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___________________

8/10/18