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Patient Intake Form

Please fill out as thoroughly as possible before your first visit.

PATIENT INFORMATION:

Name: DOB: Age: Sex: M / F

­­­­­­­­­­­­­­­­Address: City/Zipcode:

Telephone: Home: Cell: Work:

At what phone numbers can we leave health-related messages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check one: □Single □Married □Widowed □Separated □Other

Number of children and their ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you learn about the clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT HEALTH CONCERNS:

Please list concerns in order of priority:

|  |  |  |
| --- | --- | --- |
| Condition or Concern | Onset | Diagnosed by physician? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

What is your MAIN goal for today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you already have a primary care physician? □Yes □No Name of PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been seen by a naturopathic physician before? □Yes □No

Please list any prescription drugs you are taking:

|  |  |  |
| --- | --- | --- |
| Name | Dose | Duration of use? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

List any supplements you’re taking:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Brand | Dose | Duration |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

PERSONAL AND FAMILY MEDICAL HISTORY:

Please check those that apply to you personally or your immediate family members. Indicate “self” next to the line provided if you have a personal history with a condition. If a condition has occurred in your family please indicate the family member next to the line provided.

□ Measles □ Mumps □ Chickenpox

□ Whooping cough □ Scarlet fever □ Diphtheria

□ Smallpox □ Blood transfusions □ Heart Disease

□ STD’s: □ Hives or eczema □ Tuberculosis

□ Diabetes □ Cancer: □ Polio

□ Glaucoma □ Hernia □ Kidney disease

□ Bleeding tendency □ Anxiety □ Infectious Mono

□ Rheumatic fever □ Mitral valve prolapsed □ Stroke

□ Hepatitis □ Thyroid disease □ AIDS or HIV

□ Anemia □ Depression □ Auto-immune disease

□ Hypertension/ High BP □ Liver disease □ Mental illness

□ Seizures □ Eating disorders □ Elevated cholesterol

Please list any allergies to medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any Hospitalizations, surgeries, and previous traumas (with year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

REVIEW OF SYSTEMS:

Please circle the condition or symptom you have personally experienced within the past 4 weeks time.

General: Skin: Head:

Weight gain Rash Headache

Weight loss Acne Migraine

Fatigue Night sweats/Fever Head trauma

Hair loss Dizziness

Neck:

Lumps Mouth and throat: Eyes:

Swollen lymph nodes Gum problems Impaired vision

Dental problems Increased tearing or dryness

Ears: Frequent sore throat Double vision

Impaired hearing Sore tongue Glaucoma

Ringing Post nasal drip Cataracts

Ear pain

Nose and sinuses: Respiratory:

Endocrine: Nose bleeds Cough (wet or dry?)

Hypothyroid Sinus congestion Wheezing

Hyperthyroid Sinus infection Bronchitis

Diabetes Pneumonia

Hypoglycemia Musculoskeletal: Emphysema

Joint pain/stiffness Difficulty breathing

Cardiovascular: Broken bone(s)

Varicose veins Muscle spasm/cramps Gastrointestinal:

Heart murmur Muscle weakness Heartburn

Chest pain

Ankle swelling Emotional: Change in appetite/thirst

Heart palpitations Irritability Nausea/Vomiting

Elevated cholesterol Depression Blood in stool

Hypertension Anxiety Belching/burping

Emotional lability Gas/bloating

Ulcer

Neurologic: Urinary tract: Bowel movements per day:

Seizures Frequent urination

Fainting Incontinence Miscellaneous:

Paralysis Frequent UTI’s Anemia

Numbness/tingling Blood in urine Easy bruising

Memory difficulties Kidney stones Bone loss

Brain fog Chemical sensitivities

Loss of coordination Female reproductive: Cravings

Vaginal dryness/itching Frequent colds

Male Reproductive: Low libido

Sexual difficulties Pain w/ intercourse Cycle history:

Hernia Nipple discharge Last menstrual period:

Testicular mass PMS/painful menses Length cycle:

Testicular pain Excessive flow Menses length:

Prostate disease Scanty/little flow Current birth control:

Difficulty conceiving Number pregnancies: Number miscarriages:

Please list the estimated dates of your last exams:

Full physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Annual Gyn exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone density screening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Screening mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preventive dental exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood tests (what did they include?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Weight: \_\_\_\_\_\_\_\_\_\_lbs Current Height: \_\_\_\_\_\_\_\_\_\_\_inches

Lifestyle Choices:

Tobacco use? □ yes □ no Type: \_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol use? □ yes □ no Type: \_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational drug us? □ yes □ no Type: \_\_\_\_\_\_\_\_\_\_

Exercise routine? □ yes □ no Type: \_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet:

Typical Breakfast: Lunch:

Dinner: Snacks:

Daily water intake:

Hours of sleep per night:

PEDIATRIC PATIENTS ONLY:

Nickname: Mother’s name: Father’s name:

Term: □ Early □ Full □ Late Birth weight: \_\_\_\_lbs. \_\_\_\_oz. Length of labor: \_\_\_\_\_\_

Pregnancy complications? □ yes □ no Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Labor complications? □ yes □ no Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breastfed? □ yes □ no How long? \_\_\_\_\_\_\_\_ Formula fed? □ yes □ no Milk/Soy/Other

Age your child began: Solid food: \_\_\_\_ Sitting: \_\_\_\_ Crawling: \_\_\_\_ Walking: \_\_\_\_ First words: \_\_\_\_

Please indicate if your child has ever had any of the following: (circle)

Birth defects Birth injuries Colic

Constipation Cough Cries easily

Diarrhea Fever Jaundice

Nightmares Nose bleeds Rash

Seizures Teeth problems Developmental issues

**Vaccination History:**

□ Up to Date (CDC recommended schedule)

□ Alternative vaccination schedule (Please bring records or child’s vaccine booklet)

                    □ I have chosen not to vaccinate my child

Is there any family history of any autoimmune, neurological or neurodevelopmental disorders?  Y/N

Has your child had any reactions to previously administered vaccinations? Y/N

**Last well child visit (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

statement of financial responsibility

Payment Policy:

I understand that payment is expected in full at time of service and that accepted forms of payment include cash, personal checks, Visa, Mastercard and Discover. I am aware that NSF checks will be subjected to a $25 fee. I understand that Generations will bill my insurance for services rendered and further understand that Generations Natural Health Clinic does not guarantee reimbursement by my insurance company, and that it is my responsibility to determine my coverage and pay my responsibility.

I understand that I may request the fees for various procedures before they occur in order to include that information in my healthcare decision-making process. I understand that my practitioner may offer telephone consultations at an additional fee, which I will be made aware of in advance.

Cancellation Policy:

I am aware that Generations Natural Health Clinic requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. I understand that missed appointments without notification may be charged the full visit fee, and cancellations with less than 24 hours notice may be billed 50% of the visit fee.

Patient and/or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT:**

Naturopathic medicine is considered a safe and effective method of care. Occasionally, however, complications can arise that are not predictable. Any procedure or treatment intending to help may have complications, and while the chances of experiencing such complications are small, it is the practice of this clinic to inform our patients of them.

I authorize Dr. Janel Newman-Kovacev ND to order/perform diagnostic tests and prescribe / perform treatments that I am in agreement with and that are in accordance with the Standards of Naturopathic Care for the state of Washington state. This includes but is not exclusive of: common diagnostic procedures (venipuncture, PAP smears, lab tests), minor office procedures (wound dressing, ear lavage), medical use of nutritional therapies (therapeutic nutrition, nutritional supplements, vitamin injections), botanical medicine (plant substances prescribed as teas, alcohol or glycerite-based tinctures, capsules, tablets, powders, creams, plasters or suppositories), homeopathic medicines (the use of highly dilute quantities of natural substances to gently stimulate the body’s own healing processes), lifestyle counseling and hygiene (diet/nutrition therapy, recommendations for exercise, sleep, stress reduction and balancing of social and work activities), psychological counseling, contraceptive management, prescription medications.

While rare, potential risks include but are not limited to: soreness, bruising, inflammation, soft tissue injury, dizziness, allergic reactions to prescribed herbs or supplements and aggravations of pre-existing conditions.

Potential benefits include: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the doctor if they know or suspect that they may be pregnant, since some of the therapies used could present a potential risk to your pregnancy.

If procedures are performed, I have given my permission to do so and acknowledge that full disclosure of information has been made. If I have questions about these procedures I will ask them until they are answered to my full satisfaction. I further acknowledge that there is no guarantee or warrantee, expressed or implied, concerning the outcome of any of the procedures used in the course of my care.

I understand that Generations Natural Health Clinic does not administer emergency medical care. I understand and agree that if I experience a medical emergency while under Dr. Janel Newman-Kovacev’s care, I am to immediately dial 911. After emergency care has been administered, I may seek naturopathic care as follow-care as appropriate.

I recognize that a record will be kept of my care, and that I have the right to obtain a copy of my record upon request. I understand that obtaining a copy of my record may require payment of an administrative fee.

**Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Guardian Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION FORM:**

**Please fill out this form if you DO or DO NOT have insurance coverage for your visits with Dr. Janel.**

 Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you called your insurance to see if visits with Dr. Janel are covered?**

□ Yes, I have called and visits are covered

□ No, I haven’t called, but Dr. Janel is on my provider list

□ No, I haven’t called and I have no idea if visits are covered or not

**Please fill out what you know:**

Co-pay amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Annual Deductible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Percentage visits covered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there Naturopathic benefits/coverage? Y/N

**If your insurance is through someone else (spouse, parent, other) please fill out the following:**

Name of insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date of insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please read, sign and date:**

Generations Natural Health Clinic offers a cash discount for services paid at the time of visit. If your insurance allows you to submit for reimbursement, you have the option of paying this cash discounted fee at the time of your visit. Our office will provide you with the codes needed for you to request reimbursement from your insurance company. This process is usually most beneficial for those patients who may not meet their deductible for the year. This is also a great option for those who know Dr. Janel is not a part of their insurance plan. Please ask for clarification if you think you may benefit from this discount.

Please be aware that Dr. Janel may determine that some non-covered (your insurance will not pay for) tests or other services that may be important for your treatment. Dr. Janel will discuss these potential labs and services with you ahead of time whenever possible. By signing below, you are agreeing to pay for any testing or services that are not covered by your insurance policy and you are agreeing to not hold Generations Natural Health Clinic or Dr. Janel Newman-Kovacev responsible for payment of non-covered services.

**Patient/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Guardian Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**