New Patient Intake Form

• All information herein will remain strictly confidential, unless you consent to our sharing it, by signing a Release Form.
• The more I know about you, the better I am able to help you. Therefore, please take time to thoroughly complete this form before your first office visit.

Date:_____

Last Name:_____ First: _____ Middle Initial: ____

Other names used: _____

Gender: **F M** Date of Birth: _____/_____/_____ SSN _____

Address: _____

City: _____ State:_____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

May we leave confidential voice messages at your home number? **Y N** At cell number? **Y N**

Email address: _____

Emergency Contact Name and Phone number(s): _____

_____ Relationship: _____

Minor's Mother's Name: _____ Father's Name:_____

Please circle: **Single** **Married** **Significant Other**

Names and ages of children: _____

_____

How would you describe your family relationships? _____

_____

Name of Primary Care Physician (PCP): _____

Are you under the care of another health care practitioner(s)? Please list: _____

_____

Severe/Life Threatening Allergies: _____

Drug Allergies: _____

_____

Employer Name: _____

Employer Address: _____

Work Phone: (_____)_____ May we leave confidential messages at this number? **Y N**

Do you enjoy your work? **Y** **N** **Sometimes** Position: _____

How did you hear about Dr. Galbraith? _____

Reason for visit- Please list *in order of importance to you* (we may need more than one visit to address all concerns):

1._____

2._____

3._____

4._____

5._____

6._____

Current prescription/over-the-counter medications

Brand and name of medication:	Dose (mg/day):	Prescribed For:

Have you had any adverse reactions to medications? If yes, please describe:_____

_____

How many times have you been treated with antibiotics? _____

Current supplements (vitamins/minerals/herbs/homeopathics)

Brand and name of product:	Dose (mg/day):	Taken For:

Have you had any adverse reactions to supplements? If yes, please describe:_____

_____

Do you use essential oils on your body or in your home? **Yes** **No**

If yes, how do you use them? **Externally** **Orally** **Other**_____

Serious Illnesses/Injuries/Hospitalizations/Surgeries: Date:

_____ _____

_____ _____

_____ _____

_____ _____

Date of last physical exam: _____ Last PAP:_____

Last breast exam: _____ Last blood tests: _____

Condition	Self	Relation*	Past (P) or Current (C)?	Condition	Self	Relation*	Past (P) or Current (C)?
Alcoholism				Mental Illness			
Addiction				Miscarriage			
Allergies				Mononuceleosis			
Anemia				Parasites			
Arthritis				Pneumonia			
Asthma				Prostatitis			
Cancer				Psoriasis			
Depression				Rheumatic fever			
Diabetes				Scarlet fever			
Eczema				Sinusitis			
Epilepsy				STD			
Headache				Stroke			
Heart disease				Thyroid disease			
Hepatitis				Tonsillitis			
High blood pressure				Tuberculosis			
Kidney disease				Other			

*Use MGM for Maternal Grandmother; MGF for Maternal Grandfather; PGM for Paternal Grandmother; PGF for Paternal Grandfather.

Do you have any inherited conditions? _____

Have you ever served in the military? If yes, which branch and dates served: _____

_____

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc)? If yes, please describe: _____

_____

Please indicate which immunizations you have had:

_____DPT (diphtheria, pertussis, tetanus) ___Hepatitis A ___Hepatitis B

_____MMR (measles, mumps, rubella) ___Smallpox ___Polio

_____Hemophilus Influenza ___Flu ___Tetanus Booster

_____Gardasil (HPV) ___Zostavax (shingles) ___Varicella (chicken pox)

Other: _____

Have you ever had an adverse reaction to an immunization? **Y** **N**

If Yes, which?_____

Please indicate use of the following:

Tobacco (per day):_____ History of Tobacco use:_____

Alcohol (per day):_____ History of alcohol abuse:_____

Coffee (per day):_____ Black/green tea (per day):_____

Soda (per day):_____ Recreational drugs (per day):_____

Aspirin/NSAIDs (per day):_____ Laxatives (per week):_____

Antacids (per day):_____ Hormones (per day):_____

Cortisone (per day):_____ Sedatives (per day):_____

Birth control method:_____ How long?_____

Other birth control used in past:_____

First day of last menstrual period:_____

Exercise (per week & type):_____

_____

What is your typical daily diet?

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Desserts:_____

Beverages:_____

Water (ounces):_____

Do you restrict any foods from your diet? If yes, please describe:_____

_____

_____

If you crave any foods, please list:_____

Have you ever had a bad reaction to any foods?_____

_____

How many times a day do you urinate?_____

Do you get up at night to urinate? **Y** **N** If so, how often?_____

How often do you have a bowel movement? _____

On average, how many hours of sleep do you get per night?_____

Do you have trouble falling asleep? **Y** **N** Staying asleep? **Y** **N** Do you wake refreshed? **Y** **N**

Has your weight changed by more than 5 pounds, recently? ↑ ↓ #_____

Have you traveled outside the U.S. in the last two years? **Y** **N**

Since your health concerns began? **Y** **N** If so, when?_____

Please indicate your level of stress (10 worst): 0 1 2 3 4 5 6 7 8 9 10

Please indicate your level of energy (10 best): 0 1 2 3 4 5 6 7 8 9 10

Do you feel your general state of health is: **Excellent** **Good** **Fair** **Poor**

Do you make time for relaxation? **Y** **N** How often?_____

What are your hobbies? _____

_____

What have been the most stressful events in your life? From - To

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____
5. _____ Date:_____

Is there anything else Dr. Galbraith should know about you or your health concerns?_____

_____

_____

What is your most cherished goal? _____

_____

FINANCIAL NOTICE

Please note that Naturopathic Medicine enjoys limited insurance coverage in the state of New Hampshire. It is expected that you understand your coverage prior to your first appointment, and that you are prepared to pay all co-pays, co-insurance, and any amount not covered due to deductibles that have not been met, or refusal by your plan to pay claims made, including lab tests. Payment in full is expected at the time of the visit, or if claims are denied, upon receipt of a bill from our office. If a check is returned you will be billed the original amount plus the bank fee.

I, _____, understand that I will be expected to pay for services rendered & supplements purchased at the time of my visit, and that any unpaid balance greater than 90 days old may be reported to a collection agency, including Missed Appointment Fees.

Signature_____ Date_____

7/19/18