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New Patient Intake Form

Date of First Visit: _____

Personal Information:

Name: _____ Preferred Name/Nickname:_____

Age ____ Date of Birth _____ SSN: _____ Gender_____

Single Married Partnership Separated Divorced Widowed

Live with: Spouse Partner Parents Children Friends Alone

Employer: _____ Occupation: _____

Contact Information:

Address:

_____

City: _____ State: _____ Zip Code: _____

Telephone # (home)_____ (work) _____

(cell)_____ Is it ok to leave a message?_____

Where do you prefer to receive calls? _____ Home _____ Work _____ Cell

When is the best time to reach you? Time _____ Days _____

Emergency Contact #1:

_____

Relationship: _____ Phone: _____

Address:

_____

Emergency Contact #2 (optional):

_____

Relationship: _____ Phone: _____

Address:

_____

Are you currently receiving other healthcare? _____ Y _____ N

If yes, where and from whom?

_____

If no, when and where did you most recently receive medical or health care?

_____

If so, what was the reason?

_____

How familiar are you with Naturopathic Medicine?

_____

How familiar are you with Homeopathic Medicine?

_____

What role do you expect me to play in your healthcare?

□ Primary Care Physician □ Adjunctive Care □Homeopathy Only

What are your most important health problems? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

General Information:

Height: _____ Weight: _____ Weight 1 year ago: _____

Use of tobacco: ____ Never ____ Previously, but quit _____ Currently, pack/day

Use of alcohol: ____ Never ____Rarely ____ Moderate _____ Daily, amount

Use of drugs: ____ Never _____ Type, frequency

Excessive exposure at work or home to:

____ Fumes ____ Dust ____ Solvents ____ Noise ____ Air-borne particles

History of Current Illness: (if applicable)

Location: _____ Quality: _____

(Where is the pain/problem?) *(Describing the pain, discoloration, activity, etc.)*

Severity: _____ Duration: _____

(On a scale of 1-10, 10 being the most severe?) *(How long have you had this pain/problem?)*

Timing: _____ Context: _____

(Does the problem occur at a specific time/ day/month/season?) *(Where were you at the onset of this problem?)*

Associated signs/symptoms: _____

(What other associated problems are you having?)

Modifying factors: _____

(What makes the problem better or worse? Have you had previous episodes?

Medications: *(include herbs, supplements, over-the-counter meds, etc.)*

_____

_____

Allergies: *(include all allergies to drugs, foods, and environmental triggers)*

_____

_____

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Past Medical History:

Have you ever had the following? Please Circle Y for yes and N for no. Leave blank if uncertain.

Measles	Y N	*Anemia*	Y N	*Back Trouble*	Y N
Mumps	Y N	*Bladder Infections*	Y N	*High Blood Pressure*	Y N
Chickenpox	Y N	*Epilepsy*	Y N	*Low Blood Pressure*	Y N
Whooping Cough	Y N	*Migraine Headaches*	Y N	*Hemorrhoids*	Y N
Scarlet Fever	Y N	*Tuberculosis*	Y N	*Bleeding Tendency*	Y N
Diptheria	Y N	*Diabetes*	Y N	*Asthma*	Y N
Smallpox	Y N	*Cancer*	Y N	*Hives or Eczema*	Y N
Pneumonia	Y N	*Polio*	Y N	*AIDS or HIV+*	Y N
Rheumatic Fever	Y N	*Glaucoma*	Y N	*Infectious Mono*	Y N
Heart Disease	Y N	*Hernia*	Y N	*Bronchitis*	Y N
Arthritis	Y N	*Stroke*	Y N	*Hepatitis*	Y N
Ulcer	Y N	*Kidney Disease*	Y N	*Thyroid Disease*	Y N
Venereal Disease	Y N	*Mitral Valve Prolapse*	Y N		
Blood or Plasma Transfusion	Y N				

Date of last chest X-Ray _____ Other Imaging Done _____

Previous Hospitalization/Surgeries/Serious Illnesses:

	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Systems: Please indicate any personal history below.
Y= Yes, present condition N= No, never had the condition P = Problem of the past

Constitutional Symptoms

Good general health lately	*Y*	*N*	*P*
Recent weight change	*Y*	*N*	*P*
Fever	*Y*	*N*	*P*
Fatigue	*Y*	*N*	*P*
Headaches	*Y*	*N*	*P*

Eyes

Eye disease or injury	*Y*	*N*	*P*
Wear glasses/ contact lenses	*Y*	*N*	*P*
Blurred or double vision	*Y*	*N*	*P*

Ears/Nose/Mouth/Throat

Hearing loss or ringing	*Y*	*N*	*P*
Earaches or drainage	*Y*	*N*	*P*
Chronic sinus problems or rhinitis	*Y*	*N*	*P*
Nosebleeds	*Y*	*N*	*P*
Mouth sores	*Y*	*N*	*P*
Bleeding gums	*Y*	*N*	*P*
Bad breath or bad taste	*Y*	*N*	*P*
Sore throat or voice change	*Y*	*N*	*P*
Swollen glands in neck	*Y*	*N*	*P*

Cardiovascular

Heart trouble	*Y*	*N*	*P*
Chest pain or angina pectoris	*Y*	*N*	*P*
Palpitations	*Y*	*N*	*P*
Shortness of breath			
With walking	*Y*	*N*	*P*
With lying flat	*Y*	*N*	*P*
Swelling of feat, ankles, or hands	*Y*	*N*	*P*

Respiratory

Do you have a persistent cough or throat clearing not associated with a known illness, lasting more than 3 weeks?	*Y*	*N*	*P*
Spitting up blood	*Y*	*N*	*P*
Shortness of breath	*Y*	*N*	*P*
Wheezing	*Y*	*N*	*P*

Gastrointestinal

Loss of appetite	*Y*	*N*	*P*
Change in bowel movements	*Y*	*N*	*P*
Nausea or vomiting	*Y*	*N*	*P*
Frequent diarrhea	*Y*	*N*	*P*
Painful bowel movements	*Y*	*N*	*P*
Constipation	*Y*	*N*	*P*
Rectal bleeding/ blood in stool	*Y*	*N*	*P*
Abdominal pain	*Y*	*N*	*P*

Endocrine

Glandular or hormone problem	*Y*	*N*	*P*
Excessive thirst or urination	*Y*	*N*	*P*
Heat or cold intolerance	*Y*	*N*	*P*
Skin becoming dryer	*Y*	*N*	*P*
Change in hat or glove size	*Y*	*N*	*P*

Genitourinary

Frequent urination	*Y*	*N*	*P*
Burning or painful urination	*Y.*	*N*	*P*
Blood in urine	*Y*	*N*	*P*
Change in force/ strain during urination	*Y*	*N*	*P*
Incontinence or dribbling	*Y*	*N*	*P*
Kidney stones	*Y*	*N*	*P*
Sexual difficulty	*Y*	*N*	*P*
Male – testicular pain	*Y*	*N*	*P*
Female – pain with periods	*Y*	*N*	*P*
Female – irregular periods	*Y*	*N*	*P*
Female – vaginal discharge	*Y*	*N*	*P*

Female - # of pregnancies _____

Female - # of miscarriages _____

Female – date of last pap smear _____

Musculoskeletal

Joint pain	*Y*	*N*	*P*
Joint stiffness or swelling	*Y*	*N*	*P*
Weakness of muscles or joints	*Y*	*N*	*P*
Muscle pain or cramps	*Y*	*N*	*P*
Back pain	*Y*	*N*	*P*
Cold extremities	*Y*	*N*	*P*
Difficulty in walking	*Y*	*N*	*P*

Skin, Breast

Rash or itching	*Y*	*N*	*P*
Change in skin color	*Y*	*N*	*P*
Change in hair or nails	*Y*	*N*	*P*
Varicose veins	*Y*	*N*	*P*
Breast pain	*Y*	*N*	*P*
Breast lump	*Y*	*N*	*P*
Breast discharge	*Y*	*N*	*P*

Neurological

Frequent or recurring headaches	*Y*	*N*	*P*
Light-headedness or dizziness	*Y*	*N*	*P*
Convulsions or seizures	*Y*	*N*	*P*
Trembling or tingling sensations	*Y*	*N*	*P*
Tremors	*Y*	*N*	*P*
Paralysis	*Y*	*N*	*P*
Head injury	*Y*	*N*	*P*

Psychiatric

Memory loss or confusion	*Y*	*N*	*P*
Nervousness	*Y*	*N*	*P*
Depression	*Y*	*N*	*P*
Insomnia	*Y*	*N*	*P*
Suicidal thoughts	*Y*	*N*	*P*
Violent or unusual thoughts	*Y*	*N*	*P*

Hematologic/Lymphatic

Slow to heal after cuts	*Y*	*N*	*P*
Bleeding or bruising tendency	*Y*	*N*	*P*
Anemia	*Y*	*N*	*P*
Phlebitis	*Y*	*N*	*P*

Consent for Treatment:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I, also, understand that my care as a patient at Arbor Vitae Natural Health, LLC is directed by Naturopathic Physicians and/or other licensed professionals. I consent to services rendered and provided to me under the instructions of these professionals assisting in my care.

I have fully read and understand the above agreements and authorizations.

_____ _____

Print Name and Sign: Patient (18 years or older) *Date*

_____ _____

Print Name and Sign: Parents, Guardian, Responsible Party *Date*

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

_____

Patient or Guardian Name

_____

Signature

_____

Date

Statement of Financial Responsibility:

I understand that I or the responsible party, as mentioned above, will be responsible for payment of services rendered, including lab tests and dispensary items. I understand that my insurance carrier may pay less than the actual bill of services, and I agree to be responsible for any and all charges that my insurance carrier would not be able to cover. I, also, understand that I may receive a discount should I pay in full at the time of service.

To the best of my knowledge, the questions on this form have been accurately answered. I have fully read and understood the above agreements and authorizations.

_____ _____

Print Name and Sign: Patient or Responsible Party *Date*

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more efficiently and effectively. If you have any questions at any time, please ask – we are always happy to help.