501 Islington Street, Suite 2B
Portsmouth, NH 03801
P: 603-610-8882 F: 603-463-0943

New Patient Intake Form

Personal Information

Today's Date: ___________________

Name: ____ Age: _______ DOB:________________

Parent/Guardian (if minor): 1. ______________________________ 2. ________________________________

Phone: H (_____)______________________ W (_____)___________________ Cell (_____)________________________

Preferred ______ Home ______ Work ______ Mobile   Is it OK to leave messages? _____ Yes _____No

Address: ____

City, State, Zip:____

Email Address: ____

How did you hear about our office? ____

If you were referred to us, whom may we thank? ____

Are you interested in receiving email notifications of classes and lectures? _____ Yes _____ No

Emergency Contact

Name: ____ Relationship: _________________________

Phone # H (_______)____________________ W (_______)__________________ Cell (_______)_______________________

Address: ____

City, State, Zip: ____

Insurance Information

****It is the patient's responsibility to know the benefits under their insurance plan prior to receiving care****

Health Insurance Company: ____

Member ID: ____ **(include all numbers and letters)**

Subscriber name (if other than self): __________________________________ Subscriber DOB: _______________

Subscriber Relationship to Patient: Spouse   Parent   Partner

For Office Use Only

Received: Scheduled: PCP: Current Patient:

NOTES:

Name:____ DOB__________ Today's Date: _____________

Health History Questionnaire

Your responses to this form will better help us provide care and assess your medical needs and conditions. If you are uncomfortable answering any questions, please leave blank. If you are unsure of specifics, please provide as much detail as you are able. Add any notes you think are important. All information contained in this questionnaire is strictly confidential.

Main reason for establishing care:

___Change in PCP ___New Insurance ___Re-establishing ___Specific Medical Concern

When was the last time you received medical care and why?

____

____

What are your primary health concerns? List them in order of importance to you:

____

____

____

What is the primary expectation you have for your visit at our clinic today?

____

____

Current and Past Healthcare Providers

Name	Specialty	Contact	Current/Past

Preferred Pharmacy

Name: ____

Address: ____

Phone: (____) ___________________________________

Name:___________________________________ DOB:_________________ Today's Date: ____________

Please list ALL prescription medications, supplements and over-the-counter medications

Medication	*Dosage*	*Frequency*	*Reason for taking*

Please list all allergies/intolerances

Allergy/Intolerance	Reaction	Date of Onset

Name:___________________________________ DOB:_________________ Today's Date: ____________

Medical History

Please check all that apply	Current	Past	Please check all that apply	Current	Past
ADD/ADHD			Fibromyalgia		
AIDS/HIV			GI Problems		
Abuse/Domestic Violence			Gout		
Allergies (list in above section)			Headaches		
Anemia			Heart disease		
Anesthesia complications			Heart problems		
Anxiety disorder			Hepatitis		
Arthritis			High cholesterol		
Asthma			Hospitalizations		
Autism Spectrum Disorder (ASD)			Hypertension		
Bedwetting			Hyperthyroidism		
Birth defects or inherited disease			Hypothyroidism		
Bladder or kidney problems			Impaired fasting glucose		
Blood diseases			Infertility		
Blood transfusion			Kidney disease		
Breast problem(s)			Kidney stones		
COPD			Liver disease		
Cancer, Type_______________			Lung disease		
Chronic ear infections			Lyme		
Congestive heart failure (CHF)			MRSA exposure		
Constipation			Meniere's Disease/Vertigo		
Coronary artery disease			Mental disorder/Illness		
Depression			Mononucleosis		
Developmental or behavioral disorders			Muscle, joint or bone problems		
Diabetes—Gestational			Nasal polyps		
Diabetes—Type 1			Obesity		
Diabetes—Type 2			Osteoporosis		
Difficulty Swallowing			Polyps		
Diverticulitis			Pre-eclampsia		
Ear or hearing problems			Psoriasis		
Eating disorder			Pulmonary embolism		
Eczema			Reflux/GERD		
Endometriosis			Seizures/Epilepsy		
Other: (Please write in)			Skin problems		
			Stroke		
			Thyroid problems		
			Varicosities		
			Vision or eye problems		

Please list any Surgeries

Procedure	Date

Name:_________________________________ DOB:________________ Today's Date: ____________

Preventative Medical History

Event	Date	Location
Physical exam		
Colonoscopy		
Blood work		
Dental exam		
Electrocardiogram (if applicable)		
Fecal occult blood screening		

Women—Obstetric and Gynecological History

Age at first child:			
Age at first menstrual period:			
Date of last menstrual period or onset of menopause:			
Current birth control method:			
Date of last mammogram:	Where:		
Date of last Pap smear:	Where:		
Date of last bone density:	Where:		
Number of pregnancies:	Births:	Miscarriages:	Abortions:

Family History

Relation	Significant Health Problems and Age at Onset	Alive and Healthy	Age at Death
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Mother			
Father			
Sister			
Sister			
Brother			
Brother			
Other			
Other			
Other			

Name:_________________________________ DOB:________________ Today's Date: ____________

Lifestyle History

___ Exercise ______ hours per week

Activities ____

___ Watch TV ______ hours per week

___ Tobacco use ______ packs per day

___ Alcohol ______ drinks per day ______ per week

___ Recreational drug use

___ Mercury amalgam fillings

___ Employed outside the home

Occupation ___________________________________

Hours per week _______________________________

Employer ____________________________________

Do you enjoy your work? ___ yes ___ no

Height ________________________________

Weight ________________________________

Weight one year ago ____________________

Maximum weight ________________________

When? ________________________________

Sleep __________ hours per night

Is this enough? ___ yes ___ no

# of Meals per day________________________

Bowel movements per day ________________

Dietary restrictions _______________________

____

Level of stress ___ Low ___ Average ___ High

Who do you live with? ____

___ Toxic exposure ____

___ Major life change in last year ____

___Wear Glasses ___Wear contacts ___Wear reading glasses

____

Vibrant Health
Naturopathic Medical Center
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HIPAA CONSENT FORM

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment or to obtain payment from insurance companies.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient Name: ____ DOB: _________________
Signature: ____ Date: _________________
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient: ________________________