

Happy N' Healthy Naturopathy

Robin Sinclair, ND

7 Stiles Rd Suite 101 Salem, NH 03079

603-685-6977



New Patient Intake Form: 13-17 years old

Please print clearly

Name: _____ Name you go by: _____

Social Security # ____/____/____ Age: ____ Sex: ____ Date of Birth: ____/____/____

Address: _____

Phone (home): _____ (cell): _____

Email: _____

Pets: _____ Hobbies: _____

Emergency Contact _____ Phone# _____

Name and relationship

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?

Substance	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS:

Name of Drug	Reason taking	Dose	How long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Vitamins minerals and herbal supplements you are taking

Name	Reason	Dose	How long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History:

	Mother	Father	Brother(s)	Sister(s)
Age (if living)				
Health (good/avg)				
Deceased age				

Check (√) all that apply for each:

	Mother	Father	Siblings
Allergies			
Alcohol/Drug Abuse			
Anemia			
Arthritis (OA or RA)			
Autoimmune			
Alzheimers			
Cancer (specify kind)			
Diabetes			
Epilepsy/Seizures			
Hepatitis			
Kidney Disease			
Heart Disease			
High Blood Pressure			
Stroke			
Mental Illness			
Obesity			
Thyroid Condition			
Other			

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 _____
 _____ year _____
 _____ year _____

MEDICAL CONDITIONS:

Circle (C) if currently are experiencing condition or (P) if you have previously experience condition.

- | | | | | | |
|---|---|--------------------|---|---|---------------------|
| C | P | Allergies | C | P | Hepatitis |
| C | P | Anemia | C | P | High Blood Pressure |
| C | P | Asthma | C | P | HIV/AIDS or ARC |
| C | P | Autoimmune | C | P | Hypertension |
| C | P | Cancer | C | P | Irritable Bowel |
| C | P | Canker Sores | C | P | Joint Problems |
| C | P | Chronic Fatigue | C | P | Lung Disease |
| C | P | Chronic Infections | C | P | Mononucleosis |
| C | P | Depression/Anxiety | C | P | Pneumonia |
| C | P | Diabetes | C | P | Seizures |
| C | P | Ear Infections | C | P | Substance Abuse |
| C | P | Eating Disorder | C | P | Stroke |
| C | P | Eczema | C | P | Syphilis |
| C | P | Fracture | C | P | Tonsillitis |
| C | P | Glaucoma | C | P | Ulcers |
| C | P | Gonorrhea | C | P | Venereal Disease |
| C | P | Heart Disease | C | P | Weight Change |
| C | P | Herpes | | | |

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

Accidents/Injuries/Transfusions (Type, Date and Important Details):

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.

Are you under excess stress? Explain.

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

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

What is your current weight? Maximum? Ideal?

Have you ever been physically, sexually, and / or emotionally abused? Explain.

Do you use any recreational drugs (include type and frequency)?

How old is your residence? _____ Type of heating: _____

Type of flooring (hardwood, linoleum, carpets, rugs, etc.): _____

Any pets? _____ What kind? _____

Please use the space below to include any further information regarding your personal health history, family history, past medical history or lifestyle / environmental factors that may be of relevance to your service provider:

REVIEW OF SYSTEMS

Please check off any conditions you currently have :

General:

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

Head:

- Headaches
- Eye problems
- Ear infections
- Earaches
- Nasal congestion
- Other?
- Dizziness
- Hearing problems
- Ringing / buzzing in ear(s)
- Nosebleeds
- 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
- Varicose veins
- Swelling of ankles / feet
- Other?
- Palpitations
- Calf pain

Female:

- Age of first period? _____
- Length of full cycle? _____
- Premenstrual symptoms
- Painful periods
- Infertility
- Frequent vaginal infections
- Discharge
- Breast lumps / tenderness
- Pregnancies # _____

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
- Other

Abdomen & gastrointestinal system:

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

Urinary system:

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

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?

Female cont:

- Miscarriages # _____
- Abortions # _____
- Abnormal Pap tests
- Sexually transmitted diseases
- Birth control (if so, what type?)
- Sexual difficulties / difficulties with libido
- Other gynecological concerns?
- O 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

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:

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 _____