Happy N Healthy Naturopathy

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New Patient Intake Form- Senior (60+ years)

Please print clearly

Name: ___________________________________ Name you go by: ________________
Social Security #_____/______/_____ Age:____ Sex:____
Date of Birth:____/____/_____
Address:____
Address:___________________________ City:______________ State:_____ Zip _______
Home Phone: (_____)__________________ Cell Phone: (_____)____________________
Occupation (past and/or present):_______________________ Part or Full Time or Retired
Email__________________________________

☐Married ☐Separated ☐Divorced ☐Widowed ☐Single ☐Cohabitating

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 Primary Care 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 ☐Pnuemococcal ☐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 and Supplements:

Name of Drug or Supplement	Dose	When started	Reason taking

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 of 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, strenuous sports, etc..	☐	☐	☐
b. Working at a job	☐	☐	☐
c. Walking uphill of climbing stairs	☐	☐	☐
d. Bending, lifting, or stooping	☐	☐	☐
e. Walking one block	☐	☐	☐
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

General

Weight________ Weight 1 year ago_______ Maximum weight________ When_____Height_________

Please circle one, only if it applies to you:

C=Chronic Condition, **N**=New, **P**=Past.

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
Lesions.................................C N P

Neck

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

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

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

Urinary

Pain on urination…………..C N P
Increased frequency……...C N P
Frequency at night………..C N P

Wheezing..............................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

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

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

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

Emotional

Depression……………..C N P
Mood swings…………..C N P
Irritability………………..C N P
Anxiety/nervousness….C N P
Cry easily………………C N P
Cry rarely………………C N P
Fall often……………….C N P
Unsteady sensations…C N P

Musculoskeletal

Joint pain or stiffness ....C N P
Joint swelling.........................C N P
Arthritis.................................C N P
Frequent dislocations ....C N P
Broken bones........................C N P
Muscle spasm/cramps ....C 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 Anemia …………........C N P
Easy bleeding/bruising..........C N P
Blood disease.......................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)________________________________

Do you exercise? What forms and how often?

1)________________________________
2)________________________________
3)________________________________

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 reacreational 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:
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.

First Office Call, *Established* Patient: fee $150
This fee covers the first time a patient is seen by Dr. Klasman, 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. 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 24 hours in advance. Patients that do not keep appointments or cancel with less than 24 hours notice will be charged a fee. This includes cancellation messages left on our answering machine after hours, the day 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 ____