Happy N Healthy Naturopathy

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New Patient Intake Form- 13-17 years of age

Please print clearly

Name: ___________________________________ Name you go by: ________________
Social Security #_____/______/_____ Age:____ Sex:____
Date of Birth:____/____/_____
Address:____
____
Phone (home): ________________________ (cell): _______________________
Email: ____
Pets:___________________________
Hobbies:____________________________________
Emergency Contact ____________________________ Name and relationship
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:

Name of Drug or Supplement	Dose	When started	Reason taking

FAMILY HISTORY:

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

Mother____
Father____
Siblings____

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 _____

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

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

LIFESTYLE / ENVIRONMENTAL FACTORS
Do you consume any of the following **at least once a week**?
o Antacids o Artificial sweeteners o Alcohol
o Carbonated drinks o Distilled water o Fried foods
o Laxatives o Luncheon meat o Margarine
o Salt (in excess) o Tea o Tobacco
o Coffee o Fast foods o 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? ____________

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 or have had in the past. Please indicate with a **C** for current or a **P** for past.

General/Skin:
- o Poor appetite
- o Rash / hives
- o Sleep difficulties
- o Easy bruising
- o Intolerance to heat / cold
- o Lumps
- o Fever / chills
- o Hair problems / changes
- o Fatigue / weakness
- o Jaundice
- o Significant weight change
- o Itching

Head: Mouth, throat & neck:
- o Headaches
- o Dizziness
- o Frequent sore throats
- o Eye problems
- o Hearing problems
- o Sore tongue/mouth /gums
- o Ear infections
- o Ringing in ear(s)
- o Chronic bad breath
- o Earaches
- o Nosebleeds
- o Swollen glands
- o Nasal congestion
- o Frequent nasal discharge
- o Dental cavities - silver fillings

Respiratory system:
- o Chronic cough
- o Nausea / vomiting
- o Sputum / phlegm
- o Breathing noises (e.g. wheezing)
- o Shortness of breath / difficulty breathing
- o Coughing up blood
- o Asthma or COPD

Female:

Age of first period? ____________

Length of full cycle? _____________

- o Infertility
- o Premenstrual symptoms
- o Sexually transmitted diseases
- o Painful periods

Abdomen & gastrointestinal system:
- o Change in appetite
- o Change in thirst
- o Blood in stool
- o Tarry black stool
- o Belching / flatulence
- o Heartburn or Indigestion
- o Bloating
- o Diarrhea
- o Constipation
- o Hernias
- o Food allergies / intolerances
- o Abdominal pain
- o Hepatitis
- o Change in bowel habit
- o Change in stool color

Heart & circulation:
- o Murmurs
- o Palpitations
- o Chest pain
- o Urinary frequency
- o Varicose veins
- o Calf pain

Urinary system:
- o Blood in urine
- o Frequency at night
- o Difficulty passing urine
- o Frequent infections
- o Change in color
- o Cloudiness
- o Sense of urgency
- o Pain
- o Swelling of ankles / feet
- o Dribbling

Male:
- o Pain in genitals
- o Discharge
- o Varicose veins in scrotum
- o Difficulty starting or stopping urine flow?
- o Lumps or masses in testicles
- o Sexually transmitted diseases
- o are you sexually active? ____________

Female Cont'd	**Musculoskeletal: Nervous system:**
o Discharge o Frequent vaginal infections o Breast lumps / tenderness o Discharge o Abnormal Pap tests o Pregnancies o Sexually transmitted diseases o Birth control (if so, what type?)_________ ______________________________________ o Other gynecological concerns? _____ _____________________________________ o are you sexually active? ____________	o Broken bones o Muscle cramps o Fainting o Numbness/tingling o Joint swelling / pain / stiffness o Loss of balance o Weakness o Paralysis o Tremors o Bone pain o Back pain o Other? o Osteoporosis o Rheumatoid arthritis o 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. 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 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 ____