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:___________________

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, who 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: ____

Have you been to a Doctor of Naturopathic Medicine before? _______ If yes, when? _____________________________

What were you being treated for? ____

____

Were you satisfied with your care? _________ If not, please explain: ____

____

When was the last time you had medical care and for what reason? ____

____

____

Name & Phone # of PCP: ____

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?______________________________________

____
____
____

Health History

Please list any known allergies (environmental, drug, food, animals, chemicals/perfumes): ____________________

____
____

Do you take any of the following over-the-counter medications? Please check any that apply:

___Aspirin ___Ibuprofen or acetaminophen ___Antihistamine ___ Sleeping pills

___Laxatives ___Appetite Depressants ___Antacid ___Medicine to stay awake

***Please list any pharmaceutical and/or natural medications (including vitamins) that you are taking or have taken in the last year*.**

Medication	*Dosage*	*Dates*	*Reason for taking*

Which diagnostic studies have you had? Please indicate dates:

Hospitalization ______________________________

Surgery ______________________________

X-ray ______________________________

MRI ______________________________

Rectal Exam ______________________________

Electrocardiogram ______________________________

Endoscopy ______________________________

Colonoscopy ______________________________

Mammogram ______________________________

CT Scan ______________________________

Bone Scan ______________________________

Other ______________________________

For the following conditions and symptoms, please indicate any that apply to you by marking a "C" for current or "P" for past:

___ Skin rash
___ Anemia
___ Easy bleeding or bruising
___ Varicose veins or hemorrhoids
___ Bone or joint disease
___ Mood swings
___ Anxiety or nervousness
___ Difficulty sleeping
___ Feel unsafe at home
___ Physical abuse
___ Frequent antibiotic use
___ Frequent colds or flu
___ HIV or AIDS
___ Lyme disease
___ Rheumatic Fever
___ Vaccinations

___ Chronic pain
___ Fatigue
___ Weakness
___ Dizziness or fainting
___ Numbness/tingling/paralysis
___ Neurological disease
___ Seizures
___ Memory loss
___ Headaches
___ Head injury
___ Dental problems
___ Cold sores
___ Ear infections
___ Impaired hearing/vision
___ Sinus problems
___ Thyroid problems

___ Difficulty breathing
___ Chest pain
___ Heart palpitations
___ Atherosclerosis
___ Gastrointestinal paralysis
___ Heartburn
___ Gastritis or ulcers
___ Excessive thirst/hunger
___ Hypoglycemia
___ Eating disorder
___ Parasites
___ Liver disease
___ Gallbladder disease
___ Kidney disease
___ Problems with urination
___ Sexual difficulties

When are your symptoms worse?

___ Morning ___ Afternoon ___ At home ___ At work ___ Upon waking
___ Evening ___ Overnight ___ No pattern
___ Other: ____
____
____

Family History

If you or anyone in your immediate family has had any of the following conditions, please indicate who was affected (self, mother, father, sister, brother, child):

Cancer ______________________
Heart Disease ______________________
Stroke ______________________
High blood pressure ______________________
Alcoholism or substance abuse ______________________
Attempted suicide ______________________
Diabetes ______________________
Asthma, hay fever, rashes ______________________
Osteoporosis ______________________
Depression ______________________
Autoimmune disease ______________________
Other ______________________

For Men Only

Please check all that apply to you:

___ Prostate exam _____/_____/_____
___ Regular self-testicular exam
___ Impaired fertility
___ Sexual abuse
___ Abnormal discharge from penis
___ Pain or lump in scrotum
___ Prostate problem
___ Sexually transmitted infection

For Women Only

Last menses _____/_____/_____
Last pap smear _____/_____/_____
Age menses began _________
Number of pregnancies _________
Number of live births _________

If you are still having periods:

Average number of days of bleeding _________
Average number of days in cycle _________
Bleeding is: ___ Regular ___ Irregular
___ Light ___ Medium ___ Heavy
Symptoms: ___ Bleeding between periods
___ Mood swings ___ PMS
___ Painful menses ___ Breast tenderness

If you are no longer having periods:

___ Hot flashes ___ Vaginal dryness
___ Dry skin ___ Changes in memory
___ Spotting ___ Changes in libido
___ Facial hair ___ Changes in mood
___ Hair loss ___ Hormone replacement therapy
___ Incontinence ___ Urinary tract infections

Please check all that apply to you:

___ Hysterectomy _____/_____/_____
___ Abnormal pap smear
___ Breast pain/lump/nipple discharge
___ Sexual difficulties
___ Frequent vaginitis/chronic yeast infections
___ Abnormal vaginal discharge
___ Endometriosis
___ Polycystic ovary syndrome
___ Sexually transmitted infection
___ Pelvic inflammatory disease
___ Uterine fibroids
___ Impaired fertility
___ Sexual abuse
___ Regular self-breast exam
___ Sexually active
___ Use methods to prevent pregnancy and/or sexually transmitted infections:
Current: ______________________
Past: ______________________

Lifestyle History

Please check any that apply to you and fill in corresponding details:

___ 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

___ Toxic exposure ____
___ Major life change in last year ____
____

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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: _________________________