

IMAGE OF HEALTH



New Patient Intake Form

Please fill out this questionnaire as thoroughly as possible. Print all information clearly and mark anything you don't understand with a question mark. All information contained in these pages is completely confidential.

Personal Information

Today's Date _____

Name _____ Age _____ Date of birth ____/____/____

Phone - Home (____) _____ Work (____) _____ Mobile (____) _____

Preferred ___ Home ___ Work ___ Mobile ___ Is it OK to leave messages? ___ Yes ___ No

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Email address _____

Are you interested in receiving email notifications of classes and lectures? ___ Yes ___ No

If the patient is under the age of 18:

Name of mother _____ Phone number _____

Name of father _____ Phone number _____

Who may we thank for your referral? _____

Have you been to a Doctor of Naturopathic Medicine before? ___ If so, when? _____

Under what circumstances? _____

When did you last receive medical care? _____

Where? _____ Why? _____

What is your most important reason for making this appointment? _____

Please list other medical concerns, in order of importance: _____

Emergency Contact

Name _____

Relationship _____

Phone Number _____ Day (____) _____ Evening (____) _____

Address _____ Apt # _____

Health History

Please list any known allergies (environmental, drug, food): _____

Do you take any of the following over-the-counter medications? Please check any that apply:

___ Aspirin ___ Ibuprofen or acetaminophen ___ Antihistamine ___ Sleeping pills

___ Laxatives ___ Appetite depressants ___ Antacid ___ Medicine to stay awake

Please list any pharmaceutical and/or natural medications (including vitamins) that you are taking or have taken in the last year:

Medication	Dosage	Dates	Reason for taking

If any of the following apply to you, please indicate dates:

- | | |
|-------------------------|-------------------|
| Hospitalization _____ | Endoscopy _____ |
| Surgery _____ | Colonoscopy _____ |
| X-ray _____ | Mammogram _____ |
| MRI _____ | CT scan _____ |
| Rectal exam _____ | Bone Scan _____ |
| Electrocardiogram _____ | Other _____ |

For the following conditions and symptoms, please indicate any that apply to you by marking "C" for current or "P" for past:

- | | | |
|--|--|--|
| <input type="checkbox"/> Skin rash | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Easy bleeding or bruising | <input type="checkbox"/> Weakness | <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> Varicose veins or hemorrhoids | <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Atherosclerosis |
| <input type="checkbox"/> Bone or joint disease | <input type="checkbox"/> Numbness / tingling / paralysis | <input type="checkbox"/> Gastrointestinal disorder |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Neurological disease | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> Seizures | <input type="checkbox"/> Gastritis or ulcers |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Excessive thirst / hunger |
| <input type="checkbox"/> Feel unsafe at home | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Head injury | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Frequent antibiotic use | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Frequent colds or flu | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Gallbladder disease |
| <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Impaired hearing / vision | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Problems with urination |
| <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Sexual difficulties |

When and where are your symptoms worse?

<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> At home	<input type="checkbox"/> At work	<input type="checkbox"/> Upon waking
<input type="checkbox"/> Other _____		<input type="checkbox"/> Evening	<input type="checkbox"/> Overnight	<input type="checkbox"/> No pattern

Family History

If you or anyone in your immediate family has or had any of the following conditions, please indicate who was affected (self, mother, father, sister, brother, child):

- | | |
|-------------------------------------|---------------------------------|
| Cancer _____ | Diabetes _____ |
| Heart Disease _____ | Asthma, hay fever, rashes _____ |
| Stroke _____ | Osteoporosis _____ |
| High blood pressure _____ | Depression _____ |
| Alcoholism or substance abuse _____ | Autoimmune disease _____ |
| Attempted suicide _____ | Other _____ |

For Men Only

Please check all that apply to you:

- Prostate exam _____ / _____ / _____
- Regular self testicular exam
- Impaired fertility
- Sexual abuse

- Abnormal discharge from penis
- Pain or lump in scrotum
- Prostate problem
- Sexually transmitted infection

For Women Only

- Last menses _____ / _____ / _____
- Last pap smear _____ / _____ / _____
- Age menses began _____
- Number of pregnancies _____
- Number of live births _____

Please check all that apply to you:

- Hysterectomy _____ / _____ / _____
- Abnormal pap smear
- Breast pain / lump / nipple discharge
- Sexual difficulties
- Frequent vaginitis / chronic yeast infections
- Abnormal vaginal discharge
- Endometriosis
- Polycystic ovary syndrome
- Sexually transmitted infection
- Pelvic inflammatory disease
- Uterine fibroids
- Impaired fertility
- Sexual abuse
- Regular self breast exam
- Sexually active
- Use methods to prevent pregnancy and/or sexually transmitted infections:
Current _____
Past _____

If you are still having periods:

- Average number of days of bleeding _____
- Average number of days in cycle _____
- Bleeding is Regular Irregular
- Light Medium Heavy
- Symptoms Bleeding b/n periods Mood swings
- PMS Painful menses Breast tenderness

If you are no longer having periods:

- Hot flashes Vaginal dryness
- Dry skin Changes in memory
- Spotting Changes in libido
- Facial hair Changes in mood
- Hair loss Hormone replacement therapy
- Incontinence Urinary tract infections

Lifestyle History

Please check any that apply to you and fill in corresponding details:

- Exercise _____ hours per week
- Activities _____
- Watch TV _____ hours per week
- Tobacco use _____ packs per day
- Alcohol use _____ drinks per week
- Recreational drug use
- Mercury amalgam fillings
- Employed outside the home
- Occupation _____
- Hours per week _____
- Employer _____
- Do you enjoy your work? Yes No
- Toxic exposure _____
- Major life change in last year _____

- Height _____
- Weight _____
- Weight one year ago _____
- Maximum weight _____
- When? _____
- Sleep _____ hours per night
- Is this enough? Yes No
- Meals per day _____
- Bowel movements per day _____
- Dietary restrictions _____
- Level of stress Low Average High

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HIPPA CONSENT FORM

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient: _____