Naturopathic Medicine Intake Form

Today's Date:__/____/____Birthdate:____/____/____ Sex: M / F

Full Name:_____ MI:_____

Other/Maiden Names:_____

Mailing Address:_____

Apt #:_____City:_____State:_____Zip Code:_____

Phone Numbers:

Home:_____Cell:_____Work:_____

Email Address:_____

Occupation:_____ Full Time: Y / N Marital Status: S / M / D / W

Emergency Contact:_____Relationship:_____

Contact's Phone Number:_____Contact's Email:_____

Referred by:_____

Please list any **Life Threatening Allergies:**_____

_____

Insurance Information:

Health insurance company name, address, & phone #:

_____

Policy ID # _____ Group # _____

Policy holder's name _____

I certify that I, and/or my dependent(s) have coverage with the above named insurance company and assign directly to Kingston Crossing Wellness Clinic all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agencies for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____ _____

(Print Patient/Guardian Name) (Signature of Patient/Guardian) (Date)

Current Health Care Team:

Primary Care Physician:_____Office Number:_____

Specialist
Physician:_____

Specialty:_____Office Number:_____

Specialist
Physician:_____

Specialty:_____Office Number:_____
Other Health Care Team Members (Ex:massage therapist,nutritionist, acupuncturist,etc)

Practitioner
Name:_____

Specialty:_____Office Number:_____

Practitioner
Name:_____

Specialty:_____Office Number:_____

Primary Health Concerns:

Please list primary health concerns and goals for this appointment.

Concern	Onset	Frequency	Severity

Family Medical History:

If someone in your family has had any of the following place the appropriate letter(s) in the blank box.

F-Father, M-Mother, S-Sibling, G-Grandparent

Condition	Family Member	Condition	Family Member	Condition	Family Member
Alcoholism or Substance Abuse		Lung Disease (Asthma, COPD)		Mental Trouble Depression Anxiety Suicide	
Anemia		Stroke		High Blood Pressure	
Seizures, Epilepsy		Gall Bladder Trouble		High Cholesterol	
Digestive Problems		Hay Fever, Allergy, Eczema		Headaches: Migraines	
Diabetes Type I or II		Glaucoma		Pneumonia	
Kidney Disease		Tuberculosis		Liver Disease, Hepatitis	
Ulcers		Vision/Eye Problems		Thyroid Disease	
Heart Murmur		Arthritis/ Joint Disease		Osteoporosis	
Cancer Type:		Heart: Attack Disease Failure		Other:	

Last Name:_____DOB____/_____/____ Today's Date:___/____/___

Medical History:
Please check the following conditions that apply to you. If a choice is given please indicate the appropriate one. If not listed please write in.

Condition	Yes	Condition	Yes	Condition	Yes	Condition	Yes
Alcoholism or Substance Abuse		Lung Disease (Asthma, COPD)		Mental Trouble/ Depression/ Anxiety		Urinary Difficulties (Incontinence, UTI)	
Anemia		Frequent Sinusitis		High Blood Pressure		Skin Disease	
Infertility		Gall Bladder Trouble		High Cholesterol		Seizures, Epilepsy	
Blood Clots/ Phlebitis		Hay Fever, Allergy, Eczema		Arthritis/ Joint Disease		Kidney Infection/ Stones	
Diabetes Type I or II		Hearing Loss		Pneumonia		Stroke	
Digestive Problems		Tuberculosis		Radiation Treatments		Liver Disease, Hepatitis	
Easy Bleeding		Vision/Eye Problems		Rheumatic Fever		Thyroid Disease	
Cancer Type:		Headaches: Migraines Tension Cluster		Sexually Transmitted Disease Type:		Heart: Attack Disease Failure Murmur	

Other:

Please list

Last Name:_____DOB____/_____/____ Today's Date:___/____/___

Operations/Surgical/Blood Transfusions/Major Injuries	Date

Immunizations/Vaccinations	Date

Date of Last Physical Exam:_____Last Blood Test:_____

<u>Health Habits:</u>
Sleep:
Hours per Night_____ Sleep Quality: *Poor* *Fair* *Good*

Water Intake:
Number of 8oz glasses per day:_____

Food:
Dietary Restrictions:_____

_____

_____

Describe Your Relationship with food:_____

_____

_____

_____

Physical Activities:

Activity	Frequency/ Duration

Which of the following have you used/ do you currently use? Please include amount, frequency, and duration of use.

Substance	Amount, Frequency & Duration of use	Substance	Amount, Frequency & Duration of use
Tobacco		Cortisone	
Alcohol		Sedatives	
Recreational Drugs		Laxatives	
Steroids		Antacids	
Coffee/Black Tea/ Cola		Other:	

What are the major stressors in your life?

_____

_____

What are your interests/hobbies

_____

_____

Overall level of satisfaction with current postion in life: (*Circle one)*

Unsatisfied **Somewhat Satisfied** **Moderately Satisfied** **Very Satisfied**

Medications & Supplements:*(additional pages available if needed)*

Medication Supplement(Brand)	Reason	Date Started	Dosage Per Day	Meds. Prescribed by

Please list any other information that you would like me to know about you and your health:

_____

_____

_____

_____

_____

Consent for Care

I,_____ (the patient or guardian), grant permission to Kingston Crossing Wellness Clinic to perform the examinations and procedures that may be professionally deemed necessary or advisable for me as a patient. I understand this may include one or more of the following:

Chiropractic Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Vertebral subluxation is the misalignment of one or more of the 24 vertebra. This causes the alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to achieve maximum health.

Naturopathic Care: a holistic, proactive prevention, diagnosis and treatment. It uses protocols that minimize the risk of harm-helping to facilitate the body's inherent ability to restore health. These may include nutritional counseling, bio-identical hormone treatment, behavioral modification, IV therapy, herbal and drug prescriptions. The doctor , if necessary, may also draw blood and perform lab testing.

Acupuncture: a technique of oriental medicine that includes the insertion of fine, sterile needles at specific points along the body. The points lie along meridians, or channels. Meridians are pathways through which the body's vital energy flows throughout the body. The points provide gateways to influence, redirect, increase or decrease the body's vital substances-qi and blood-thus correcting many of the body's imbalances.

Massage: techniques that manipulate the muscles of the body, increasing your range of motion and ridding the body of toxic waste. It aids in stress relief, increases circulation and release endorphins which inhibit the "feel good response".

I do not expect the doctor(s) or licensed practitioner(s) to be able to anticipate and explain all risks and complications of treatment. I understand in signing this form I am expressing my wish to rely upon the doctor(s) or licensed practitioner(s) to exercise judgement and decide upon the course of treatment which the doctor(s)/practitioner(s) feels, based upon the facts then known to him/her is (at the time) in my best interest.

I have read the explanations above of the treatments offered at Kingston Crossing Wellness Clinic. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing care and treatment. I have freely decided to undergo the recommended care and treatment, and herby give my full consent to care and treatment here.

_____ _____ _____

Patient/Responsible Party Signature **Printed Name** **Date**

_____ _____ _____

Kingston Crossing Staff Signature **Printed Name** **Date**

Last Name:_____DOB____/_____/____ Today's Date:___/____/___

Kingston Crossing Wellness Clinic Policies

I,_____ ,understand and agree to the following:

OFFICE POLICIES
At Kingston Crossing we understand that life happens. If you need to reschedule an appointment please call or email us 24 hours in advance of the scheduled appointment time. Failure to do so may result in a fee to compensate the practitioner's time.

CONSENT FOR RELEASE OF INFORMATION
Kingston Crossing Wellness Clinic respects your privacy. We understand that your personal health information (PHI) is very sensitive. We will not disclose your information to others unless you allow us to do so, or unless the law authorizes us to do so.

Federal and state laws allow us to disclose your PHI for purposes of treatment and health care operations. State law requires us to get your written authorization to disclose this information for payment purposes.

I,_____, authorize Kingston Crossing Wellness Clinic:

1. The release, use and disclosure of my PHI under HIPAA's Privacy Rule to any and all of my health care providers to facilitate my health care, as well as, any and all of my insurance companies to facilitate the processing of my claims.
2. To release any and all of my insurance/medical information to my spouse, significant other and/or family member(s).
3. To call me (and leave a message if necessary) at any phone number I have provided to Kingston Crossing Wellness Clinic.

FINANCIAL POLICIES & AGREEMENTS
I am solely responsible for the expenses of my/my depndant(s) care. While I may assign payment of benefits to Kingston Crossing Wellness Clinic, any uncovered services, deductibles, and co-payments are my financial obligation, to the extent allowed by terms of Kingston Crossing Wellness Clinic's provider contracts with insurance plans.

INSURANCE NON-COVERED SERVICE DISCLOSURE & AGREEMENT

1. Potential non-covered status include: the service is, or may be, deemed;
    a. investigational or experimental under the carrier's internal guidelines
    b. not medically necessary under the carrier's internal care or cost management guidelines
    c. not covered under the plan to which you are subscribed
    d. not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines.
2. The carrier authorizes the provider to charge the patient for the above services so long as this disclosure is made and signed by the patient prior to the services being provided.
3. I acknowledge that the non-covered status of the proposed service(s) has been explained and that a certain portion of my care may not be covered by or has not been authorized by my insurance plan. If any portion of the care provided is not, or may not be covered by insurance, then I shall be responsible for payment and shall make necessary financial agreement with the healthcare provider to pay for these services.

AUTHORIZATION FOR TAKING AND RETAINING X-RAY FILM

I herby authorize the taking of analytical x-ray films by the doctors, clinic, and/or staff of Kingston Crossing Wellness Clinic of areas that may be of anatomical interest and which may be recommended from time to time by the doctor(s). Furthermore, I agree that the doctor(s)/ clinic shall be the sole owner retaining custody and control of said analytical films until I sign a Release Form stating otherwise. Kingston Crossing Wellness Clinic agrees to provide a Release Form upon my request.

By signing below I, the patient, acknowledge that I have read and agree to the above statements regarding my care and treatment at Kingston Crossing Wellness Clinic. This consent will remain in effect until revoked by me, the patient, in writing.

_____	_____	_____
Patient/Responsible Party Signature	**Printed Name**	**Date**

Medication Supplement(Brand)	Reason	Date Started	Dosage Per Day	Meds. Prescribed by

Last Name:_____DOB____/_____/____ Today's Date:___/____/___