

# Happy N Healthy Naturopathy

## New Patient Intake Form- Adult

*Please print clearly*

Name: \_\_\_\_\_ Name you go by: \_\_\_\_\_

Social Security # \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (cell): \_\_\_\_\_

Email: \_\_\_\_\_

Relationship status and name of partner:

Single: \_\_\_\_\_ Married: \_\_\_\_\_ Separated: \_\_\_\_\_

Divorced: \_\_\_\_\_ Domestic Partner: \_\_\_\_\_ Widowed \_\_\_\_\_

Live with: (Y or N) Spouse \_\_\_ Partner \_\_\_ Parents \_\_\_ Children \_\_\_ Friends \_\_\_ Alone \_\_\_

Children: (name and age) \_\_\_\_\_

Pets: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_

How did you hear about Happy N' Healthy Naturopathy?

\_\_\_\_\_

**Current Health Concerns:** *Please list in order of importance the health concerns that you would like to address today.*

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

What if any treatments have you tried for these conditions and what were the results?

---

---

**ALLERGIES**

*Are you allergic to any medications, herbs, foods, animals or any other substances not mentioned?*

<b>Substance</b>	<b>Reaction</b>
_____	_____
_____	_____
_____	_____

**CURRENT MEDICATIONS:**

<b>Name of Drug</b>	<b>Reason taking</b>	<b>Dose</b>	<b>How long</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_  
\_\_\_\_\_

**Vitamins minerals and herbal supplements you are taking**

Name	Reason	Dose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medical care:**

Name of primary care doctor \_\_\_\_\_

last check up \_\_\_\_\_

Name of dentist \_\_\_\_\_

last check up \_\_\_\_\_

Name of eye doctor \_\_\_\_\_

last check up \_\_\_\_\_

Name of chiropractor \_\_\_\_\_

last appointment \_\_\_\_\_

**Family History:**

*List any illness that pertain to the following family members (ex. hypertension, diabetes, hypothyroidism, osteoarthritis, any autoimmune disease, cancers etc)*

Mother \_\_\_\_\_

Father \_\_\_\_\_

Siblings \_\_\_\_\_

Spouse \_\_\_\_\_

Children \_\_\_\_\_

**PAST MEDICAL HISTORY:**

**Childhood illnesses.** Check (✓) if apply

Chickenpox \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_ Whooping cough \_\_\_\_\_ Mono \_\_\_\_\_  
Measles \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Hepatitis \_\_\_\_\_ Other \_\_\_\_\_

**Hospitalizations, surgeries, motor vehicle accidents**

\_\_\_\_\_ year \_\_\_\_\_  
\_\_\_\_\_ year \_\_\_\_\_  
\_\_\_\_\_ year \_\_\_\_\_

**X-Rays, CAT Scans, or Other Diagnostic Studies:**

\_\_\_\_\_  
\_\_\_\_\_

**LIFESTYLE / ENVIRONMENTAL FACTORS**

Do you consume any of the following **at least once a week?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Antacids          | <input type="checkbox"/> Artificial sweeteners | <input type="checkbox"/> Alcohol        |
| <input type="checkbox"/> Carbonated drinks | <input type="checkbox"/> Distilled water       | <input type="checkbox"/> Fried foods    |
| <input type="checkbox"/> Laxatives         | <input type="checkbox"/> Luncheon meat         | <input type="checkbox"/> Margarine      |
| <input type="checkbox"/> Salt (in excess)  | <input type="checkbox"/> Tea                   | <input type="checkbox"/> Tobacco        |
| <input type="checkbox"/> Coffee            | <input type="checkbox"/> Fast foods            | <input type="checkbox"/> Sweets / candy |

Do you have any dietary restrictions? Explain.

\_\_\_\_\_

How do you relax (include hobbies and leisure activities)?

\_\_\_\_\_

How is your energy level? Rate on a scale of 1 to 10 (1=very low; 10=excellent). \_\_\_\_\_

Do you smoke? Y or N Have you smoked in the past? Y or N How many packs per day for how many years? \_\_\_\_\_

Do you exercise regularly (include frequency, duration, and type)?  
\_\_\_\_\_

## REVIEW OF SYSTEMS

Please check off any conditions you currently have (indicate with **X**) or have had in the past (indicate with **✓**):

### General:

- Poor appetite
- Sleep difficulties
- Intolerance to heat / cold
- Fever / chills
- Fatigue / weakness
- Significant weight change

### Head:

- Headaches     Dizziness
- Eye problems     Hearing problems
- Ear infections     Ringing in ear(s)
- Earaches     Nosebleeds
- Nasal congestion     Frequent nasal discharge

### Respiratory system:

- Chronic cough
- Sputum / phlegm
- Breathing noises (e.g. wheezing)
- Shortness of breath / difficulty breathing
- Coughing up blood
- Chest pain
- Other?

### Heart & circulation:

- Murmurs     Palpitations
- Varicose veins     Calf pain
- Swelling of ankles / feet
- Other?

### Skin:

- Rash / hives
- Easy bruising
- Lumps
- Hair problems / changes
- Jaundice
- Itching

### Mouth, throat & neck:

- Frequent sore throats
- Sore tongue/mouth /gums
- Chronic bad breath
- Swollen glands
- Dental cavities - silver fillings

### Abdomen & gastrointestinal system:

- Change in appetite     Nausea / vomiting
- Change in thirst     Blood in stool
- Tarry black stool     Belching / flatus
- Heartburn     Indigestion
- Bloating     Diarrhea
- Constipation     Hernias
- Food allergies / intolerances
- Abdominal pain     Hepatitis
- Change in bowel habit
- Change in stool color

### Urinary system:

- Urinary frequency     Frequency at night
- Sense of urgency     Pain
- Dribbling     Blood in urine
- Difficulty passing urine
- Frequent infections     Change in color
- Cloudiness

**Female:**

- Age of first period? \_\_\_\_\_
- Length of full cycle? \_\_\_\_\_
- Premenstrual symptoms
- Painful periods
- Infertility
- Frequent vaginal infections
- Discharge
- Breast lumps / tenderness
- Pregnancies # \_\_\_\_\_
- Miscarriages # \_\_\_\_\_
- Abortions # \_\_\_\_\_
- Abnormal Pap tests
- Sexually transmitted diseases
- Birth control (if so, what type? )
- Sexual difficulties / difficulties with libido
- Other gynecological concerns? \_\_\_\_\_
- are you sexually active with men, women or both? (circle)

**Musculoskeletal:**

- Broken bones
- Muscle cramps
- Joint swelling / pain / stiffness
- Weakness
- Bone pain
- Back pain
- Osteoporosis
- Other?
- Rheumatoid arthritis

**Male:**

- Infertility
- Sexual difficulties / difficulties with libido
- Sexually transmitted diseases
- Discharge
- Rashes
- Pain in genitals
- Varicose veins in scrotum
- Difficulty starting or stopping urine flow?
- Are you sexually active with men, women or both? (circle)
- Lumps or masses in testicles

**Nervous system:**

- Fainting
- Numbness/tingling
- Loss of balance
- Paralysis
- Tremors
- Other?

## Informed Consent

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

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.

Happy N' Healthy Naturopathy strongly recommends that I am an active patient of a licensed health care provider.

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 Family Medicine. 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 \$150**

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 Family Medicine 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 \$90**

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

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** \_\_\_\_\_