

Happy N' Healthy Naturopathy

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SENIOR INTAKE FORM (60+ YEARS YOUNG)

Patient's Name: _____ Date: _____

Age: ____ Date of Birth: ____ / ____ / ____ female male

Address: _____ City: _____ State: ____ Zip _____

Home Phone (____) _____ Work Phone(____) _____

Occupation (past and/or present) _____ Part or Full Time or Retired

Soc. Sec. # _____ email _____

Married Separated Divorced Widowed Single Cohabiting

Live with: Spouse Partner Relatives Children Friends Parents Alone

Next of Kin or other to reach in case of emergency _____ Relationship _____

Address _____ Phone _____ Work Phone _____

Name of Family Doctor: _____ Phone _____

Current Health Condition

When, where and from whom did you last receive medical or health care?

Reason? _____

How did you hear about Happy N' Healthy Naturopathy? : _____

List of most important health problems, in order of importance:

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Family History

If any blood relative had any of the following, please indicate their relationship to you (see key below) and name the disease on the line provided, following each condition:

F=father **M**=mother **GF**=grandfather **GM**=grandmother **S**=sister **B**=brother **A**=aunt **U**=uncle
O=offspring

Genetic Disease _____ Bleeding easily _____ Anemia _____
Allergies/Hay fever _____ Asthma _____ Eczema _____
Arthritis/Rheumatism _____ Cancer/Tumor _____ Diabetes _____
High blood pressure _____ Heart Disease _____ Stroke _____
Kidney disease _____ Thyroid trouble _____ Diabetes _____
Celiac disease _____ Epilepsy _____ Dementia _____
Alcohol addiction _____ Drug addiction _____ Other _____

Childhood Illnesses: Scarlet fever Diphtheria Rheumatic fever Mumps Measles

German measles Other _____

Immunizations: Polio Pertussis Diphtheria Tetanus shot Measles/Mumps/Rubella

Influenza Pneumococcal TB Other _____

Hospitalizations and/or Surgeries: (include reason/diagnosis and dates)

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Allergies: (list any foods, drugs, or other allergens)

Current Medications: (include name, dosage, and frequency of use)

Prescription drugs

- 1) _____ 5) _____
- 2) _____ 6) _____
- 3) _____ 7) _____
- 4) _____ 8) _____

Over-the-counter drugs: including supplements

- 1) _____ 5) _____
- 2) _____ 6) _____
- 3) _____ 7) _____
- 4) _____ 8) _____

Social Assessment:

1) Has any of the following happened in the last year? (describe if yes)

Death of spouse _____

Death of other close family member or friend _____

Change in health of family member _____

Change in living situation Divorce or separated Marriage or "pairing up" _____

Change in financial status _____

2) How often do visitors come to see you? Daily Weekly Less often Never

3) Describe what you ate yesterday (or on any typical day):

Breakfast _____

Lunch _____

Dinner _____

Snack/Drinks _____

Functional Status:

1) For how long (if at all) has your health limited you in each of the following activities?

	Limited for more than 3 months	Limited for less than 3 months	Not limited at all
a. The kinds or amounts of vigorous activities you can do, like lifting heavy objects, running, participating in strenuous sports, etc.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Working at a job.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Walking uphill or climbing stairs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Bending, lifting, or stooping.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Walking one block.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

f. Eating, dressing, bathing, or using the toilet.....

2) Do you require help for any of the following? If yes, who provides it?

Meal preparation_____

Shopping_ _____

Light housekeeping Laundry_ _____

Getting out of bed Getting into bed Dressing_____

Bathing_____

Review of Symptoms

Please circle one, only if it applies to you:

C=chronic condition, N=new, P=Past.

General

Weight_____ Weight 1 year ago_____ Maximum weight_____

When_____ Height_____

Skin

Rashes.....C N P

Eczema, hives.....C N P

Lesions.....C N P

Itching.....C N P

Color change.....C N P

Lumps.....C N P

Night sweats.....C N P

Excessive dryness.....C N P

Head

Headache.....C N P

Head injury.....C N P

Eyes

Impaired vision.....C N P

Eye pain.....C N P

Tearing or dryness.....C N P

Double vision.....C N P

Glaucoma.....C N P

Cataracts.....C N P

Ears

Impaired hearing.....C N P

Ringing.....C N P

Earache.....C N P

Dizziness.....C N P

Hearing aid.....C N P

Nose and Sinuses

Frequent colds.....C N P

Nose bleeds.....C N P

Stuffiness.....C N P

Hay fever.....C N P

Sinus problems.....C N P

Mouth and Throat

Frequent sore throat.....C N P

Sore tongue.....C N P

Gum problems.....C N P

Hoarseness.....C N P

Dental cavities.....C N P

Dentures.....C N P

Lesions.....C N P

Neck

Lumps.....C N P
 Swollen glands.....C N P
 Goiter.....C N P
 Pain or stiffness.....C N P

Respiratory

Asthma.....C N P
 Bronchitis.....C N P
 Pneumonia.....C N P
 Pleurisy.....C N P
 Emphysema.....C N P
 Difficulty breathing.....C N P
 Pain on breathing.....C N P
 Shortness of breath at night.....C N P
 lying down.....C N P
 Tuberculosis.....C N P
 Cough.....C N P
 Sputum.....C N P
 Spitting up blood.....C N P
 Wheezing.....C N P

Cardiovascular

Heart disease.....C N P
 Angina.....C N P
 High blood pressure.....C N P
 Murmurs.....C N P
 Rheumatic fever.....C N P
 Chest pain.....C N P
 Swelling in ankles.....C N P
 Palpitations, fluttering.....C N P

Gastrointestinal

Trouble swallowing.....C N P
 Heartburn.....C N P
 Change in thirst.....C N P
 Change in appetite.....C N P
 Nausea.....C N P
 Vomiting.....C N P
 Vomiting blood.....C N P
 Loose stool.....C N P
 Constipation.....C N P
 Bowel movements.....C N P
 How often? _____
 Is this a change? _____

Gastrointestinal cont

Blood in stool.....C N P
 Belching/passing gas.....C N P
 Jaundice (yellow skin).....C N P
 Liverdisease.....C N P
 Gall bladder disease.....C N P
 Ulcer.....C N P
 Hemorrhoids.....C N P

Abdominal mass.....C N P

Urinary

Pain on urination.....C N P
 Increased frequency.....C N P
 Frequency at night.....C N P
 Inability to hold urine.....C N P
 Involuntary urine leak.....C N P
 Bladder problems.....C N P
 Hesitancy/straining.....C N P
 Intermittent stream.....C N P
 Frequent infections.....C N P
 Kidney stones.....C N P

Female Reproductive

Menstrual.....C N P
 Menopausal.....C N P
 Menopause symptoms.....C N P
 Vaginal bleeding.....C N P
 Hysterectomy.....C N P
 Reason? _____
 Birth control?.....C N P
 What type? _____
 Number of pregnancies? _____
 Number of live births? _____
 Number of miscarriages? _____
 Number of abortions? _____
 Sexually active?.....C N P
 Sexual difficulties.....C N P
 Venereal disease.....C N P
 Sexual preference: (circle one)
 Heterosexual Bisexual Homosexual

Breasts

Do you self exam?
 Lumps/masses.....C N P
 Pain or tenderness.....C N P
 Nipple discharge.....C N P

Male Reproductive

Hernias.....C N P
 Testicular masses.....C N P
 Testicular pain.....C N P
 Prostate disease.....C N P
 Venereal disease.....C N P
 Discharge or sores.....C N P
 Sexually active?.....C N P

Sexual difficulties.....C N P
Sexual preference: (circle one)
Heterosexual Bisexual Homosexual

Musculoskeletal

Joint pain or stiffnessC N P
Joint swelling.....C N P
Arthritis.....C N P
Frequent dislocationsC N P
Broken bones.....C N P
Muscle spasm/crampsC N P
Weakness.....C N P
Peripheral Vascular.....C N P
Deep leg pain.....C N P
Cold hands/feet.....C N P
Varicose veins.....C N P
Thrombophlebitis.....C N P
Nerve pain.....C N P
Fainting.....C N P
Seizures.....C N P
Paralysis.....C N P
Resting tremors.....C N P
Muscle weakness.....C N P
Numbness or tingling.....C N P
Forgetfulness.....C N P
Endocrine.....C N P
Hypothyroid.....C N P
Hyperthyroid.....C N P
Heat/cold intolerance.....C N P
Excessive thirst.....C N P
Excessive hunger.....C N P
Extreme fatigue.....C N P
Blood AnemiaC N P
Easy bleeding/bruising.....C N P
Blood disease.....C N P

Emotional

DepressionC N P
Mood swingsC N P
IrritabilityC N P
Anxiety/nervousnessC N P
Cry easilyC N P
Cry rarelyC N P
Fall oftenC N P
Unsteady sensations.....C N P

Habits:

What are your main hobbies and interests? List in order of preference, and amount of time spent on each:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Do you exercise? What forms and how often?

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Lifestyle

Do you eat 3 meals daily..... Y..... N
Awaken rested..... Y..... N
Sleep well..... Y..... N
Average 6-8 hours sleep..... Y..... N
Nap during day..... Y..... N
How often? _____
Insomnia..... Y..... N
Spend time
outside..... Y..... N
How often? _____
Watch television..... Y..... N
How many hours a day? _____
Read..... Y..... N
How many hours a
day?.....
Take vacations..... Y..... N
How often? _____
Been treated for drug dependence.....
Y..... N
Use recreational drugs..... Y..... N
Use alcoholic beverages..... Y..... N
Been treated for alcoholism..... Y..... N
Smoke or chew tobacco..... Y..... N

Informed Consent

I acknowledge and understand that I have been informed and understand that:

1. Any education, advice or health plans provided to me as a client of Happy N' Healthy Naturopathy are **not** to replace medical care that I am receiving from another licensed health care provider or medical doctor.
2. Happy N' Healthy Naturopathy strongly recommends that I am an active patient of a licensed health care provider.
3. I agree to pay for any fees for service, costs of supplements, and remedies at time of service.

First Office Call, New Patient: Fee \$175

This fee covers the first time a patient is seen by Dr. Sinclair, provided the patient *has not been previously* seen at Happy N Healthy. It includes pertinent physical exams, possible lab test to be ordered (fee for labs is separate) and is approximately one and one half hours in length.

First Office Call, *Established* Patient: fee \$120

This fee covers the first time a patient is seen by Dr. Sinclair, provided the patient is *already an established* patient at Happy N Healthy and has been referred by one of the Happy N Healthy Doctors or Nurse Practitioners. It includes pertinent physical exams, possible lab tests to be ordered (fee for labs is separate) and is approximately one and one half hours in length.

Return Office Call: fee \$80

This fee covers successive appointments with Dr. Sinclair. It is approximately one hour in length.

4. I have read the above information and consent to pay for services rendered at the time of service. I acknowledge that I may request the fees for various procedures and medications before they occur or are prescribed, and include that information in the decision regarding my healthcare. I consent to treatment as agreed upon between Dr. Sinclair and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any concerns in my care with Dr. Sinclair.

Signature _____ **date:** _____
(Patient or Parent / Legal Guardian)

Print Name of patient _____