

Patient Intake Form

Full Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: female \_\_\_\_\_ male \_\_\_\_\_

Are you (check one): Single \_\_\_\_ Married \_\_

Partner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address:

(Street / PO Box)

(City)

(State)

(Zip code)

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Relationship)

What are the concerns for which you are seeking care? (Primary concern first)

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

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

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

Who is your primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the name and phone number of any other physicians if you would like us to request your medical records.

(Name) (Phone)

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

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

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

Please sign the attached Medical release form.

For what concern did you last receive health or medical care?

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

**Medications and Supplements**

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all of your allergies to medications, environment and food:

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

Circle each that you currently use:

􀀀 Laxatives

􀀀 Pain relievers

􀀀 Antacids

􀀀 Cortisone

􀀀 Antibiotics

􀀀 Heart/Blood medication

􀀀 Allergy Medication

􀀀 Thyroid medication

􀀀 Sleeping pills

􀀀 Anti-depressants

􀀀 Birth Control Pills

􀀀 Hormones

Do you have any known diseases/diagnosis at this time? 􀀀 Yes 􀀀 No

If yes, what?\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalizations, Surgery, X-Ray and Special Studies**

What hospitalizations, surgeries, x-rays, or special studies have you had?

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

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General**

Weight \_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Check any of the following you have or have had in the past 6 months.**  **SKIN** | **HEAD / NECK** | | **IMMUNE** |
| \_\_\_Rashes | \_\_\_Headache/migraine | | \_\_\_Chronic Fatigue Syndrome |
| \_\_\_Eczema, Hives | \_\_\_Faintness | | \_\_\_Chronic infections |
| \_\_\_Acne, Boils | \_\_\_Dizziness | | \_\_\_Chronically swollen glands |
| \_\_\_Itching | \_\_\_Jaw Pain | | \_\_\_Slow wound healing |
| \_\_\_Fungal Infections | |
| \_\_\_Color change | \_\_\_Goiter | | **MUSCLES / JOINTS/ BONES** |
| \_\_\_Hair Loss | \_\_\_Pain or stiffness | | \_\_\_Joint pain |
| \_\_\_Dry skin / scalp | \_\_\_TMJ | | \_\_\_Muscle pain |
| \_\_\_Lumps | | \_\_\_Muscle spasms / cramps | |
| \_\_\_Night Sweats | **RESPIRATORY** | | \_\_\_Restless leg Syndrome |
| \_\_\_Slow healing ulcerations | \_\_\_Chest congestion | | \_\_\_Sciatica |
| \_\_\_Flushing or hot flashes | \_\_\_Wheezing | | \_\_\_Osteoporosis |
| \_\_\_Asthma | | | |
| **NOSE AND SINUSES** | \_\_\_Bronchitis/Pneumonia | | **NEUROLOGIC** |
| \_\_\_Frequent colds | \_\_\_Emphysema | | \_\_\_Seizures |
| \_\_\_Nose Bleeds | \_\_\_Difficulty/Pain breathing | | \_\_\_Paralysis |
| \_\_\_Stuffiness | \_\_\_Shortness of breath | | \_\_\_Muscle weakness |
| \_\_\_Hay fever | \_\_\_Tuberculosis | | \_\_\_Numbness or tingling |
| \_\_\_Sinus problems | \_\_\_Cough \_\_\_Wet or \_\_\_Dry | | \_\_\_Easily stressed |
| \_\_\_Loss of smell | \_\_\_Coughing blood | | \_\_\_Vertigo or dizziness |
| \_\_\_Loss of balance | | | |
| **EYES AND EARS** | **CARDIOVASCULAR** | | \_\_\_Tics |
| \_\_\_Itchy eyes | | \_\_\_Heart disease | |
| \_\_\_Watery eyes | \_\_\_Angina/Chest pain | | **DIGESTION** |
| \_\_\_Dry eyes | \_\_\_High/Low Blood Pressure | | \_\_\_Trouble swallowing |
| \_\_\_Swollen/painful eyes | \_\_\_Murmurs | | \_\_\_Heartburn / Acid Reflux |
| \_\_\_Red Eyes | \_\_\_Blood clots | | \_\_\_Change in thirst/appetite |
| \_\_\_Impaired vision/Blurriness | \_\_\_Irregular heart beat | | \_\_\_Ulcer |
| \_\_\_Floaters in vision | \_\_\_Palpitations/Fluttering | | \_\_\_Nausea/Vomiting |
| \_\_\_Cataracts | \_\_\_Swelling in ankles | | \_\_\_Gas/Bloating |
| \_\_\_Color blindness | | \_\_\_Belching or passing gas | |
| \_\_\_Double Vision | **CIRCULATION** | | \_\_\_Diarrhea |
| \_\_\_Glaucoma | \_\_\_Easy bleeding or bruising | | \_\_\_Constipation |
| \_\_\_Hearing difficulty | \_\_\_Anemia | | \_\_\_Pain or cramps |
| \_\_\_Ringing | \_\_\_Deep leg pain | | \_\_\_Mucous in stools |
| \_\_\_Earaches/Infection | \_\_\_Varicose veins | | \_\_\_Black / Bloody stool |
| \_\_\_Cold hands/feet | | \_\_\_Hemorrhoids | |
| **MOUTH AND THROAT** | | \_\_\_Itchy / Burning Anus | |
| \_\_\_Sore throat | **ENDOCRINE** | | \_\_\_Rectal Pain |
| \_\_\_Copious saliva | \_\_\_Hypothyroid | | \_\_\_Liver/Gall Bladder trouble |
| \_\_\_Teeth grinding | \_\_\_Heat or cold intolerance | | \_\_\_Jaundice (yellow skin) |
| \_\_\_Sore tongue/lips | \_\_\_Hypoglycemia | | Bowel Movements: How often?\_\_\_ |
| \_\_\_Gum problems | \_\_\_Diabetes | | Is this a change? \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Hoarseness | \_\_\_Excessive thirst | | Stools \_\_\_Hard \_\_\_Firm |
| \_\_\_Gagging/choking | \_\_\_Excessive hunger | | \_\_\_Soft \_\_\_ Loose |

|  |  |
| --- | --- |
| **Check any of the following you have or have had in the past 6 months.**  **URINARY** | **FEMALE ONLY** |
| \_\_\_Pain on urination | \_\_\_Irregular cycles |
| \_\_\_Increased frequency | \_\_\_Bleeding between cycles |
| \_\_\_Frequency at night | \_\_\_Pain during intercourse |
| \_\_\_Frequent infections | \_\_\_Clotting |
| \_\_\_Inability to hold urine | \_\_\_Heavy or excessive flow |
| \_\_\_Kidney stones  \_\_\_Blood in Urine | \_\_\_PMS  \_\_\_Difficulty conceiving |
|  | \_\_\_Endometriosis |
|  | |
| **MENTAL/ EMOTIONAL** | \_\_\_Painful menses |
| \_\_\_Mood Swings | \_\_\_Vaginal discharge? Color? \_\_\_\_\_\_ |
| \_\_\_Anxiety or nervousness | \_\_\_Vaginal Odor |
| \_\_\_Considered/Attempted suicide | \_\_\_Ovarian cysts |
| \_\_\_Depression | \_\_\_Menopausal symptoms |
| \_\_\_Poor concentration | \_\_\_Abnormal PAP |
| \_\_\_Poor Memory | \_\_\_Sexually transmitted disease |
| \_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_Breast pain/tenderness |
|  | |
| **GENERAL** | \_\_\_Breast Lumps |
| \_\_\_Poor Sleep / Insomnia | Age at which menses began \_\_\_\_\_\_ |
| \_\_\_Dream disturbed Sleep | Age of last menses (if menopausal)\_\_\_ |
| \_\_\_Fatigue / Low Energy | Length of Cycle (Day 1 to Day 1)\_\_\_\_\_\_\_ |
| \_\_\_General feel Hot | Duration of Flow \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_General feel Cold | Date of last period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Chills | Are you sexually active? Yes No |
| \_\_\_Fevers | Sexual orientation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Poor Appetite | Birth control? Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Constant Hunger | Number of pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Cravings \_\_\_\_\_\_\_\_\_\_\_ | Number of live births \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Peculiar taste in mouth | Number of miscarriages \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Low Libido |  |
| \_\_\_Experience High Stress | \_\_\_Difficult or premature births |
| Do you do breast self-exams? Yes No | |
| **MALE ONLY** | Date of last Pap smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Hernias |  |
| \_\_\_Testicular masses |  |
| \_\_\_Testicular pain |  |
| \_\_\_Prostate disease | |
| \_\_\_Sexually transmitted disease | |
| \_\_\_Discharge or sores | |
| \_\_\_Sexual dysfunction | |
| Are you sexually active? Yes No | |
| Sexual orientation? \_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | |

I would like to take a moment to welcome you to my practice. Whether you are here for a one-time visit, or are looking for a longer-term comprehensive health solution, I look forward to my role in your care. Below are a few questions that really assist me in understanding “where you’re coming from” and how I can best support your health.

1) How did you discover this clinic and why did you decide to see Dr. Catherine Onuoha now?

2) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% **0 1 2 3 4 5 6 7 8 9 10** 100%

If you answered less than “10”, what stands between your current commitment and 100%?

3) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

4) What do you love most about your life at this time?

5) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)

6) What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols which I will be sharing with you?

7) What are your top three expectations of me?

**INFORMED CONSENT**

The purpose of this form is to present risks and benefits of the therapies I offer. Please initial the sections that apply to you. This must be signed before treatment is rendered. Ask me of you have any questions or concerns at any time.

**NATUROPATHIC MEDICINE** Initials:\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Naturopathy combines safe and effective traditional therapies with the most current advances in modern medicine by attempting to find the underlying cause rather than focusing on symptomatic treatment. The doctors in our clinic treat a variety of conditions including women’s health, stress, pain, organ dysfunction, infections, and much more. There is risk of pharmaceutical/supplement interaction, so inform your ND of current medications. Your ND may suggest hydrotherapy, which encourages circulation, enhanced immune function and relaxation. Side effects are minimal, but may include dizziness, fatigues, detoxification reactions and irritated skin.

**SUPPLEMENTS, HERBALS, HOMEOPATHICS**

Initials:\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

These are products that can aid in healing by nutritional, energetic, and mechanical support; They can be effective for many conditions. Be sure to inform your practitioner about all medications you currently take to minimize drug/supplement interactions. Some side effects may be gas, bloating, and less commonly allergic reaction. If biomechanical support is needed, back braces, cervical pillows, cervical traction, or orthotics may be suggested for your particular case.

**IMAGING, REFERRALS** Initials:\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Further lab work (X-rays, MRI, blood work, urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested. The following are examples: medical management (referral to a specialist such as neurologist, ENT, allergist, ect), physical therapy, vestibular testing, psychological evaluation, injection therapy, surgery, naturopathic, chiropractic, acupuncture, massage, etc.

There are many alternatives to the therapies I offer. I recommend consulting with your Primary Care Physician if you have any concerns about my recommendations.

**Uses and Disclosures**

We may use and disclose your health information for different reasons.

• Treatment: To assist in your diagnosis and treatment.

• Payment: In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plan to get reimbursed for services.

• Health Care Operations: For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

We must disclose, when required by law, for the following examples:

• Avoid threat to health or safety. To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.

• Coroners, Funeral Directors, Organ Donation. To said professionals such that they can carry out their duties.

• Health oversight activities. To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.

• Health-related benefits or services. For appointment reminders or to give you information about treatment alternatives or services that may be of interest to you.

• Law Enforcement, judicial and administrative proceedings. In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.

• National security and intelligence. As required by military officials for security and military purposes.

• Public health activities. To public health agencies for reasons such as preventing or controlling disease, injury or disability.

• Research. For medical research – Such circumstances include taking steps to protect your privacy.

• Victims of abuse, neglect or domestic violence. To government agencies and law enforcement personnel as required by law.

• Workers’ compensation. In compliance with workers’ compensation laws.

**Authorization**

Any uses or disclosures other than those described above will be made only with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

• I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments initialed above.

Patient Name (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_