Dr. Joshua H. Friedman
Integrative Depression Solutions
Josh@IntegrativeDepressionSolutions.com
Fax: 866-615-3670

Name:_____

And now we begin…

The first step in our working together is you taking about 45 to 60 minutes to fill out the following i**ntake paperwork** on the following pages.

This will give you some information about my practice and will help me begin to understand what may be contributing to your depressive symptoms.

My having this information will help me know where to start the process of helping you find the key to unlocking your symptoms.

Please print out, complete the paperwork, and fax or email the intake back to me, AT LEAST 48 HOURS before your scheduled initial appointment, to give me time to really go through it before we meet.

My Fax number is: 866-615-3670

My email is: Josh@IntegrativeDepressionSolutions.com

I am excited that you have taken this step towards healing your depression!

Looking forward to our work together,

Dr. Josh Friedman

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Name:_____

DEMOGRAPHIC INFORMATION

Today's Date: _____

Name of Client: _____

Sex: □ Male □ Female Age:_____ Date of Birth: _____ Age:_____

Current Address:_____

City:_____ State:____ Zip:_____

Best Number For Phone Session:_____

Email:_____

Emergency Contact: _____

Emergency Contact Phone Number:_____

I agree for this person to be contacted in an emergency (initial) _____

Primary Care Physician: _____

Phone #: (____)_____

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POLICIES AND PROCEDURES

New Clients –First Appointment

Your 1st consultation will be approximately 45 minutes. During this time, Dr. Friedman will be asking many questions to best understand the possible underlying factors contributing to your depression.

After the first appointment, he will create a written treatment plan to address your specific issues. This will likely include dietary and supplement suggestions, stress management tools and may include recommendations for functional testing that will allow us to understand the "root" causes of your depression.

You will be provided information on how to order tests.

Dr. Friedman will email you this treatment plan following the 1st appointment.

Follow-Up Appointments

If indicated, Dr. Friedman will email you a link, to pay for and choose a time for the next appointment.

These appointments are either 25 minutes or 45 minutes and are by phone. Dr. Friedman will suggest the time needed for the follow up, and he will call you for the appointment at the number provided.

Fees Schedule For Dr. Friedman's Services

$375	45-Minute Case Review
$275	30-minute follow-up
$350	45-minute follow-up

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Lab Testing

Most of the Laboratory tests are ordered through Direct Health Access Laboratory (DHA Lab). You will pay Integrative Depression Solutions directly when ordering tests. An ordering provider (MD, DO, PA, NP) at DHA Lab will order the testing on your behalf. Since the ordering medical provider will not be seeing your for an evaluation before ordering the tests, your insurance provider will NOT pay for the testing. If tests are from a different lab, you will be provided information on "direct to consumer" companies where you can order the suggested tests.

We receive your lab results 2-4 weeks after you mail your sample to the lab. If you don't already have a follow-up appointment scheduled, you will be contacted to schedule one to review the findings.

Cancellations

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 will still be charged for that appointment.

International Clients

If you are outside the United States, you will be required to call for your appointment at the allotted time. Please email us at Josh@IntegraiveDepressionSolutions.com to make sure you have the correct number to call for the appointment.

Insurance Requests

We are not in a position to offer super bills or collaborate with insurance companies for reimbursement of any services. The receipt you receive when purchasing items with Integrative Depression Solutions is the only document offered to substantiate services.

Important Notes

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Josh Friedman is not a medical doctor and does not service medical emergencies. **If you have a medical emergency, you must contact your primary care physician or dial 911!**

If you are in need of psychotherapy or psychiatric care it is critical that you find one, or both in your local area. Work with Dr. Friedman is in no way viewed as a replacement for psychotherapy, psychiatric, or medical care.

Please contact me at Josh@IntegrativeDepressionSolutions.con if you are not clear on any of our policies or procedures.

I, _____, have read and understood Integrative Depression Solutions' Policies and Procedures.

Signature_____Date:_____

CONSENT TO TREATMENT

It is with full consent that I am entering into a professional relationship with Dr. Joshua Friedman.

I have been made aware that he addresses brain health and overall wellbeing with nutrition and lifestyle recommendations. I am aware that he may recommend dietary changes and specific supplements, and may educate me about specific functional laboratory tests and tell me how I can order these tests.

I have been made aware that he is a licensed Psychologist, but that in our professional relationship he is working as a Certified Holistic Health Counselor, accredited by the American Association for Drugless Practitioners and not as a psychologist.

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Therefore, I am aware that his work with me will not be considered psychotherapy or the practice of Psychology. As such, he will not diagnose any mental health disorders or use mental health therapy procedure codes, and therefore his services will not be billable through third party insurance carriers. I have been made aware that if I am in need of either psychological or psychiatric care, that I should find a qualified professional in the area whereI live.

He has informed me that the dietary education he may provide is not intended to "treat" or "cure" any disease.

Even though personal health information may be provided during consultation with Josh Friedman, these consults shall not constitute the practice of medicine and should not be considered a replacement for the care of a physician, psychiatrist, psychotherapist or other health care provider.

He has advised me to speak to my physician before making any dietary changes, taking any dietary supplements, or ordering any functional laboratory tests. Any decision to stop taking any prescribed medication should be made in full collaboration between you and the prescribing medical provider.

By signing below you agree to take full responsibility for taking any natural remedy that Josh Friedman might provide education about. You agree that he is not liable for any adverse effects or complications from such natural remedies, however rare. You agree to stop taking any supplements that cause any adverse effects, and to notify him and your primary medical provider immediately.

Additionally, you will notify Dr. Friedman of any new medications you are taking, especially psychotropic medications such at antidepressants, as supplement adjustments may be necessary. You will also notify him if you become pregnant, as some supplements may be inappropriate during pregnancy.

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Dr. Friedman may provide you education about functional laboratory testing that research has shown maybe helpful for identifying biochemical factors linked to depression. You are advised to speak to your doctor or other healthcare practitioner about whether these tests might be helpful for you. Dr. Friedman will not be ordering these tests but will help you find ordering providers if you wish.

Dr. Friedman will not intentionally release any personal medical information to any other parties without written consent from you.

Please sign and print your name below to indicate that you have read the above statements and willingly agree to enter into a professional health counseling relationship with Joshua H. Friedman, CHHC.

Signature of Client(s) (or Legal Guardian):

_____Date:_____

CREDIT/ DEBIT CARD

All clients are required to provide a credit or debit card to be kept on file:

_____

Credit card number Expiration Date

_____

Security Code Zip Code
(3 digits on back of card)

I agree for Dr. Josh Friedman to charge my credit card for any outstanding fees

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Name:_____

owed:

Card holder's signature:_____Date:_____

Mental Health History

What is your chief concern?_____

_____

Other Concerns?_____

Occupation:_____ Hours of work per week:_____

Relationship status:_____ Children?:_____

Do you sleep well?_____Do you wake up at night?_____

What times?_____To urinate?_____

What time do you generally get up in the AM?_____

Constipation/diarrhea?_____

Women: Are your periods regular?_____

How many days is your flow?_____

How frequent?_____ Painful or symptomatic?_____

Please explain (if necessary);_____

Do you take supplements or medication? If so which?_____

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_____

Any therapies or healers you are involved with?

What role does exercise play in your life?_____

Do you drink coffee, smoke cigarettes, or have any major addictions?

_____

What percentage of your food is home cooked?_____

Where do you get the rest from?_____

Please describe your current level of stress:

_____

_____

How do you relax?_____

What do you do for fun?_____

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Name:_____

Please tell me about the food you eat during a typical day (use a day recently that you remember).

Breakfast Lunch Dinner

_____

_____

_____

_____

Snacks Liquids

_____

_____

_____

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Mental health Symptoms Chart

1) In Column A, put a number from 1 to 10 by each symptoms experienced, with 1 being slightly felt or hardly ever felt and 10 being strongly felt or felt all the time. 2) Check the substances in Column B that are used to reduce the symptoms in the same section of Column A.

A: Symptoms

B: Substances Used

Type 1:Low Serotonin

___Afternoon or evening cravings
___negativity, depression
___winter blues, SAD
___worry, anxiety
___low self-esteem
___guilt
___obsessive thought or behaviors
___perfectionistic
___irritability, rage
___panic attacks; phobias (i.e. fear of heights, small spaces etc.)
___suicidal thoughts, feelings
___hyper-activity
___dislike of hot weather
___fibromyalgia, TMJ
___night-owl, hard to get to sleep
___frequent awakening during night
___waking up too early
typical sleep hours:
____to____

___sweets
___starches
___tobacco
___chocolate
___Ecstasy
___marijuana
___alcohol
___anti-depressant medication

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Type 2: Low Catecholemines

___apathetic depression
___lack of energy
___lack of drive, motivation
___lack of focus/concentration
___Attention Deficit Disorder
___easily bored

___sweets
___starch
___chocolate
___Aspartame
___alcohol
___marijuana
___caffeine
___Cocaine
___speed
___tobacco

Type 3: Low GABA

___stiff , tense or painful muscles
___over stressed and burned out
___unable to relax and loosen up
___often fee overwhelmed

___sweets
___starch
___tobacco
___marijuana
___ Xanax, Klonopin

Section 4: Endorphin Deficiency

___very sensitive to emotional or physical pain
___cry (tear up) easily
___crave comfort, reward, or numbing from drugs, alcohol, foods or behaviors

___sweets
___starch
___chocolate
___tobacco
___heroin
___marijuana
___alcohol

Adapted from *The Mood Cure* by Julia Ross

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Did any of the following events occur in the 6 month period prior to: 1) the initial onset of depression, or 2) the period in which your mental health started to decline?

___High levels of stress/anger (e.g. family/relationship related)

___Emotionally traumatic event(s) (e.g. death of a loved one)

___Excessive physical &/or work activity for you

___Sleep deprivation/sleep disruption/night shift work

___New medications (e.g. antibiotics, antacids, hormones, psychiatric)

___Changed dose of medication (e.g. lowered hormones)

___Started supplement containing > 600 mcg (0.6 mg) of copper

___Illicit drug use or started smoking

___Significant change in diet (e.g. crash dieting)

___Increased coffee, diet soft drink or alcohol intake

___New house/job/office/school/class room

___House/work/school renovated or repaired (inc. vinyl wall paper)

___House/work/school freshly painted or sprayed with pesticides

___New mattress, pillow, carpet, furniture or refinished furniture

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___Amalgam (silver) filling insertion or removal

___Root canal insertion

___Broke glass thermometer

___Three or more servings of fish per week (1 serving = 150 grams)

___Regularly eating one of the following fish - Swordfish, shark/flake, marlin, broadbill, orange roughly/sea perch or catfish

___New gas heater, gas stove or other gas appliance

___Water contamination (e.g. leaks/flooding) in house/work/school

___New or increased mold growth in your house/work/school

___Commenced new hobby

___Other chemical exposure (e.g. work or home related)

___Insertion of breast implants, silicon injections, metal crowns, braces,

___Joint/hip replacement, metals screws/pins/nails/slips, etc.

___New cordless phone near bed, started using electric blanket, started

___Sleeping near a meter box or new WiFi system

___Food poisoning / gastroenteritis / parasitic infection

___Household member with parasitic or bacterial infection

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___International travel, camping, wilderness activities and/or
Travel to parasite prone area

___Viral or bacterial infection (other than typical 'cold') / fever

___Tick or spider bite

___Recent Vaccination (e.g. Hepatitis B or Tetanus)

___Blood transfusion or donation

___Hospitalization

___Surgery (e.g. hysterectomy/appendectomy)

___Pregnancy/miscarriage/abortion/menopause onset

___Injury / head injury / stroke

___Unprotected sex with people of unknown STD status

Section A- Mark the symptoms that apply to you

4 ___Low energy
4 ___Easily Chilled (especially hands and feet)
4 ___Family members with thyroid issues
4 ___Can gain weight without overeating; hard to lose excess weight
3 ___Have to force yourself to do even moderate exercise
4 ___Hard to get going in the morning
3 ___High Cholesterol
3 ___Low blood pressure
4 ___(For women) weight gain began near the start of menses, a pregnancy, or menopause

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3 ___Chronic headaches
3 ___Use food, caffeine, tobacco, and/or stimulants to get going

Total_____ (add up the numbers next to symptoms marked)

Section B**-** Mark the symptoms that apply to you

3___Crave milk, ice cream, yogurt, cheese, doughy foods (pasta, bread, cookies among others and eat them frequently
3 ___Experience bloating after meals
4 ___Gas, frequent belching
3 ___Digestive discomfort of any kind
3 ___Chronic constipation and/or diarrhea
4 ___Respiratory problems, such as asthma, postnasal drip, congestion
3 ___Low energy or drowsiness, especially after meals
4 ___Allergic to milk products or other common foods
3 ___Under eat or often prefer beverages to solid food
3 ___Avoid food or throw up food because bloating after eating makes you feel fat or tired
4 ___Can't gain weight
3 ___Hyperactive or manic-depressive
3 ___Severe headaches, migraines
4 ___Food allergies in you family

Total_____ (add up the numbers next to symptoms marked)

Section C- Mark the symptoms that apply to you

4 ___Often bloated, abdominal distention
3 ___Foggy-headed
4 ___Depressed

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5 ___Yeast or sinus infections
4 ___Used antibiotics extensively (at any time in life)
4 ___Used cortisone or birth control pills for more than one year
4 ___Have chronic fungus on nails or feet
3 ___Achy muscles and joints
3 ___Chronically fatigued
4 ___Rashes
3 ___Stool unusual in color, shape, or consistency

Total_____(add up the numbers next to symptoms marked)

Section D- Mark symptoms that apply to you

___Being anxious, shy or fearful or experiencing inner tension since childhood but hiding these feelings from others
___Having bouts of depression or nervous exhaustion
___Poor dream recall. Stressful or bizarre dreams or nightmares (Low B6)
___Excessive reaction to tranquilizers, barbiturates, alcohol, or other drugs in which a little produces a powerful response (low B6)
___Preferring not to eat breakfast, experiencing light nausea in the morning or being prone to motion sickness (low B6)
___White spots or flecks on the fingernails, or opaquely white or paper-thin nails
___Liquid Zinc sulfate having a mild taste or tasting like water
___Poor appetite or having a poor sense of smell or taste (Low Zinc)
___Joints popping, crackling, or aching pain or discomfort between the shoulder blades; or cartilage problems (low zinc)
___Pale or fair skin or being the palest in the family, or sun burning easily; now or when younger
___Disliking protein or having ever been a vegetarian or vegan
___Being sensitive to bright sunlight or noise
___Upper abdominal pain on your left side under the ribs or, as a child,

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having a stich in your side as you ran
___Frequent fatigue
___Being prone to iron anemia or low ferritin levels
___Tending to have cold hands or feet
___Reaching puberty later than normal or having irregular menstruation or PMS
___Having frequent colds or infections, or unexplained chills or fever
___Having allergies, adrenal issues, or problems with sugar metabolism
___Having gluten sensitivity
___Neurotransmitter imbalances, especially low serotonin
___For women, belonging to an all-girl family or having look alike sisters

Total _____ (one point for each symptom marked)

Section E- (For Women Only) - Mark the symptoms that apply to you

5 ___Premenstrual mood swings
4 ___Irregular periods
4 ___Premenstrual or menopausal food cravings
3 ___Experienced a miscarriage, an abortion, or infertility
4 ___Use(d) birth control pills or other hormone medication
3 ___Uncomfortable periods-cramps, lengthy or heavy bleeding or sore breasts
4 ___Peri- or postmenopausal discomfort (e.g. ho flashes, sweats, insomnia, or mental dullness
3 ___Excessive hair growth or loss, acne

Total_____ (add up the numbers next to symptoms marked)

Section F (For Men Only)- Mark the symptoms that apply to you

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Name:_____

___Testosterone deficiency
___Lower sex drive/libido
___Difficulty achieving an erection
___Softer erections
___Takes longer to achieve orgasm
___Decreased ejaculate volume
___Less sexual enjoyment/satisfaction
___Increased abdominal fat
___Loss of muscle mass/strength
___Tendency to feel depressed or irritable
___Decreased memory
___Fatigue / lowered stamina
___Loss of muscle mass/ strength
___Slowed growth or reduction of hair on face, chest, legs or pubic area
___Reduction or absence of voice deepness

Total_____(one point for each symptom marked)

Section G- Mark symptoms that apply to you

___Do you get canker sores?
___Do you have slow sexual responsiveness or low libido?
___Do you have tension headaches or seldom have headaches?
___Do you have heavy growth of body hair?
___Do you tend to carry an excess fat in your lower extremeties rather than evenly distributed around your body (pear shaped figure)?
___Do you have a lot of dental fillings?
___Do you have a head full of grand plans but are easily frustrated?
___Are you suspicious of people or do you feel paranoid?
___Have you ever heard voices inside your head?
___Are you able to stand pain well?
___Do you have ringing in your ears?

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___Do you get few or no colds?
___Do you have low tolerance for medications or drugs?
___Do you tire easily?
___Do you need at least 8 hours of sleep at night and are you a slow riser in the AM?
___Is your mouth usually dry?
___Do you have a tendency to despair, or have bouts of crying?
___Do you experience frequent irritability?

Total_____(one point for each symptom marked)

Section H- Mark symptoms that apply to you

___Do you tend to sneeze in bright sunlight?
___Were you a shy and oversensitive teenager?
___Can you make tears easily, and are you never bothered by a lack of saliva or dry mouth?
___Do you hear your pulse in your head on the pillow at night?
___Do you have frequent muscle cramps?
___Do you have a high sensitivity to pain?
___Do you find it easy to have an orgasm

Total_____(one point for each symptom marked)

Section I- Mark symptoms that apply to you

4___Crave chips, cheese, ad other rich foods more than, or addition to sweets and starches
4___Have ancestry that includes Irish, Scottish, Welsh, Scandinavian, or Coastal Native American
3___Alcoholism and depression in family history

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4___Feel heavy, uncomfortable, and "clogged up" after eating fatty foods
3___Had your gallbladder removed
4___History of Hepatitis or other liver or gallbladder problems
4___Light-colored stool
4___Hard or foul smelling stool
4___Pain on right side under your rib cage

Total_____(one point for each symptom marked)

Please Provide any additional information below that you think may be contributing to your depression or other mental health symptoms: