



# Vibrant Health

Naturopathic Medical Center

501 Islington Street, Suite 2B

Portsmouth, NH 03801

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## New Patient Intake Form

### Personal Information

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: H (\_\_\_\_) \_\_\_\_\_ W (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Preferred \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_ Is it OK to leave messages? \_\_\_\_\_ yes \_\_\_\_\_ no

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

If you were referred to us, who may we thank? \_\_\_\_\_

Are you interested in receiving email notifications of classes and lectures? \_\_\_\_\_ yes \_\_\_\_\_ no

### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # H (\_\_\_\_) \_\_\_\_\_ W (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Have you been to a Doctor of Naturopathic Medicine before? \_\_\_\_\_ If yes, when? \_\_\_\_\_

What were you being treated for? \_\_\_\_\_

Were you satisfied with your care? \_\_\_\_\_ If not, please explain: \_\_\_\_\_

When was the last time you had medical care and for what reason? \_\_\_\_\_

Name & Phone # of PCP: \_\_\_\_\_

What are your primary health concerns? List them in order of importance to you:

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

What is the primary expectation you have for your visit at our clinic today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Health History**

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Please list any known allergies (environmental, drug, food, animals, chemicals/perfumes): \_\_\_\_\_

\_\_\_\_\_

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

Which diagnostic studies have you had? 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 a "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 paralysis |
| <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 are your symptoms worse?

Morning       Afternoon       At home       At work       Upon waking  
 Evening       Overnight       No pattern  
 Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family History**

*If you or anyone in your immediate family has 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:*

<input type="checkbox"/> Prostate exam _____/_____/_____	<input type="checkbox"/> Abnormal discharge from penis
<input type="checkbox"/> Regular self-testicular exam	<input type="checkbox"/> Pain or lump in scrotum
<input type="checkbox"/> Impaired fertility	<input type="checkbox"/> Prostate problem
<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> 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:

***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 between 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

Current: \_\_\_\_\_  
 Past: \_\_\_\_\_

**Lifestyle History**

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

<input type="checkbox"/> Exercise _____ hours per week	Height _____
Activities _____	Weight _____
<input type="checkbox"/> Watch TV _____ hours per week	Weight one year ago _____
<input type="checkbox"/> Tobacco use _____ packs per day	Maximum weight _____
<input type="checkbox"/> Alcohol _____ drinks per day _____ per week	When? _____
<input type="checkbox"/> Recreational drug use	Sleep _____ hours per night
<input type="checkbox"/> Mercury amalgam fillings	Is this enough? ___ yes ___ no
<input type="checkbox"/> Employed outside the home	# of Meals per day _____
Occupation _____	Bowel movements per day _____
Hours per week _____	Dietary restrictions _____
Employer _____	_____
Do you enjoy your work? ___ yes ___ no	Level of stress ___ Low ___ Average ___ High
<input type="checkbox"/> Toxic exposure _____	
<input type="checkbox"/> Major life change in last year _____	

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**Nicole Schertell ND, CCT    Johanna Mauss, ND**

## **HIPAA CONSENT FORM**

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment or to obtain payment from insurance companies.

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: \_\_\_\_\_