



# New England Naturopathic Health

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## Adult Intake Paperwork

Sex: \_\_\_\_\_

Full Legal Name: \_\_\_\_\_ Today's 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*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 bring last 2 years of lab results with you to initial visit or fax to us ahead of time.*

# Personal Medical History

Who is your Primary Care Physician (name and title)? \_\_\_\_\_

What is your Primary Care Physician's Address? \_\_\_\_\_

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 (name and address): \_\_\_\_\_

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)

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Endocrine: (thyroid, PCOS, endometriosis)

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

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

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Musculoskeletal: (chronic back or limb pain)

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Psychological: (anxiety, depression)

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Urinary: (difficulty urinating, painful urination, incontinence)

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

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

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Dental issues:

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# 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:

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Diabetes:

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Cancer: Type?

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Alcoholism/Drug Addiction:

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Mental Health Disorder: Type?

---

Asthma/Respiratory Issues:

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COPD:

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Stroke:

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Liver Disease:

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Kidney Disease:

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Digestive Issue or Diagnosis:

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Arthritis:

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Vision Problems:

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Any other serious health conditions?

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# 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:

<b>Breakfast</b>	
<b>Lunch</b>	
<b>Dinner</b>	
<b>Snacks</b>	

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

# 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. Froman will be billed at the same rate as an in-office visit.
- I understand that I may message Dr. Marinaro's/Dr. Froman's support staff through **Charm**, Email is not an acceptable communication format due to confidentiality concerns.
- I understand that any supplements purchased at NENH or via Fullscript/Wellerate (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.
- I understand it is my responsibility to ensure insurance coverage for both office visits and labs ordered by a Naturopathic Doctor. Please refer to the Insurance Benefits Verification form for additional information.
- I understand that Naturopathic doctors in the state of Maine serve as specialists and not primary care doctors. For this reason, I understand that it is my responsibility to have a PCP, or to be actively looking to establish care with a PCP, prior to establishing care at New England Naturopathic Health.

# Terms of Consent for Care

I, \_\_\_\_\_, hereby authorize Dr. Marinaro/Dr. Froman 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. Froman 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 seven years, 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. Refunds for supplements up to 90 days after purchase (unopened items only).

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_





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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Previous Name: \_\_\_\_\_ SSN: \_\_\_\_\_

I request and authorize **New England Naturopathic Health**

- to give my health information to, and/or
- to receive my health information from:

Office Name: \_\_\_\_\_ Fax: \_\_\_\_\_

Requesting documentation regarding:

- Healthcare information relating to the following treatment, condition, or dates:
- Labs and imaging only
- Other:

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papillomavirus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

- Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
- Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED**

