

**NATUROPATHIC MEDICINE INTAKE FORM**

Name: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

**MEDICATIONS** List all prescription and over the counter medications you are taking:

Medication	Dose	Date started (year)	Reason/Condition	Does it help?

**VITAMINS/SUPPLEMENTS/HERBS** Please list all vitamins, herbs and other supplements you are currently taking including the brand names of the items, also **bring the bottles to your first appointment.**

Vitamin/Supplement	Dose (mg/IU, etc.)	Date Started (year)	Reason/Condition

**ALLERGIES** Please list all of your known allergies:

Medications	
Foods	
Environmental/Other (dust, pollen, cats, chemicals)	

**SURGERY HISTORY**

Type of Surgery	Year it was Performed

**FAMILY HISTORY**

Health Condition	Family Member(s)	Health Condition	Family Member(s)
Heart Disease		Breast Cancer	
Diabetes		Colon Cancer	
Stroke		Prostate Cancer	
Autoimmune Disease		Allergies	

**YOUR CURRENT HEALTH**

What are the primary health concerns you would like to discuss with Dr. Tracy?

- 1.
- 2.
- 3.

Has anything recently changed or become worse?

Are you currently using any other therapies? (Chiropractic, Acupuncture, Massage, etc.)?

**LIFESTYLE**

Please Describe Your Typical Diet

Breakfast	
Lunch	
Dinner	
Snacks	

Do you have any dietary restrictions? (check the appropriate box)

Vegetarian  Vegan  Gluten/Wheat Free  Dairy Free  Other, please specify

Alcohol (how much/how often)? \_\_\_\_\_

Smoking (how much/how often)? Exercise (what type/ how often)? \_\_\_\_\_

Caffeinated drinks (coffee, tea, soda a day (in cups or ounces)? \_\_\_\_\_

How much water do you drink daily (in cups or ounces)? \_\_\_\_\_

How many servings of fruit a day? \_\_\_\_\_ How many servings of vegetables a day? \_\_\_\_\_

Exercise (what type/ how often)? \_\_\_\_\_

How many hours do you sleep per night? \_\_\_\_\_ Do you wake rested? \_\_\_\_\_

How many hours do you work each day? \_\_\_\_\_ Occupation: \_\_\_\_\_

How many hours of relaxation/play do you have each week? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

What is your current stress level? (check the appropriate box)

Minimal  Average  Considerable  Unbearable

What are the main sources of your stress? (check appropriate boxes)

Job  Family  Health  Finances  Other, please specify

What do you do to reduce/manage/deal with stress?

**Select the symptoms that apply to you by checking in the appropriate boxes:**

	Past	Present		Past	Present
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Belching or Passing Gas	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Itching or Rash	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Gall Stones	<input type="checkbox"/>	<input type="checkbox"/>
Tension headaches	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Spasms/Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Ear Wax	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in the Ears	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Cold/Flu	<input type="checkbox"/>	<input type="checkbox"/>	Cold Hands/Feet	<input type="checkbox"/>	<input type="checkbox"/>
Postnasal drip	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<b>FOR WOMEN ONLY</b>	<b>Past</b>	<b>Present</b>
Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	Menopause	<input type="checkbox"/>	<input type="checkbox"/>
Mouth Sores or Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Cycles/Missed Periods	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Painful Periods	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Periods	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	PMS	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Pain with Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Conceiving	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Yeast Infections	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian Cyst	<input type="checkbox"/>	<input type="checkbox"/>
Low Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Uterine Fibroids	<input type="checkbox"/>	<input type="checkbox"/>
Sugar or Salt Cravings	<input type="checkbox"/>	<input type="checkbox"/>	Breast Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Breast Mass/Cyst	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or Vomiting	<input type="checkbox"/>	<input type="checkbox"/>			

**Consent to Treatment**

The following may be used to address your health concerns:

**Herbs/Natural Medicines** Herbs, minerals and vitamins may be given in the form of teas, pills, powders, tinctures, topical creams, suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.

**Dietary Advice and Therapeutic Nutrition** Additions, subtractions or modifications to the diet may be recommended  
**Lifestyle Counseling and Exercise Recommendations**

**General Diagnostic Procedures** May include blood, saliva, stool and urine labwork and general physical exams.

**Potential benefits:** Restoration of health and wellbeing, relief of pain and symptoms of disease, improved energy and mental function.

**Potential Risks:** Allergic reactions to prescribed herbs or supplements and aggravation of pre-existing symptoms.

**Notice to Pregnant Women:** All female patients must alert the doctor if they know or suspect that they are pregnant because some therapies used could present a risk to the pregnancy.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Amanda D. Tracy, ND.

**Privacy Practices**

According to the *Health Insurance Portability and Accountability Act* of 1996 (HIPPA), we are required to notify you of our Privacy Practices and supply you with a copy of these practices. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes disclosures to other third parties that are involved in your health care elsewhere. We may use your protected health information in order to support various business activities of our clinic. For example, we may call you by name in the waiting room when ready to see you, and we may use your protected health information, to contact you by mail, email or phone to remind you of your upcoming appointments.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

**Financial Policy**

Naturopathic medical care is not covered by insurance companies in Massachusetts. I understand that I am financially responsible for the charges I incur while under the care of Amanda D. Tracy, ND including office visits, phone and email consults and supplements. I understand full payment is required at the time of service or purchase and can be made by personal check, cash, debit card, Visa, MC, AMEX, or Discover cards.

**Reservation Fee**

Upon scheduling your first appointment, we will collect a reservation fee as a measure of good faith. The fee will be \$50.00 and is entirely refundable if you decide not to keep your appointment (provided you cancel or reschedule at least 24 hours prior to your appointment time) and is applied 100% towards your initial consultation; it is not an additional fee.

Initial 60 minute naturopathic consultation and one-month 30 minute follow-up consultation will be provided for \$250. Subsequent 30 minute follow-up appointments will be provided as needed for \$100.

**Cancellations**

Because we reserve your appointment time especially for you, a 24-hour cancellation notice is required. A charge of \$25 will apply to all non-emergency cancellations with less than 24-hours notice.

Patient's Signature & Date \_\_\_\_\_