New England
Naturopathic Health
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Adult Intake Paperwork

Name: _____ Date: _____

Preferred name/ nickname: _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Home Phone: _____ Preferred Method of Contact: _____

Date of Birth: _____ Social Security Number: _____

Your occupation: _____ Your employer: _____

Whom to contact in case of emergency? (Please list relation and best contact number)

_____

Please provide your insurance information below:

Primary Insurance Company: _____ Group #: _____

Member ID #: _____ Relationship to Subscriber: _____

Claims address: _____

Subscriber Name (if other than patient): _____ DOB: _____

Secondary Insurance Company: _____ Group #: _____

Member ID #: _____ Relationship to Subscriber: _____

Claims address: _____

Subscriber Name (if other than patient): _____ DOB: _____

Please list what brought you in today in order of priority: _____

_____

_____

_____

_____

_____

Personal Medical History

Who is your Primary Care Physician? _____

What is your Primary Care Physician's Address? _____

Please complete the attached records release form if applicable so that we may view lab results and other treatment details for better continuity of care.

Please list any allergies to medicine or foods and include the type of reaction (for example, anaphylaxis, stomach upset, rash, etc.): _____

_____

Please list your preferred pharmacy: _____

Please list pharmaceutical medicines you take, along with the dose:

Medication name	Dose	Frequency (how often you take medication)

Please list any health supplements you take, along with the dose:

Health Supplement name	Dose	Frequency (how often you take supplement)

Please list any major illnesses, accidents or hospitalizations (excluding routine childbirth) including dates:

_____

_____

Date of your last physical exam: _____ Any abnormal results? _____

Date of your last blood work: _____ Any abnormal results? _____

Do you have any problems with any of the following body systems? If yes, please check the box and describe on the lines provided. The items in parentheses are only examples, please include your own/additional diagnoses as pertinent:

❑ Constitutional: (fever/chills, weight gain or loss, weakness, fatigue)

_____

❑ Head, Ears, Eyes, Nose, Throat: (headache, vision problems, hearing problems, difficulty swallowing, sinus infections)

_____

❑ Cardiovascular: (heart palpitations, chest pain, cold hands and feet, varicose veins)

_____

❑ Respiratory: (allergies, asthma, chronic cough)

_____

Personal Medical History Continued

- ❑ Digestive: (GERD, heartburn, nausea, constipation, diarrhea, gas, bloating)

- ❑ Endocrine: (thyroid, PCOS, endometriosis)

- ❑ Nervous system: (dizziness, imbalance, slow thinking, poor memory)

- ❑ Skin/hair/nails: (psoriasis, eczema, acne)

- ❑ Musculoskeletal: (chronic back or limb pain)

- ❑ Psychological: (anxiety, depression)

- ❑ Urinary: (difficulty urinating, painful urination, incontinence)

- ❑ Male reproductive history: (erectile dysfunction, testicular mass, BPH)

- ❑ Female reproductive history: (please include date of last menstrual period, date/age onset of menopause, pregnancy and birth history)

- ❑ Dental issues:

Family Medical History

Do any members of your immediate family suffer from any of the following health conditions? If so, please check the box and explain on the lines provided. Please specify which family member.

- ❑ Heart Disease/High Blood Pressure/High Cholesterol:
- ❑ Diabetes:
- ❑ Cancer: Type?
- ❑ Alcoholism/Drug Addiction:
- ❑ Mental Health Disorder: Type?
- ❑ Asthma/Respiratory Issues:
- ❑ COPD:
- ❑ Stroke:
- ❑ Liver Disease:
- ❑ Kidney Disease:
- ❑ Digestive Issue or Diagnosis:
- ❑ Arthritis:
- ❑ Vision Problems:
- ❑ Any other serious health conditions?

Lifestyle

Do you use any of the following? Please indicate form and quantity per day or week.

Tobacco: _____

Alcohol: _____

Caffeine: _____

Diet: Do you follow a specific diet? Do you have any food allergies or sensitivities, or dietary restrictions? If so, please describe here: _____

_____

Please provide examples of typical meals:

Breakfast	
Lunch	
Dinner	
Snacks	

How much water do you drink in a day? _____

Do you exercise? Please list types and amount per week:

_____

_____

Do you have any problems with sleep? How many hours do you typically sleep in a night?

_____

Please list your health goals in order by priority: _____

_____

_____

_____

_____

Global Health

Please circle the appropriate responses below

In general, my health is:

Excellent Very good Good Fair Poor

In general, my quality of life is:

Excellent Very good Good Fair Poor

In general, I would rate my physical health as:

Excellent Very good Good Fair Poor

In general, I would rate my mental health, including my mood and ability to think, as:

Excellent Very good Good Fair Poor

In general, I would rate my satisfaction with my social activities and personal relationships as:

Excellent Very good Good Fair Poor

I am able to carry out my everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair….:

Completely Mostly Moderately A little Not at all

In the past 7 days:

How often have you been bothered by emotional problems, such as feeling anxious, depressed, or irritable?

Never Rarely Sometimes Often Always

How would you rate your fatigue on average?

None Mild Moderate Severe Very Severe

How would you rate your pain on average?

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain imaginable

Terms of Consent for Care

I, _____, hereby authorize Dr. Marinaro/Dr. Hayford to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, radiology, laboratory, X-ray

Minor office procedures: e.g., cleaning, dressing a wound, ear lavage, skin scraping

Medical use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Botanical medicine: plant substances may be prescribed as teas, alcohol-based tinctures, glycerites, capsules, tablets, creams or suppositories

Craniosacral Therapy, Visceral Manipulation: gentle forms of bodywork used to address back pain and other musculoskeletal complaints, headaches and organ dysfunction

Counseling: utilization of mental health counseling and techniques

Medical use of ozone: therapeutic ozone gas administered to isolated parts of the body, combined with depuration in an ozone sauna and injected subcutaneously or intramuscularly to address chronic pain and infections

I recognize the potential risk and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of medications or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. Please notify Dr. Marinaro/ Dr. Hayford if you experience any symptoms which may be secondary to the above procedures.

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or it's progression.

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

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by physician, or any personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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 myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the last day of my visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

I understand that all sales of goods and services are final.

Signature of Patient: _____ Date: _____

New England Naturopathic Health Policies

Please initial in the following boxes:

☐ I understand that payment of consultation fees, lab fees, supplements and any other services are due at the time of service.

☐ I understand that phone consultations and phone lab reviews with Dr. Marinaro/Dr. Hayford will be billed at the same rate as an in-office visit.

☐ I understand that I may message Dr. Marinaro's/Dr. Hayford's support staff through Patient Fusion. Email is not an acceptable communication format due to confidentiality concerns.

☐ I understand that any supplements purchased at NENH or via Health Wave (per NENH request) cannot be returned once opened.

☐ I understand that if I am more than ten minutes late for an appointment. I may not be seen and may be assessed a cancellation fee.

☐ I understand that should I miss an appointment or cancel with less than a twenty-four hours' notice, I will be assessed a cancellation fee.