

Happy N Healthy Naturopathy

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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: (✓) 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?

Substance Reaction

CURRENT MEDICATIONS and SUPPLEMENTS:

Name of Drug or Supplement	Dose	When started	Reason taking

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 _____

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:

_____ year _____

_____ year _____

_____ year _____

LIFESTYLE / ENVIRONMENTAL FACTORS

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

- Antacids Artificial sweeteners Alcohol
- Carbonated drinks Distilled water Fried foods
- Laxatives Luncheon meat Margarine
- Salt (in excess) Tea Tobacco
- Coffee Fast foods 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 or have had in the past. Please indicate with a **C** for current or a **P** for past.

<p>General/Skin:</p> <ul style="list-style-type: none"><input type="checkbox"/> Poor appetite<input type="checkbox"/> Rash / hives<input type="checkbox"/> Sleep difficulties<input type="checkbox"/> Easy bruising<input type="checkbox"/> Intolerance to heat / cold<input type="checkbox"/> Lumps<input type="checkbox"/> Fever / chills<input type="checkbox"/> Hair problems / changes<input type="checkbox"/> Fatigue / weakness<input type="checkbox"/> Jaundice<input type="checkbox"/> Significant weight change<input type="checkbox"/> Itching <p>Head: Mouth, throat & neck:</p> <ul style="list-style-type: none"><input type="checkbox"/> Headaches<input type="checkbox"/> Dizziness<input type="checkbox"/> Frequent sore throats<input type="checkbox"/> Eye problems<input type="checkbox"/> Hearing problems<input type="checkbox"/> Sore tongue/mouth /gums<input type="checkbox"/> Ear infections<input type="checkbox"/> Ringing in ear(s)<input type="checkbox"/> Chronic bad breath<input type="checkbox"/> Earaches<input type="checkbox"/> Nosebleeds<input type="checkbox"/> Swollen glands<input type="checkbox"/> Nasal congestion<input type="checkbox"/> Frequent nasal discharge<input type="checkbox"/> Dental cavities - silver fillings <p>Respiratory system:</p> <ul style="list-style-type: none"><input type="checkbox"/> Chronic cough<input type="checkbox"/> Nausea / vomiting<input type="checkbox"/> Sputum / phlegm<input type="checkbox"/> Breathing noises (e.g. wheezing)<input type="checkbox"/> Shortness of breath / difficulty breathing<input type="checkbox"/> Coughing up blood<input type="checkbox"/> Asthma or COPD <p>Female:</p> <p>Age of first period?</p> <p>Length of full cycle?</p> <ul style="list-style-type: none"><input type="checkbox"/> Infertility<input type="checkbox"/> Sexual difficulties / difficulties with libido<input type="checkbox"/> Premenstrual symptoms<input type="checkbox"/> Sexually transmitted diseases	<p>Abdomen & gastrointestinal system:</p> <ul style="list-style-type: none"><input type="checkbox"/> Change in appetite<input type="checkbox"/> Change in thirst<input type="checkbox"/> Blood in stool<input type="checkbox"/> Tarry black stool<input type="checkbox"/> Belching / flatus<input type="checkbox"/> Heartburn or Indigestion<input type="checkbox"/> Bloating<input type="checkbox"/> Diarrhea<input type="checkbox"/> Constipation<input type="checkbox"/> Hernias<input type="checkbox"/> Food allergies / intolerances<input type="checkbox"/> Abdominal pain<input type="checkbox"/> Hepatitis<input type="checkbox"/> Change in bowel habit<input type="checkbox"/> Change in stool color <p>Heart & circulation:</p> <ul style="list-style-type: none"><input type="checkbox"/> Murmurs<input type="checkbox"/> Palpitations<input type="checkbox"/> Chest pain<input type="checkbox"/> Urinary frequency<input type="checkbox"/> Frequency at night<input type="checkbox"/> Varicose veins<input type="checkbox"/> Calf pain <p>Urinary system:</p> <ul style="list-style-type: none"><input type="checkbox"/> Blood in urine<input type="checkbox"/> Other?<input type="checkbox"/> Difficulty passing urine<input type="checkbox"/> Frequent infections<input type="checkbox"/> Change in color<input type="checkbox"/> Cloudiness<input type="checkbox"/> Sense of urgency<input type="checkbox"/> Pain<input type="checkbox"/> Swelling of ankles / feet<input type="checkbox"/> Dribbling <p>Male:</p> <ul style="list-style-type: none"><input type="checkbox"/> Pain in genitals<input type="checkbox"/> Discharge<input type="checkbox"/> Varicose veins in scrotum<input type="checkbox"/> Difficulty starting or stopping urine flow?<input type="checkbox"/> Lumps or masses in testicles<input type="checkbox"/> Sexually transmitted diseases<input type="checkbox"/> Sexual difficulties / difficulties with libido<input type="checkbox"/> are you sexually active with men, women or both? (circle)
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<p>Female Cont'd</p> <ul style="list-style-type: none"> <input type="checkbox"/> Painful periods <input type="checkbox"/> Discharge <input type="checkbox"/> Infertility <input type="checkbox"/> Rashes <input type="checkbox"/> Frequent vaginal infections <input type="checkbox"/> Breast lumps / tenderness <input type="checkbox"/> Discharge <input type="checkbox"/> Pregnancies # _____ <input type="checkbox"/> Miscarriages # _____ <input type="checkbox"/> Abortions # _____ <input type="checkbox"/> Abnormal Pap tests <input type="checkbox"/> Sexually transmitted diseases <input type="checkbox"/> Birth control (if so, what type?) <input type="checkbox"/> Difficulties with libido <input type="checkbox"/> Other gynecological concerns? _____ <hr/> <p><input type="checkbox"/> are you sexually active with men, women or both? (circle)</p>	<p>Musculoskeletal: Nervous system:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Broken bones <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Fainting <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Joint swelling / pain / stiffness <input type="checkbox"/> Loss of balance <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremors <input type="checkbox"/> Bone pain <input type="checkbox"/> Back pain <input type="checkbox"/> Other? <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Other?
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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. Klasman. 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.

Return Office Call: fee \$90

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

Missed Appointment: fee \$50

We do understand that there may be extenuating circumstances; however, we do request that any cancellation or change in your appointment be made 48 hours in advance. Patients that do not keep appointments or cancel with less than 48 hours notice will be charged a fee. This includes cancellation messages left on our answering machine after hours, a day or two before your appointment.

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. Klasman and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any concerns in my care with Dr. Klasman.

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

Print Name of patient _____