NORTH VALLEY MEDICAL CENTER

Patient Intake Form

Please fill out this form completely and accurately. All information and communication is strictly confidential.

Name: _____ **Age:** _____ **DOB:** ____/____/_____ **Male** ____ **Female** ____

Primary phone #: _____ **Email:** _____

Address: _____ **City/Zip:** _____

EMERGENCY CONTACT: Name: _____ **Phone #:** _____

Who's your doctor? Name: _____ **Phone:** _____ **Fax:** _____

Do you have any drug or food allergies? If yes, please list them: _____

Pharmacy Name/Address: _____ **Phone:** _____

How did you hear about us? _____

LIST YOUR HEALTH CONCERNS

1) _____
2) _____
3) _____

List Yes (Y), No (N) or Past (P) regarding use of the following:

Cigarette smoking: Y N P **Alcohol:** Y N P If yes, how much per week? _____ **Recreational Drugs:** Y N P

List all Prescription Medicines & Nutrient Supplement with dosages that you are currently taking:

Medications: 1: _____ **2:** _____ **3:** _____

Supplements: 1: _____ **2:** _____ **3:** _____

SOCIAL LIFE

Job Title: _____ **Hours worked per week**: _____ **Highest Level of Education**: _____

Enjoy job: Y N P **Active spiritual practice**: Y N P **Quality of significant relationship**: _____

REVIEW OF SYSTEMS

Present Weight: _____ **Height**: _____ **Maximum weight and when**: _____/___/_____ **Ideal Weight**: _____

How is your energy level (circle): High Med Low Very-low What Time is your energy lowest: _____

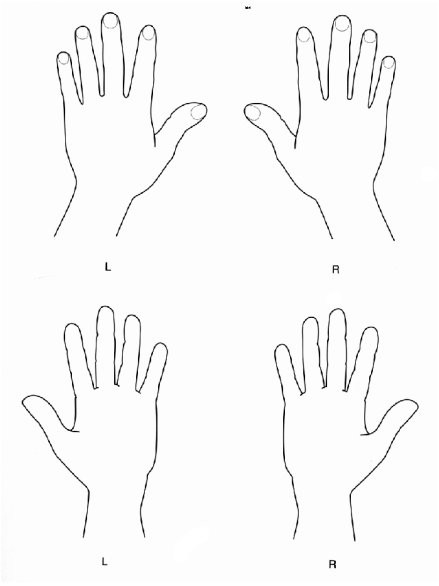
REGARDING THE NEXT SECTION ❑=negative ■=positive

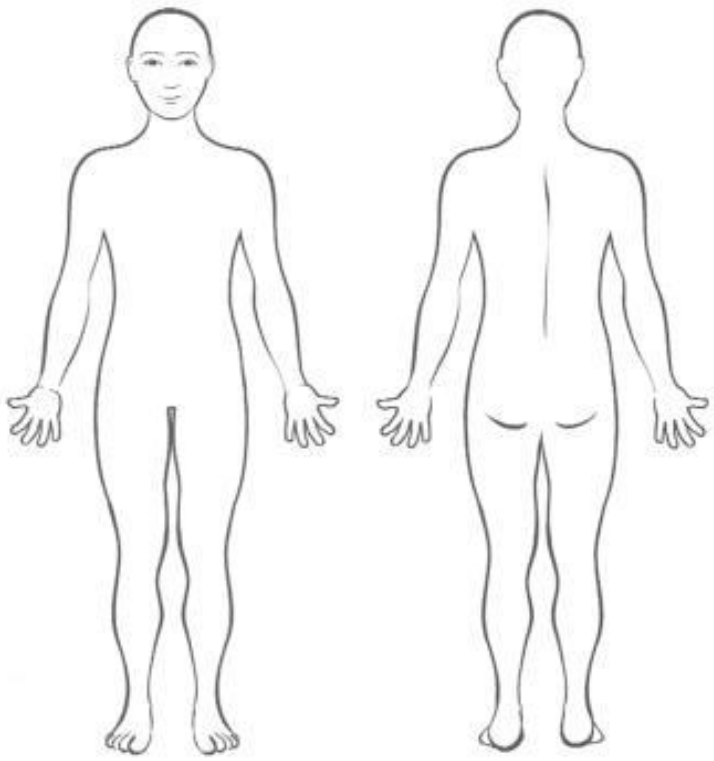
GENERAL: ❑chills ❑fever ❑sweats ❑ night sweats ❑weight changes ❑ fatigue ❑sleep problems	
DERM: ❑rashes ❑Hives ❑Psoriasis/Eczema ❑Dry ❑Cancer ❑Color changes ❑Itching ❑Warts/Moles ❑Perspiration	
HEAD: ❑head injury ❑migraines/Headache ❑Seizures ❑ Hair loss	
EYES: ❑ Glasses or contacts ❑cataracts ❑photophobia ❑ recent vision changes ❑Dryness ❑Glaucoma	
EARS: ❑discharge ❑hearing changes ❑tinnitus ❑Pain	
NOSE/SINUSES ❑sinusitis ❑decreased smell ❑Drippy nose ❑Nose bleeds ❑septal deviation/broken nose	
MOUTH/THROAT: ❑tenderness or lesions ❑sore throats ❑persistent hoarseness ❑pain or difficulty when swallowing ❑Cavities ❑Thrush/Candida overgrowth	
NECK: ❑Stiffness ❑Swollen Glands ❑Tension ❑Injury ❑Pain	
CHEST: ❑ asthma ❑bronchitis ❑COPD ❑chronic cough ❑coughing up blood ❑shortness of breath ❑tuberculosis ❑ Valley fever	
CARDIOVASCULAR: ❑chest pain ❑congestive heart failure ❑stroke ❑bluing of the skin, hands, feet or lips ❑dizziness ❑shortness of breath ❑hypertension ❑dizziness when going from seated to standing position	
GASTROINTESTINAL: ❑constipation ❑clay colored stools ❑diarrhea ❑black stools or blood in stools ❑nausea ❑vomiting ❑hemorrhoids ❑hernias ❑indigestion ❑yellowing of skin or white of eyes ❑rectal bleeding	
GENITOURINARY: ❑ any pain with urination ❑discharge ❑change in frequency day or night ❑hesitancy ❑incontinence ❑chronic Urinary tract infections ❑STD's ❑kidney stones	
FEMALES: menstrual cycle: ❑regular ❑irregular ❑heavy ❑light Menses Duration: _____ days Menses frequency: every ____ weeks ❑menstrual cramps ❑swelling ❑rash or redness ❑change in libido ❑dry vagina ❑pain with intercourse ❑hot flashes how many pregnancies? ____	
MALES: ❑Testicular pain/swelling ❑ Any difficulty getting and/or maintaining and erection? Yes No ❑Prostate Disease	
BREASTS: ❑discharge ❑pain ❑tenderness ❑prior surgery or biopsy	
NEUROMUSCULAR: ❑numbness ❑muscle pains ❑dizzy/vertigo ❑weakness ❑stiffness ❑tremors ❑arthritis	
PSYCHOLOGICAL: ❑depression ❑suicidal ❑anxiety ❑anorexia ❑Anger/Irritability ❑Psych Hospitalizations ❑Memory changes	

PLEASE LOCATE YOUR PAIN BY MARKING THE HUMAN BODY WITH THE PROVIDED KEY

Key:

Dull/achy	/////
Burning	>>>
Sharp	XXX
Shooting	↓↓↓





PLEASE USE THE FOLLOWING NUMBER SCALE TO QUANTIFY YOUR CURRENT PAIN LEVEL

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

How long have you had this pain? _____ When did this pain first start? _____

Is your pain getting: Better _____ Worse _____ Same _____ Does the pain interfere with your sleep? Yes No

Did you have any of the following?
Disease (D), Got Immunized (I), or Neither (N):

Measles:	D I N	**Mumps**:	D I N
Rubella):	D I N	**Chicken Pox**:	D I N
Whooping Cough:	D I N	**Hemophilus (Hib)**:	D I N
Hepatits B:	D I N	**Tetanus**:	D I N

Family History

	Father	Mother	Grandparents
Age if living:			
Age when died:			
Reason for death:			
Cancer type:			
Heart Disease:	**Y N**	**Y N**	**Y N**
Asthma/Allergies:	**Y N**	**Y N**	**Y N**
Mental Illness:	**Y N**	**Y N**	**Y N**
Auto-Immune	**Y N**	**Y N**	**Y N**
Diabetes Mellitus:	**Y N**	**Y N**	**Y N**
Osteoporosis:	**Y N**	**Y N**	**Y N**

INFORMED CONSENT

This form is designed to present benefits and risks of the therapies offered by North Valley Medical Center (NVMC) and *must be signed* before treatment is rendered. *Ask your doctor if you have any questions or concerns regarding your consent to treat prior to signing this Informed Consent form.*

Treatments, procedures and/or products used in your treatment may or may not be FDA approved.

I am seeking medical health care services, including alternative medical therapies by NVMC I hereby request and consent to the performance of physical medicine (including but not limited to various modes of physical therapy and diagnostic testing/examination) or to the performance of acupuncture (including but not limited to needle puncture, point injection, and infrared therapy) or to the performance of naturopathic procedures (including but not limited to examination, diagnostic testing and the use of natural substances such as vitamins, minerals, botanical medicines and prescription drugs) on me (or on the patient named, for whom I am legally responsible) by NVMC.

I understand and am informed that results from treatments may vary and are not guaranteed. In addition, I understand that my compliance with diet recommendations, supplements, prescribed medications, prescribed exercises and lifestyle modification will increase the effectiveness of my care and enhance or maintain the results.

I understand a referral to another physician or specialist may be necessary due to the nature of my condition and limitations in the scope of practice of Naturopathic Medicine.

I acknowledge that the scope of practice of a Naturopathic Physician has limitations including limited prescription privileges and lack of hospital privileges. Consequently a referral to a specialist or emergency room may be deemed necessary under certain circumstances and is in my best interest.

I understand that NVMC uses diagnostic and treatment methods that are known as investigational, complementary, alternative, holistic, nutritional, and herbal oriented. Some of these methods have not been accepted by consensus mainstream medicine or the FDA.

I understand that I am in no way obligated to purchase the products or run labs recommended by NVMC. I am free to purchase these products from any source that I may choose.

I do not expect the doctor to be able to anticipate and explain all the risks and complications that could possibly happen during or because of treatment and I wish to rely on the doctor to be able to exercise judgment during the course of the procedure based upon the facts known at that time.

I understand and am informed that, as in the practice of medicine, in the practice of naturopathic medicine, in the practice of spinal manipulative care, in the practice of intravenous therapy, in the practice of acupuncture, in the practice of prolotherapy, in the practice of nutritional and other supplementation, in the practice of hormone therapy, in the practice of any treatment we administer or order there are some risks. **Some of the potential side effects to treatments and therapies are but are not limited to:** Bruising/Local Tenderness (with venipuncture, acupuncture, Botox, mesotherapy, cupping, manipulation, prolotherapy and other). Allergy (with drugs, supplements, anesthesia, nutritional IVs, chelation, and other). Drug Side-effects (with drug, supplements, herb-drug interactions). Fainting (with supplements, acupuncture, nutritional IVs, chelation and other). Infection (with acupuncture, minor surgeries, venipuncture, prolotherapy and other). Burns (with cryosurgery, hydrotherapy, infared therapy and other). Scars (with cryosurgery, acupuncture, moxabustion, venipuncture, hormone implants, minor surgery and other). Vaginal Bleeding in females (with hormone replacement therapy). Fractures, Dislocation, Sprains, Disk Injuries (with manipulation and other). Strokes (with manipulation and other). Organ Puncture (with acupuncture, prolotherapy, minor surgery, and other)

Patient Rights

You have the right to be treated with courtesy, respect and dignity. You have the right to know the process through which services are offered, including the general course of treatment, and with whom you will be working. You have the right to full confidentiality. All transactions and records within this office are kept strictly confidential. Your records may be released to other parties only when requested in writing by you, or when required by law. You have access and may request copies of your information at any time. You have the right to know and understand the practitioner's assessments and recommendations. These will be given to you at each visit including therapeutic goals, success of treatment, and proposed duration of treatment. If this is unclear please ask. If a medication is prescribed, or any other specific treatment is recommended, you have the right to know what the medication or treatment is, why it is being prescribed, what is the expected outcome, and general side effects which might be reasonably expected. Please ask your physician to explain prior to treatment. You have the right to access other community services and also the right to select and change practitioners. If you are interested in other practitioners or therapeutic modalities, please ask. You have the right to refuse service. You have the right to assert your rights as described within this document at any time without retaliation or fear of negative consequence. You as a patient have the right to full knowledge of fees. You have the right to know of any changes to services or charges and you will be notified.

✓ **I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatments and understand the risks and benefits involved.**

Patient Signature or Legal Guardian of Patient: _____ Date: ____/____/_____