Lansing, MI 48917
Fax: (517) 319-5872
Ph: (517) 319-5818
800-888-7284
www.gileadhealingcenter.org

DISCLOSURE STATEMENT

Dr. Lauchlin MacGregor, ND, is a doctor of traditional naturopathy who focuses on the whole person (body, mind, and spirit) to establish life balance and to promote optimal wellness. Dr. Lauchlin does not diagnose or treat disease, but rather identifies obstacles that block vibrant health and suggests lifestyle changes that encourage the natural healing process. He is not a medical doctor, and his services are not intended to replace the necessary services of a licensed physician. Conventional medical authorities do not license doctors of traditional naturopathy.

Dr. Lauchlin MacGregor is also a certified nutritionist and communicates a unique blend of conventional and traditional medical wisdom.

I, _____have read this disclosure statement and understand the limitations of these services.

I assume full responsibility for the decision to seek these services for:(check one)

____Myself, or
____My legal ward:_____.
(Please print your child or ward's name)

Signature:_____.

Date:_____

Name _____ Date of Birth _____

- What is your chief complaint? _____

  _____

- Other Complaints? _____

  _____

  _____

  _____

- Have you experienced these or similar conditions in the past? _____
- List previous treatments you have had: _____

  _____

  _____

- List activities that aggravate your symptoms: _____

  _____

  Is this condition interfering with your: Daily routine? _____ Work? _____
  Sleep? _____ Other? _____

- List all surgeries you have had and the dates (prosthesis or medical devices; pacemakers, etc): _____

  _____

  _____

- List all surgical/anesthesia complications: _____

  _____

- List all infections, viruses, and inflammations: _____

  _____

- List all chronic illness you have (such as Diabetes, Glucoma, Hypertension or High B/P)

  _____

  _____

Patient Name_____-

- List any allergies to food or medication: _____

_____

_____

- List all Prescription drugs you are on or have recently taken:

Name ***Strength*** ***How Taken***

_____

_____

_____

_____

_____

_____

- List all non– prescription drugs, vitamins, herbs or nutritional supplements you are taking:_____

_____

_____

_____

_____

_____

- **FEMALE CODE**

_____Age period began
_____How many days do periods last
_____Bleed or spot between
_____Pain or cramps
_____Date of last period
_____ Date of last pap smear
_____Date of last mammogram
_____Itching in vaginal area
_____Pain with intercourse
_____Type of birth control
_____Number of pregnancies
_____Number of full term pregnancies
____Number pf preterm births

MALE CODE

____Discharge from penis
____Pain or lump in testicle
____Impotence
____Last prostate exam

Date_____

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Dr. Lauchlin MacGregor ND

COMPLETE HEALTH HISTORY

PATIENT NAME_____ PATIENT#_____

To help us meet all your needs, please fill out both sides of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Marital status _____
Hobbies _____
Exercise/recreation_____
Habits:
Smoking (type & amount per day) _____
If former smoker, date you quit _____
Alcohol (type & amount per week) _____
Caffeine (type & amount per day) _____
Street drugs (type & amount per day) _____
Usual weight _____

When was your last physical exam?_____
Name of doctor_____Phone_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): none_____
_____
_____
_____

Attach extra sheet if necessary.

Past Medical History
Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain):

Measles_____ no yes
Mumps _____ no yes
Chickenpox_____ no yes
Whooping cough__ no yes
Scarlet fever _____ no yes
Diphtheria_____ no yes
Smallpox_____ no yes
Pneumonia _____ no yes
Rheumatic fever __ no yes
Heart disease_____ no yes
Arthritis_____ no yes
Venereal Disease__ no yes
Anemia _____ no yes
Bladder infections_ no yes
Epilepsy _____ no yes

Migraine headaches__ no yes
Tuberculosis_____ no yes
Diabetes_____ no yes
Cancer_____ no yes
Polio_____ no yes
Glaucoma_____ no yes
Hernia_____ no yes
Blood or Plasma____ no yes
transfusions
Back trouble_____ no yes
High or low blood__ no yes
pressure
Hemorrhoids_____ no yes
Date of last chest x-ray _____
Asthma_____ no yes

Hives or eczema_____ no yes
AIDS or HIV_____ no yes
Infectious Mono_____ no yes
Bronchitis_____ no yes
Mitral Valve Prolapse___ no yes
Stroke_____ no yes
Hepatitis_____ no yes
Ulcer_____ no yes
Kidney Disease_____ no yes
Thyroid Disease_____ no yes
Bleeding tendency_____ no yes
Any other disease_____ no yes
(please list)

Family History

		Relationship
Cancer_____	no	yes_____
Tuberculosis_____	no	yes_____
Diabetes_____	no	yes_____
Heart Disease_____	no	yes_____
High blood pressure____	no	yes_____
Asthma_____	no	yes_____
Chronic lung disease____	no	yes_____
Drug or alcohol problem_	no	yes_____
Mental illness _____	no	yes_____
Leukemia_____	no	yes_____
Migraine headaches____	no	yes_____
Obesity_____	no	yes_____
Thyroid Disease_____	no	yes_____
Ulcer_____	no	yes_____
Depression_____	no	yes_____
High Cholesterol_____	no	yes_____
Kidney Disease_____	no	yes_____
Glaucoma_____	no	yes_____
Gout_____	no	yes_____

		Relationship
Stroke_____	no	yes_____
Epilepsy_____	no	yes_____
Allergies_____	no	yes_____
Anemia_____	no	yes_____
Bleeding tendency_	no	yes_____

Present age of parents:_____ If living, health (good, fair, poor) or age of death _____ If deceased, cause of death.

MEDICATION ALLERGIES:
_____
_____
_____
_____
_____