Redefined Health

NATUROPATH PATIENT INTAKE FORM

Please complete the following questions:

What are your current health concerns?

Please list them in **order of importance**:

1._____

2._____

3._____

4._____

Allergies:

Are you **hypersensitive or allergic** to any of the following?

Drugs: _____

_____

_____

Foods: _____

_____

_____

Environmental allergens: _____

_____

_____

Current Medications:

Please list all prescription medications, vitamins, or other supplements you are taking and the reason/condition for using them.

1._____

2._____

3._____

4._____

5._____

6._____

Typical daily food intake:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

Beverages: _____

_____

General:

Weight: _____lbs. Height: _____ ft. _____in.

Weight 1 year ago: _____lbs.

Max weight/when: _____

Please circle yes or no for the following:

Do you exercise:	YES	NO
Have a supportive relationship:	YES	NO
Had any major traumas:	YES	NO
Have a history of abuse:	YES	NO
Treated for drug dependence:	YES	NO
Treated for alcoholism:	YES	NO
Do you smoke cigarettes:	YES	NO
Do you use recreational drugs:	YES	NO

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Please x the appropriate answer:
Yes = A condition you are experiencing now.
No = A condition you have never had.
Past = A condition you have had in the past.

Mental/Emotional

Mood Swings	□Yes □No □Past
Anxiety or nervousness	□Yes □No □Past
Poor concentration	□Yes □No □Past
Memory Problems	□Yes □No □Past

Endocrine

Low thyroid	□Yes □No □Past
Heat or cold intolerance	□Yes □No □Past
Low blood sugar	□Yes □No □Past
Diabetes	□Yes □No □Past
Fatigue	□Yes □No □Past
Seasonal depression	□Yes □No □Past

Immune

Vaccinations	□Yes □No □Past
Reactions to vaccinations	□Yes □No □Past
Chronic infections	□Yes □No □Past
Chronic swollen glands	□Yes □No □Past
Mood Swings	□Yes □No □Past
Slow wound healing	□Yes □No □Past

Skin

Rashes	□Yes □No □Past
Eczema, Hives	□Yes □No □Past
Acne, Boils	□Yes □No □Past
Itching	□Yes □No □Past

Head

Headaches	□Yes □No □Past
Migraines	□Yes □No □Past
Head Injury	□Yes □No □Past

Ears

Earaches	□Yes □No □Past
Ringing in ears	□Yes □No □Past
Dizziness	□Yes □No □Past

Nose and Sinus

Frequent colds	□Yes □No □Past
Nosebleeds	□Yes □No □Past
Congestion	□Yes □No □Past
Seasonal allergies	□Yes □No □Past
Sinusitis	□Yes □No □Past
Loss of smell	□Yes □No □Past

Mouth and throat

Frequent sore throat	□Yes □No □Past
Burning tongue	□Yes □No □Past

Respiratory

Cough	□Yes □No □Past
Wheezing	□Yes □No □Past
Asthma	□Yes □No □Past
Bronchitis	□Yes □No □Past

Cardiovascular

Heart disease	□Yes □No □Past
High/low blood pressure	□Yes □No □Past
Palpitations	□Yes □No □Past
Strokes	□Yes □No □Past

Urinary

Increased frequency	□Yes □No □Past
Frequency at night	□Yes □No □Past
Frequent infections	□Yes □No □Past

Gastrointestinal

Heartburn	□Yes □No □Past
Passing gas	□Yes □No □Past
Belching	□Yes □No □Past
Change in thirst	□Yes □No □Past
Change in appetite	□Yes □No □Past
Constipation	□Yes □No □Past
Diarrhea	□Yes □No □Past

How many bowel movements/day? _____

Musculoskeletal

Joint pain	□Yes □No □Past
Stiffness	□Yes □No □Past
Muscle spasms	□Yes □No □Past
Arthritis	□Yes □No □Past

Redefined Health

Consent to Naturopathic Medical Care

Patient Name: _____

Date of Birth: _____

I hereby consent to my Naturopathic Doctor (Dr. Leyanna Zubach-Cassano) to treat me for the purposes I have indicated on my Client Intake form. I consent to any assessments, physical examinations and techniques which may be recommended by my Naturopathic Doctor. This can also include acupuncture, as seen fit and mutually agreed upon.

I acknowledge and understand that the Naturopathic Doctor must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Naturopathic Doctor and have disclosed all medical conditions affecting me. It is my responsibility to keep my Naturopathic Doctor updated on my medical history. The medical information I have provided is true and complete to the best of my knowledge. I authorize my Naturopathic Doctor to release or obtain information pertaining to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents of my treatment. By signing this form, I confirm my consent to Naturopathic medical care and intend this consent to cover the treatment discussed, as well as any other treatment proposed by my Naturopathic Doctor. I understand that I may withdraw my consent for future treatment at any time and my treatment will then be discontinued.

Cancellation policy: We appreciate at least **24 hours'** notice for cancellation of any appointment. If circumstances are such that an appointment must be missed, please notify us as soon as possible. **Please be advised that no-show appointments will be subject to a fee of 50% of the appointment value.** Redefined health does offer direct billing to secondary insurance companies on your behalf. It is the responsibility of the patient to confirm and understand the extent of their coverage amounts and restrictions with their individual insurance company. All service payments are due when service is rendered. For any amounts not immediately covered by extended health plans, payment is accepted in the form of Cash, Debit, Visa or MasterCard. I understand that I am responsible for payment of all services or treatments rendered at Redefined Health.

Patient name: _____

Patient signature_____ Date: _____

Witness name: _____

Witness signature: _____ Date: _____