Hartman and Sun
Naturopathic Clinic, LLC

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New Patient Intake

Name _____ **Today's date:** ____/____/____

Address _____ **City** _____ **State** _____ **Zip** _____

Birthdate ____/____/____ **Age** _____ **Sex** _____ **E-mail** _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner ☐ Other _____

Spouse/Partner name *(if applicable)* _____

Do you have children? ☐ Yes ☐ No **Ages:** _____

PHONE NUMBERS

Home	**Cell**	**Work**

Primary Care Physician _____ **Phone** _____

Employer _____ **Occupation** _____

EMERGENCY CONTACT INFORMATION

Contact is: ☐ Parent ☐ Guardian ☐ Spouse ☐ Domestic Partner ☐ Other _____

Name _____ **Phone Number** _____

How did you hear about us? _____

Insurance: Medicare ☐ Other: ☐ *If other, please provide to front office to make a copy*

Preferred Pharmacy: _____ Cross Streets: _____ Ph #: _____

(over)

Patient History

Chief Complaints:

1. _____
2. _____
3. _____
4. _____

Other physicians or caring for you:

1. _____
2. _____
3. _____

Past Medical History: (Major illnesses, surgeries or injuries) Date

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Current Prescription Medications:

	Drug name	Dosage	Taking since
1.			
2.			
3.			
4.			
5.			
6.			

Natural supplements: (vitamins, minerals, herbs, homeopathics etc.)

	Supplement name	Dosage	Taking since
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Allergies: (medications, inhalants, foods, others)

1. _____
2. _____
3. _____
4. _____

Date of last complete physical exam: _____

Tobacco use: Current _____ Past_____ How long? _____

Quit when? _____ How many cigarettes daily? (on average) _____

Current occupation? _____

Have you had any jobs that have involved exposure to chemicals/fumes/toxic metals?

_____

Do you have a water filter or buy filtered drinking water? _____

Family history of: Diabetes _____ Heart disease/stroke _____ Cancer _____

Arthritis _____ Other_____

Currently sexually active? _____ Birth Control? Y/N If yes, type(s): _____

Women Only:

Difficulty with periods? _____ Date of last period? _____

Number of live births? _____ Miscarriages?_____ Abortions? _____

Currently using birth control? _____ Have you in the past? _____

Date of last PAP smear? _____ Mammogram?_____

Anything else you would like to tell the doctor:

_____

_____

_____

_____

_____

(over)

Review of Systems

Please circle any of the conditions or symptoms below, if you have experienced them significantly within the last 6 months.

General
Fatigue Weight change Fever / chills
Weakness Night sweats Insomnia

Skin
Itching Rashes Hair/Nail changes

Head
Headache Trauma Dizziness

Nose
Bleeding Discharge Sinus infections Allergies
Post nasal drip

Eyes
Double vision Blurring Pain Discharge
Poor vision

Mouth/Throat
Sores Gums bleeding Hoarseness
Taste Silver Fillings Pain swallowing

Lungs/Breathing
Wheezing Cough Pain
Shortness of breath Coughing blood

Breasts
Masses Pain Discharge

Cardiovascular
Rapid heartbeat Swollen ankles Pain
Angina High-blood pressure Calf pain

Muscles, Joints & Bones
Trauma Pain Arthritis
Osteopenia Osteoporosis

Gastrointestinal
Appetite Nausea/Vomiting Indigestion
Constipation Diarrhea Hemorrhoids
Blood in stool Gas/belching Pain

Urinary/Urination
Pain Waking at night Incontinence
Frequent Urgency Blood

Sexually Transmitted Diseases
Syphilis Gonorrhea Chlamydia
Herpes Sores / discharge Pelvic pain

Female-Menses
Heavy bleeding Pain Irregular cycle
Menopause Spotting PMS

Male
Testicular pain Swelling Masses Discharge

Endocrine
Thyroid conditions Hormone medications
Heat / Cold intolerance Diabetes

Blood-Lymphatic system
Anemia Bleeding tendencies
Swollen lymph nodes Transfusions

Neurologic
Fainting Seizures In-coordination
Numbness/tingling Speech problems
Paralysis/Weakness Tremor

Psycho-social
Anxiety Depression Drug/alcohol abuse
Phobia Memory loss

Do you exercise? _____ If yes, please list the types of exercise and the frequency.

1. _____
2. _____
3. _____
4. _____

List the foods you typically consume for breakfast, lunch and dinner.

Breakfast	Lunch	Dinner

How many times each week do you eat desserts (e.g. cookies, cakes, ice cream, candy etc.)? _____

Do you drink soda? _____ If yes, how many times each week? _____

Do you drink fruit juice? _____ If yes, how many times each week? _____

Do you drink coffee? _____ If yes, how many cups each day? _____

Do you drink alcohol? _____ If yes, how many drinks each week? _____

HIPAA Compliance Form

How we collect information about you: Hartman and Sun Naturopathic Clinic collects data through a variety of means including letters, phone calls, emails and from the submission of applications that is either required by law, or necessary to process applications. **What we do not do with your information:** Information about your medical condition and care that you provide to us in writing, by email, on the phone, or in voice mails is held in strictest confidence. **We do not give out, exchange, barter, sell, lend or disseminate and information about clients who are treated by our clinic:** It is considered confidential and is restricted by law, or has been specifically restricted by a client in a signed **HIPAA** consent form. **How do we use your information:** Information is only used as it reasonably necessary to provide you with health or counseling services which may require communication between other health care providers.

Print name **Sign name** **Date**

Informed Consent and Waiver of Liability

I voluntarily consent to outpatient care at Hartman and Sun Naturopathic Clinic, LLC. which may include diagnostic procedures, physical examination, routine laboratory work, intravenous therapy, hyperbaric oxygen therapy, therapeutic body work and massage and naturopathic medical treatment.

I understand that the treatment suggestions provided may not all be accepted by the United States Food and Drug Administration and therefore should not be taken as such.

I understand and am informed that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I understand that I have the right to a second opinion and secure other treatment options if I have concerns as to the nature of my symptoms.

I understand that any accidental injuries incurred at the Hartman and Sun Naturopathic Clinic are not the responsibility 0f the Hartman and Sun Naturopathic Clinic

I have read this Informed Consent and waiver of liability and have had the opportunity to ask questions about its content. I intend this consent to cover the entire course of treatment for this visit and any future visits.

Print name **Sign name** **Date**