Submit by Email Print Form

New Horizons Naturopathic Clinic

Clinton M. Pomroy, ND
Doctor of Naturopathic Medicine

WELCOME!

Dear New Patient,

Thank you for your interest in ***New Horizons Naturopathic Clinic***. We look forward to serving and supporting you and your family with your health care needs. We are committed to helping people in their quest for optimum health and to educate our patients about the nature of health and disease so that they may help themselves and, in turn, help others.

Please fill out the enclosed **Patient Comprehensive Health Questionnaire** forms. You **MUST** return these completed documents by regular mail or email, 3 business days before your visit, so that we may prepare for you arrival.

In addition, bring in to the office:

1) all current supplements and medications
2) all relevant medical records in your possession (i.e. lab reports, doctor's chart notes, etc.)

Email to:
info@drpomroy.com

Mail to:
New Horizons Naturopathic Clinic
c/o Dr. Clinton M. Pomroy, ND
5308 Derry Ave, Suite K
Agoura Hills, CA 91301

Please be aware that we have a 24 hour cancellation policy. Missing or cancelling appointments with less than 24 hours notice before your scheduled appointment, you may be charged the full consultation fee. If you have any questions or concerns regarding the information provided or regarding your visit, please do not hesitate to contact us at the office, (818) 224-2404.

Healthfully,

Clinton M. Pomroy, ND
Doctor of Naturopathic Medicine

What is a Naturopathic Doctor?

A Naturopathic Doctor (ND) is a healthcare practitioner whose diverse healing modalities include modern and traditional scientific and empirical methods. Naturopathic Medicine is a distinct system of primary healthcare – an art, science, philosophy and practice of diagnosis, treatment and prevention of illness. The principles of Naturopathic Medicine are based upon objective observation of the nature of health and disease. The methods utilized by ND's are consistent with these principles, and are chosen based upon extensive medical training and experience in approaching each individual's unique needs.

What Kind of Education is Required to Become an ND?

Naturopathic medical colleges* are four-year postgraduate schools with admission requirements comparable to those of conventional medical schools. The degree of Doctor of Naturopathic Medicine requires four years of graduate level study in the medical sciences.

Why an ND Degree Can't Be Gotten Through Correspondence Schools

The four-year, post graduate residency programs offered at the seven naturopathic medical schools in North America, require hands-on clinical experience along with a standard medical school curriculum and extensive coursework in natural therapies. In fact, naturopathic medical schools require graduates to obtain significantly more hours of classroom education than most leading medical schools. On the other hand, correspondence school programs range from zero requirements (i.e. just paying a fee) to narrowly focused multi-week lectures. These programs are usually self-accredited and are not acknowledged by state and federally recognized accrediting bodies. Naturopathic medical schools, however, are accredited at the state and federal level.

What is the Scope of Practice of NDs?

Naturopathic Doctors are trained at the physician level –i.e. they are trained to do everything a general family practice MD does- but rarely find the need to resort to drugs and surgery to treat common conditions. NDs are clinically trained in a wide variety of natural medicine therapies. Some of the therapies available to the naturopathic patient include the following:

- Nutritional Counseling
- Herbal Medicine
- Hydrotherapy
- Physical Medicine
- IV (intravenous) Therapy
- Homeopathy
- Environmental Medicine & Cleansing Therapies
- Prolotherapy
- Neural Therapy
- Minor Surgery
- Naturopathic Manipulation
- Hormone Replacement
- Stress Management & Lifestyle Counseling

"The naturopathic doctor treats the 'whole person' –mind, body & spirit- for optimum health."

How are NDs Licensed?

A licensed naturopathic doctor (ND) attends a four-year, graduate level medical school and is educated in all the same modern medical sciences as an MD. The ND also studies holistic and non-toxic approaches to healing with a strong emphasis on optimizing health and disease prevention. A naturopathic doctor takes rigorous national and state professional board examinations and participates in yearly continuing education programs so that he or she may be licensed as a primary care doctor.

* The seven, accredited, 4-year naturopathic medical schools in North America are: **1)** National College of Naturopathic Medicine (Portland, OR), **2)** Bastyr University (Seattle, WA), **3)** Southwest College of Naturopathic Medicine (Tempe, AZ), **4)** University of Bridgeport (Bridgeport, CT), **5)** Canadian College of Naturopathic Medicine (Toronto, Canada), **6)** Boucher Institute of Naturopathic Medicine (Vancouver, British Columbia), and **7)** National University of Health Sciences (Chicago, Illinois).

ND *vs.* MD EDUCATION COMPARISON

National College of Naturopathic Medicine and Major Medical Schools

	National College of Naturopathic Medicine*	Johns Hopkins	Yale	Stanford
Modern Basic Sciences and Clinical Sciences Anatomy, Cell Biology, Physiology, Pathology, Neurosciences, Clinical Physical Diagnosis, Histology, Genetics, Biochemistry, Pharmacology, Pharmacognosy, Laboratory Diagnosis, Public Health, Ethics, Research & other basic coursework.	**1548**	1771	1420	1383
Observation Clerkships and Modern Medicine Lecture and clinical observation/ instruction in: Dermatology, Family Medicine, Psychiatry, General Medicine, Radiology, Pediatrics, Obstetrics, Gynecology, Neurology, Surgery, Ophthalmology & electives.	**2244****	3391	2891 + thesis	3897
Natural Therapies***				
Herbal Medicine	**96**	0	0	0
Homeopathy	**144**	0	0	0
Oriental Medicine	**72**	0	0	0
Hydrotherapy	**48**	0	0	0
Manipulation Therapy	**156**	0	0	0
Naturopathic Philosophy	**72**	0	0	0
Therapeutic Nutrition	**144**	0	0	0
Counseling	**144**	included in psychiatry, above		
TOTAL:	**4668**	5162	4311+ thesis	5280
DEGREE GRANTED:	**Doctor of Naturopathic Medicine (ND)**	Doctor of Medicine (MD)		
NATIONAL & STATE EXAMS:	**YES**	YES		

* The seven, accredited, 4-year naturopathic medical schools in North America are: **1)** National College of Naturopathic Medicine (Portland, OR), **2)** Bastyr University (Seattle, WA), **3)** Southwest College of Naturopathic Medicine (Tempe, AZ), **4)** University of Bridgeport (Bridgeport, CT), **5)** Canadian College of Naturopathic Medicine (Toronto, Canada), **6)** Boucher Institute of Naturopathic Medicine (Vancouver, British Columbia), and **7)** National University of Health Sciences (Chicago, Illinois).

** Naturopathic doctors are specifically trained as general family practice primary care providers, specialists in natural medicine. Therefore, they are not required to intern in non-general practice hospital rotations. Naturopathic doctors pursue many types of post doctoral education, including internships in specialty clinics and hospitals.

*** Because of their extensive training in natural therapies, naturopathic doctors actually have more over-all classroom training than most medical doctors.

Sources:

The 1996-98 Curriculum Directory of the National College of Naturopathic Medicine, Portland, Oregon.

The 1996-97 Curriculum Directory of the Association of American Medical Colleges. Medical schools hours for Nutrition and Lifestyle Modification are averages of Johns Hopkins, Yale and Stanford medical schools.

ND *vs.* MD & DIETITIAN EDUCATION COMPARISON

Nutrition and Lifestyle Modification

Training in nutrition and lifestyle modification, in both classroom and clinical settings, has been part of the core curriculum of naturopathic physicians since the profession was organized in the United States in 1902. Naturopathic physicians are the ***only*** licensed* primary health care providers with extensive training in therapeutic diets and preventive nutrition.

Coursework Recommended by U.S. Surgeon General	**Naturopathic Physician**	**Registered Dietitian**	**Medical Doctor**
Biochemistry and Physiology	321	120	369
Basic nutrition, nutrition assessment and interpretation	48	108	Elective
Diet and disease; therapeutic diets	84	7	0 (1)
Counseling	130	36	0 (2)
Internship	1342 (3)	900 (4)	0 (5)
National / State Exams	yes	yes	no (6)
Total Hours:	**1925** **	**1171**	**369**

Notes: (1) Not taught at most institutions.
(2) MDs receive about 170 hours of psychiatric clerkship, which is not likely to include behavior-oriented counseling.
(3) Hours spent in outpatient clinics, where supervised training always includes dietary and lifestyle assessment.
(4) May be performed in food management rather than clinical nutrition.
(5) Medical internship does not normally include training in diet and disease.
(6) Less than 4 % of tests are in nutritional area, mostly biochemistry, physiology, and pediatrics.

** Naturopathic medical programs approximately total 4,400-4,700 hours. The 1925 hours listed above reflects coursework hours in the areas of diet and lifestyle counseling only.

Sources:

The Surgeon General's Report on Nutrition and Health, 1988.
The 1996-98 Curriculum Directory of the National College of Naturopathic Medicine, Portland, Oregon.
The American Dietetic Association.
Nutrition Education in U.S. Medical Schools. National Academy Press. 1988.
The 1996-97 Curriculum Directory of the Association of American Medical Colleges. Medical schools hours for Nutrition and Lifestyle Modification are averages of Johns Hopkins, Yale and Stanford medical schools.

New Horizons Naturopathic Clinic

Initial Visit & Follow -Up Visit Fees*

TO OUR PATIENTS

DUE TO THE NATURE OF OUR PRACTICE, WE GIVE OUR PATIENTS THE UTMOST IN CARE AND SERVICE. PLEASE EXCUSE ANY DELAY. WE WILL GIVE YOU THE SAME CAREFUL ATTENTION AS SOON AS POSSIBLE.

Initial Visit	**Follow-Up**
$385 Comprehensive (2 Hour)	$285 Comprehensive (2 Hour)
$285 Comprehensive (1 ½ Hours)	$225 Comprehensive (1 ½ Hours)
$185 Comprehensive (1 Hour)	$150 Extended (1 Hour)

Follow-up appointments less than 1 Hour will be prorated according to the hourly rate.

Missed or canceled appointments without a 24 hour cancellation notice may be charged the full consultation fee.

_____ ***(initials)***

Recommended medicinary supplements and/or laboratory fees are additional.

_____ ***(initials)***

Patient's Signature: _____
OR
Parent/Guardian's Signature (if patient < 18years old): _____

Print Name: _____ **Date:** _____

PLEASE REMEMBER:
BRING TO THE OFFICE ON YOUR APPOINTMENT DAY ALL OF YOUR CURRENT SUPPLEMENTS AND MEDICATIONS.
SEND IN AHEAD OF APPOINTMENT, ALL RELEVANT MEDICAL RECORDS (i.e. LAB REPORTS, DOCTOR'S CHART NOTES, X-RAY REPORTS, ETC.).

5308 Derry Ave, Suite K, Agoura Hills, CA 91301 Phone: (818) 224-2404 Fax: (888) 760-8579

New Horizons Naturopathic Clinic
NEW CLIENT REGISTRATION

Welcome to NEW HORIZONS NATUROPATHIC CLINIC! We are happy to serve you! Please fill out the following pages completely so that we may best serve you. This information will be kept strictly confidential.

GENERAL INFORMATION

_____ ☐☐/☐☐/☐☐☐☐ ____ M☐ F☐ ☐☐/☐☐/☐☐☐☐

Name **Date of Birth** **Age** **Sex** **Today's Date**

_____ _____ _____ _____

Home Address **City** **State** **Zip Code**

_____ _____ _____ _____

Home Telephone # **Mobile #** **Work #** **Email Address**

_____ **Would you like to receive our health newsletter via email?** ☐ **Yes** ☐ **No**

Email Address

_____ _____ _____ _____

Occupation **Hours/week** **Employer** **Social Security Number**

_____ _____ _____

Spouse's Name (if married) OR Parent **Emergency Contact Person** **Phone#**

ETHNICITIES: _____ **BLOOD TYPE (ABO):** _____

MARITAL STATUS: ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Single** ☐ **Widowed**

LIVE WITH: ☐ **Spouse** ☐ **Partner** ☐ **Parents** ☐ **Children** ☐ **Friends** ☐ **Pets** ☐ **Alone**

_____

Primary Health Care Providers (M.D., D.O., Dentist, Chiropractor, Acupuncturist, etc.)

_____

_____ _____

Referred By **How Did You Hear About Us?**

What are your health goals?

_____

_____

_____

How much effort are you willing to invest to achieve your health goals?

_____

_____

_____

If you could change three things about yourself, what would they be?

_____

_____

_____

_____

HEALTH CONCERNS AND *CURRENT TREATMENTS*

Please list all of your current and ongoing health concerns and the treatments you have tried or are currently using. Rank each health concern in the order you would like it to be addressed.

	Health Concerns	Date of Onset	Treatments
Rank			
Rank			
Rank			
Rank			
Rank			
Rank			

List all other conditions diagnosed by health care providers. Please include date of diagnosis.

1._____ **3.**_____

2._____ **4.**_____

CURRENT MEDICATIONS

List all medications and dietary supplements you use (if not already listed above). Mark an X in the box next to any medicines that you sometimes use OR that you currently take.

Use/ Take		Medications (including over-the-counter)	Dosage
□	Penicillin OR Antibiotics		
□	Antacids/Ulcer Medications		
□	Sulfa Drugs		
□	Sleeping Pills/Sedative		
□	Stimulants/Caffeine		
□	Cold & Flu Medications		
□	Nasal Decongestants		
□	Aspirin	**Vitamins/Herbs/Supplements**	**Dosage**
□	Other Pain Relievers		
□	Diet Pills		
□	Laxatives		
□	Birth Control Pills		
□	Hormone Replacement		

Other medications, supplements, herbs, etc. (include dosage):_____

Date of last physical exam: _____ **Date of last blood screening:** _____

Date of last dental exam: _____ **Date of last eye exam:** _____

Height:_____**ft.** _____**in.** **Weight:**_____**lbs.** **Weight 1 yr ago:**_____**lbs.**

Maximum weight:_____**lbs.** **When?:**_____.

MEDICAL TESTS & SPECIAL STUDIES

List all x-rays, CAT scans, MRI's, electroencephalograms, hearing, speech/language, psychological, etc. Include dates and results (if possible). _____

HOSPITALIZATIONS, SURGERIES & TRAUMAS

List all hospitalizations, surgeries and significant traumas (e.g. motor vehicle accidents, severe falls, broken bones, difficult childbirth, etc.). Include dates.

TYPICAL FOOD INTAKE

Breakfast foods: _____

Lunch foods: _____

Dinner foods: _____

Snacks: _____

Amount of Water Per Day: _____ **Other Drinks:** _____

ALLERGIES/SENSITIVITIES

Drugs: _____

Foods: _____

Airborne Particles & Chemicals: _____

What types of allergy/sensitivity testing have you had? ☐ **None**

GENERAL LIFESTYLE

Frequency of Use		(circle)	(circle)
Restaurant Food	_____ time(s) per	day / week / month	
Alcohol	_____ time(s) per	day / week / month	beer / wine / liquor
Coffee	_____ time(s) per	day / week / month	
Black Tea	_____ time(s) per	day / week / month	
Soft Drinks/Sodas	_____ time(s) per	day / week / month	
Tobacco	_____ time(s) per	day / week / month	cigs / cigars / pipe / chew
"Recreational" Drugs	_____ time(s) per	day / week / month	Type: _____

Exposed to tobacco smoke? □ Yes □ Past **When and for how long?** _____

Do you react strongly to caffeine? □ Yes □ No **What reactions do you have?** _____

_____

Do you reduce the recommended dosages of medications to avoid adverse effects? □ Yes □ No

Are you intolerant to alcohol or do you feel intoxicated after 1 or 2 drinks? □ Yes □ No

Main interests and hobbies: _____

_____

Do you enjoy your job? □ Yes □ No **How often do you take vacations?** _____

Do you spend time outside? □ Yes □ No **How much?** _____

Exercise activities: _____

Exercise activity length and frequency: _____minutes _____times per week

Do you read? □ Yes □ No **How much?** _____

Do you watch television? □ Yes □ No **How much?** _____

Do you have a religious or spiritual practice? □ Yes □ No

Do you own a vegetable juicer? □ Yes □ No **If Yes, then what kind?** _____

Do you own a home air filter unit? □ Yes □ No **If Yes, then what kind?** _____

Do you own a water filter □ Yes □ No **If Yes, where do you use it?** _____

HISTORY OF PERSONAL HEALTH PROBLEMS PAST AND PRESENT

Have you had an ailment or disease condition after which you were never the same/well; OR have you had an ailment or medical condition that resulted in the worsening of other health problems? □ Yes □ No **If "Yes," explain.** _____

_____

_____

_____

Have you ever received a medical treatment or drug prescription after which your health seemed permanently affected? □ Yes □ No **If "Yes", explain?** _____

_____

_____

_____

Have you ever experienced a bad reaction to a vaccine? □ Yes □ No

If "Yes", which one(s) and what reaction(s) did you have? _____

_____

_____

_____

Mark an X in the boxes below for all health conditions that you have ever had. Please provide the approximate date (or age) when you had the problem.

GENERAL

- ☐ Abuse/Trauma
- ☐ Addictions
- ☐ Drug or Alcohol
- ☐ Dependency
- ☐ Diabetes
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Blood Disease
- ☐ Chronic Fatigue
- ☐ Cancer or Tumor
- ☐ Headaches
- ☐ Migraines
- ☐ Immune Disease
- ☐ Candida (yeast infection)
- ☐ Thyroid Disease

MENTAL-EMOTIONAL

- ☐ Anxiety
- ☐ Depression
- ☐ Death or Loss
- ☐ Post-traumatic Stress Disorder
- ☐ Attention Deficit
- ☐ Hyperactivity
- ☐ Mental "Breakdown"
- ☐ Mental Illness

HEART & VESSELS

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Stroke
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Murmur
- ☐ Vessel Disease

Other:

_____

NEUROLOGICAL

- ☐ Epilepsy/Seizures
- ☐ Nerve Pain
- ☐ Numb/Dull Senses
- ☐ Neurologic Disease
- ☐ Vertigo/Dizziness

RESPIRATORY & SINUS

- ☐ Smoker ___ pak/day # years____
- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sinusitis

EYES

- ☐ Red Eyes
- ☐ Eye Infections
- ☐ Vision Problems
- ☐ Glaucoma

EARS

- ☐ Ear Infections
- ☐ Hearing Loss

SKIN

- ☐ Abscesses
- ☐ Easy Bruising
- ☐ Cancer or Tumor
- ☐ Cold Sores
- ☐ Herpes
- ☐ Dental/Gum Disease
- ☐ Impetigo/Infections
- ☐ Eczema/Psoriasis
- ☐ Hives/Rashes
- ☐ Swollen Glands
- ☐ Varicose Veins
- ☐ Warts
- ☐ Yellow Jaundice

Other:

_____

INFECTIOUS

Date of Vaccination

- ☐ Hepatitis _____
- ☐ Chicken Pox _____
- ☐ Diphtheria _____
- ☐ Pertussis _____
- ☐ Tetanus _____
- ☐ Influenza _____
- ☐ Measles _____
- ☐ Mumps _____
- ☐ Rubella _____
- ☐ Grmn Measles _____
- ☐ Polio _____
- ☐ H.flu type b _____
- ☐ Pneumococ. _____
- ☐ Tuberculosis _____
- ☐ Typhoid _____
- ☐ Other: _____ _____
- ☐ _____ _____
- ☐ Bronchitis
- ☐ Whooping Cough
- ☐ Lyme's Disease
- ☐ Malaria
- ☐ Mononucleosis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Strep/Tonsillitis
- ☐ Other:

_____

KIDNEY & BLADDER

- ☐ Kidney Disease/Infection
- ☐ Kidney Stones
- ☐ Cystitis

MUSCLES & JOINTS

- ☐ Arthritis: Type_____
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Muscular Disease
- ☐ Osteoporosis
- ☐ TMJ Problems
- ☐ Hernia

GASTRO-INTESTINAL

- ☐ Liver Disease
- ☐ Gallbladder Disease
- ☐ Diverticulosis
- ☐ Crohn's Disease
- ☐ Hemorrhoids
- ☐ Ulcerative Colitis
- ☐ Pancreatitis
- ☐ Parasites/Worms
- ☐ Stomach Pain
- ☐ Other:

_____

_____

WOMEN

- ☐ Sex-Transmitted Disease
- ☐ Infertility
- ☐ Missed Menses
- ☐ Heavy Menses
- ☐ Miscarriage
- ☐ Menopause

MEN

- ☐ Sex-Transmitted Disease
- ☐ Infertility
- ☐ Prostate Disease

Comments: _____

_____

FAMILY HEALTH HISTORY

Fill out the following pertaining to your "blood" or natural relatives. Additional space is provided below for adding additional information related to your family history.

	Grandparents Maternal	Grandparents Paternal	Mother	Father	Siblings
Ages, if living					
Health **G=good, F=fair, P=poor (Circle choice)**	**G-Mother** **G F P** **G-Father** **G F P**	**G-Mother** **G F P** **G-Father** **G F P**	**G** **F** **P**	**G** **F** **P**	**G G G G G G G G** **F F F F F F F F** **P P P P P P P P**
Age at death					
	Below, provide name, relationship, age condition occurred, complete diagnosis and treatment. Additional comments can be added below this table.				
Anxiety					
Asthma/Allergies					
Anemia					
Alzheimer's Disease					
Arthritis					
Cancer, Tumor or Polyps					
Depression					
Diabetes					
Eczema					
Glaucoma/ Eye Disease					
Gallbladder Disease					
Gout					
Heart Disease					
Hives/Rashes					
High Blood Pressure					
Kidney Disease					
Lung Disease					
Mental Illness					
Osteoporosis					
Seizures/Epilepsy					
Smoking/ Drug Abuse					
Stroke					
Thyroid Problems					
Tuberculosis					
Ulcers					

Other:

_____

_____

_____

New Horizons Naturopathic Clinic

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent and is found on our website in "patient forms". We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting one from the front desk.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

CONTACT PERSON: Clinton M. Pomroy, N.D. 5308 Derry Ave, Suite K, Agoura Hills, CA 91301

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ASK OUR STAFF FOR A COPY IF YOU WANT A COPY.