_\_\_

Do you wake feeling refreshed? Yes No \_\_\_\_\_

Do you have recurring dreams? Yes No If yes, what is the theme? \_\_\_\_\_

### FAMILY MEDICAL HISTORY:

*(Please list ages and if deceased, what they passed from and at what age)*

Mother's Side

Father's Side

Grandfather \_\_\_\_\_

Grandfather \_\_\_\_\_

Grandmother \_\_\_\_\_

Grandmother \_\_\_\_\_

Mother \_\_\_\_\_

Father \_\_\_\_\_

Your Sisters \_\_\_\_\_

Your Brothers \_\_\_\_\_

*Has any BLOOD RELATIVE had any of the following:*

Anemia

Kidney Disease

Arthritis

Heart Disease

Mental Illness ( )

Autoimmune Condition

Asthma/Hay Fever/Hives

High Blood Pressure

Alzheimers

Bleeding Disorder

Seizure/Epilepsy

Alcoholism/Addiction

Cancer

Sickle Cell/Thalassemia

Obesity

Diabetes

High Cholesterol

Osteoporosis

Thyroid (hyper/hypo)

Liver Disease

Glaucoma

Eczema

Tuberculosis (TB)

Stroke

Other \_\_\_\_\_

Other \_\_\_\_\_

Other \_\_\_\_\_

### GENERAL STATUS

Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs. Ideal Weight \_\_\_\_\_

Weight 1 year ago \_\_\_\_\_ lbs. Max. Weight \_\_\_\_\_ When \_\_\_\_\_

When during the day is your energy the best? \_\_\_\_\_ Worst? \_\_\_\_\_

Listed below are factors which may or may not influence your state of being. Please check the appropriate box of ONLY those with SIGNIFICANT influence on your health.

BETTER WORSE

BETTER WORSE

Winter

Spring

Summer

Autumn

Cold

Heat

Dampness

Dryness

Open air (being outside)

Windows closed

Change of weather

Traveling

Ocean seashore

Mountains

Physical exertion

Upon rising

Morning

Evening

Cold application

Warm application

Bath

Before menstruation

During menstruation

After menstruation

Other things that make you significantly better or worse: \_\_\_\_\_

FOR THE FOLLOWING, PLEASE CIRCLE:

**Y**=yes/condition you have now    **N**=no/never had    **P**= problem in the past  
**S**=sometimes a problem now

<b>GENERAL</b>			
Do you sleep well?	Y N P S	Do you enjoy your work?	Y N P S
Average 6-8 hours?	Y N P S	Take vacations?	Y N P S
Awake rested?	Y N P S	Spend time outside?	Y N P S
Have a support system?	Y N P S	Eat three meals a day?	Y N P S
Have a history of abuse?	Y N P S	Do you go on diets often?	Y N P S
Experience a major trauma?	Y N P S	Do you eat out often?	Y N P S
Use recreational drugs?	Y N P S	Do you drink coffee?	Y N P S
Treated for any addictions?	Y N P S	Drink black/green tea?	Y N P S
Use alcoholic beverages?	Y N P S	Drink soda?	Y N P S
Use tobacco?	Y N P S	Do you eat refined sugar?	Y N P S
How many years? _____		Do you salt your food?	Y N P S
How much per day? _____			

<b>NEUROLOGIC</b>			
Seizures?	Y N P S	Paralysis?	Y N P S
Muscle weakness?	Y N P S	Numbness or tingling?	Y N P S
Loss of memory?	Y N P S	Easily stressed?	Y N P S
NEUROLOGIC CONT.			
Vertigo or dizziness?	Y N P S	Loss of balance?	Y N P S

<b>ENDOCRINE</b>			
Hypothyroid?	Y N P S	Hyperthyroid?	Y N P S
Hypoglycemia?	Y N P S	Diabetes?	Y N P S
Excessive thirst?	Y N P S	Excessive hunger?	Y N P S
Fatigue?	Y N P S	Seasonal depression?	Y N P S
Heat or cold intolerance?	Y N P S	Difficulty exercising?	Y N P S

<b>IMMUNE</b>			
Reactions to immunizations?	Y N P S	Chronic fatigue syndrome?	Y N P S
Chronically swollen glands?	Y N P S	Chronic infections?	Y N P S
Slow wound healing?	Y N P S	Night sweats?	Y N P S

<b>EARS</b>			
Impaired hearing?	Y N P S	Dizziness?	Y N P S
Ringing in ears?	Y N P S	Ear aches?	Y N P S

<b>EYES</b>			
Impaired vision?	Y N P S	Color blindness?	Y N P S
Cataracts?	Y N P S	Tearing or dryness?	Y N P S
Glaucoma?	Y N P S	Eye pain or strain?	Y N P S
Spots in vision?	Y N P S		

<b>HEAD</b>			
Headaches?	Y N P S	Head injury?	Y N P S
Migraines?	Y N P S	Jaw or TMJ problems?	Y N P S

**NOSE AND SINUS**

Frequent colds?	Y N P S	Nose bleeds?	Y N P S
Stuffiness?	Y N P S	Hayfever?	Y N P S
Sinus problems?	Y N P S	Loss of smell?	Y N P S

**NECK**

Lumps in neck?	Y N P S	Difficulty swallowing?	Y N P S
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**MOUTH AND THROAT**

Frequent sore throat?	Y N P S	Jaw clicks?	Y N P S
Copious saliva?	Y N P S	Teeth grinding?	Y N P S
Sore tongue or lips?	Y N P S	Gum problems?	Y N P S
Hoarseness?	Y N P S	Dental cavities?	Y N P S

**SKIN**

Rashes?	Y N P S	Eczema or hives?	Y N P S
Acne/boils?	Y N P S	Itching?	Y N P S
Change in skin color?	Y N P S	Perpetual hair loss?	Y N P S
Lumps or bumps on skin?	Y N P S		

**RESPIRATORY**

Cough?	Y N P S	Shortness of breath?	Y N P S
Sputum?	Y N P S	Shortness of breath when lying down?	Y N P S
Asthma?	Y N P S		
Wheezing?	Y N P S	Pain in breathing?	Y N P S
Bronchitis?	Y N P S	Emphysema?	Y N P S
Coughing up blood?	Y N P S	Tuberculosis?	Y N P S

**GASTROINTESTINAL**

Trouble swallowing?	Y N P S	Pancreatitis?	Y N P S
Change in thirst?	Y N P S	Heartburn?	Y N P S
Change in appetite?	Y N P S	Abdominal pain?	Y N P S
Nausea/vomiting?	Y N P S	Belching or passing gas?	Y N P S
Ulcer?	Y N P S	Constipation?	Y N P S
Jaundice?	Y N P S	Bowel movements: how often? -----	Y N P S
Gall bladder disease?	Y N P S	Is this a change?	Y N P S
Liver disease?	Y N P S	Black stools?	Y N P S
Hemorrhoids?	Y N P S	Blood in stools?	Y N P S
Goiter?	Y N P S	Pain or stiffness in neck?	Y N P S

**MENTAL/EMOTIONAL**

Treated for any problem?	Y N P S	Considered suicide?	Y N P S
Depression?	Y N P S	Attempted suicide?	Y N P S
Anxiety or nervousness?	Y N P S	Tension?	Y N P S
Poor concentration?	Y N P S	Memory problems?	Y N P S
Do you have mood swings?	Y N P S		

**URINARY**

Increased frequency of urination?	Y N P S	Frequency at night?	Y N P S
Inability to hold urine?	Y N P S	Frequent UTI's?	Y N P S
Pain in urination?	Y N P S	Kidney stones?	Y N P S

**MUSCULOSKELETAL**

Joint pain or stiffness?	Y N P S	Weakness?	Y N P S
Arthritis?	Y N P S	Muscle spasms or cramps?	Y N P S
Broken bones?	Y N P S	Sciatica?	Y N P S

**BLOOD**

Anemia?	Y N P S	Deep leg pain?	Y N P S
Easy bleeding or bruising?	Y N P S	Thrombophlebitis?	Y N P S
Cold hands/feet?	Y N P S	Varicose veins?	Y N P S

**MALE REPRODUCTIVE**

Are you sexually active?	Y N P S	Syphilis?	Y N P S
Sexual orientation:_____		Hernias?	Y N P S
Discharge or sores?	Y N P S	Testicular masses?	Y N P S
Chlamydia?	Y N P S	Testicular pain?	Y N P S
Gonorrhea?	Y N P S	Prostate disease?	Y N P S
Genital warts?	Y N P S	Impotence?	Y N P S
Herpes?	Y N P S	Premature ejaculation?	Y N P S

**FEMALE REPRODUCTIVE**

Age of first menses:_____		Are you sexually active?	Y N P S
Age of last menses _____		Sexual orientation:_____	
Length of cycle: _____days		Birth control?	Y N P S
Duration of menses: _____ days		Type: _____.	
Are your cycles regular?	Y N P S	Gonorrhea?	Y N P S
Painful menses?	Y N P S	Herpes?	Y N P S
Heavy or excessive flow?	Y N P S	Chlamydia?	Y N P S
PMS?	Y N P S	Genital warts?	Y N P S
Symptoms:_____	Y N P S	Syphilis?	Y N P S
_____		Difficulty conceiving?	Y N P S
_____		Number of pregnancies:_____	
Bleeding between cycles?	Y N P S	Number of live births:_____	
Clotting?	Y N P S	Number of miscarriages:_____	
Endometriosis?	Y N P S	Number of abortions:_____	
Ovarian cysts?	Y N P S	Do self-breast exams?	Y N P S
Vaginal odor?	Y N P S	Breast pain/tenderness?	Y N P S
Vaginal discharge?	Y N P S	Breast lumps?	Y N P S
Date of last pap:___/___/___		Nipple discharge?	Y N P S
Abnormal PAP?	Y N P S	Menopausal symptoms?	Y N P S
Cervical dysplasia?	Y N P S	Pain during intercourse?	Y N P S

# **E-Mail Authorization and Consent Agreement Between Dr. Sam Schikowitz and You, the Patient:**

I have been advised that:

- E-mail is never, ever appropriate for urgent or emergency problems.
- E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
- E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee. There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.
- All e-mail correspondence will become a part of my medical record.  
It is extremely important to include my name on each and every e-mail sent to Dr. Schikowitz's Clinic.

Since e-mail may not be monitored while my clinician is away on business or on vacation, I will follow-up by telephone or in person if I do not receive a response within a week.

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.

I have been provided with information about the use of Internet e-mail communications between my health provider, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at any time by contacting my clinician.

I designate that all e-mail correspondence coming from me or to me should be sent to the Internet e-mail address listed below.

E-mail address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Printed Name of Clinician: Dr. Sam Schikowitz, ND LAc

Signature of Clinician: \_\_\_\_\_

**DR. SAM SCHIKOWITZ MS, ND, LAC**

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**Information about the services provided by Sam Schikowitz, ND LAc.**

Sam Schikowitz, ND LAc, is licensed as a Naturopathic Physician in Connecticut State and a Licensed Acupuncturist in New York State. He received Bachelor's Degrees in Biology and Pre-Medicine from UC Santa Cruz. He received a 3 ½-year Masters of Science in Acupuncture and Oriental Medicine degree and a 5-year doctorate degree as a Doctor of Naturopathic Medicine from a fully accredited Naturopathic Medical and Acupuncture School, Bastyr University, in Seattle Washington.

New York State does not yet license Naturopathic Physicians to practice medicine. The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition. Sam Schikowitz, ND LAc does not practice medicine in the state of New York. He functions solely as a licensed acupuncturist and health consultant and focuses his practice of the enhancement of health. I understand that nothing that is said or done in his office, or in any other setting is meant for the diagnosis and/or treatment of any medical condition(s) or disease, and that he uses his education and experience to give suggestions. I agree to the physical contact necessary for assessment my case and that I make decisions that are right for you about whether to use Dr. Schikowitz's suggestions. Furthermore, his services are not meant to replace or to be a substitute for those of a licensed medical practitioner. He advises that you seek the concurrent care of a health care provider licensed in New York State.

We may discuss substances that have not been subject to double blind clinical studies or FDA approval or regulation. You assume the responsibility for the decision to take any natural remedy. If you feel you are having any adverse reaction then stop taking all supplements immediately. If you are pregnant or nursing, confirm the safety of any supplements with your obstetrician or pediatrician. Recognize that, as an effect of the suggestions provided by Sam Schikowitz, ND LAc, the signs and symptoms of your medical condition(s) may diminish or disappear.

**I have read and understand the information provided. I agree to the services provided by Sam Schikowitz, ND LAc, and attest that I am not requesting an appointment for the purpose of collecting information on methods of practice at his clinic.**

Full Name Printed \_\_\_\_\_

Full Name Signed \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**DR. SAM SCHIKOWITZ MS, ND, LAC**

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**This form is your authorization that allows Dr. Sam Schikowitz to perform specific procedures as necessary to facilitate your evaluation and therapy:**

**Procedures**

**General Evaluation Procedures** - General physical inspection, including tongue examination, pulse taking, and other physical assessments.

**Lifestyle Counseling, and Exercise Prescription.**

**Herbs/Natural Medicines** – Prescription of various therapeutic substances including plants, minerals, and animal materials. Substances may be given in the form of tea, pills, powders, tinctures which may contain alcohol, topical creams, pastes, plasters, washes, suppositories, or other forms. Homeopathic remedies often highly dilute quantities of naturally occurring substances may also be used.

**Dietary Advice and Therapeutic Nutrition** – The use of foods, diet plans, or nutritional supplements for therapies

**Soft Tissue and Osseous Techniques** – The use of bodywork, traction, neuro-muscular techniques, muscle manipulation, craniosacral therapy, tui-na, and movement of spine and extremities.

**Electromagnetic and Thermal Therapies** – Includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, infrared and ultraviolet therapies, and hydrotherapies.

**Acupuncture** – Insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body to adjust the flow of energy through meridian systems

**Traditional Oriental Techniques: Cupping** – a technique used to relieve symptoms in which cups made of glass, plastic, or bamboo are placed on the skin with a vacuum created by heat or other device, **Gua Sha** - rubbing on an area of the body with blunt, round instrument, **Moxa** – indirect or direct burning on acupoint using stick or ball of moxa to relieve symptoms, **Bleeding** – insertion of sterilized needles to acupoints to relieve symptoms.

**Potential Risks and Benefits**

**Potential risks:** Discomfort, pain, infection, discoloration, or burns from needle insertions, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapy; allergic reactions, nausea, loose bowel movements, and abdominal cramping from prescribed herbs or supplements or dietary advice; and soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

**Potential benefits:** Restoration of health and the body’s maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progress.

**Notice to Pregnant Woman:** All female patients must alert the practitioner if they know or suspect that they are pregnant or are trying to become pregnant. Some of the therapies could present a risk to the pregnancy. We do not use labor-stimulating acupuncture points or any labor-inducing substances unless the therapy is specifically for the induction of labor. A therapy intended to induce labor requires a letter from a primary care provider authorizing or recommending such a therapy.

**I recognize the potential risks and benefits of these procedures as described above,** and I understand that I may ask questions regarding my therapy before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures realizing that no guarantees have been given to me by the clinic or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

Patient’s Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian/Representative(Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_