

New Patient Intake

Welcome! Holistic health care and preventive medicine are most effective when the doctor has a complete understanding of your health history. Please fill out this questionnaire as thoroughly as possible. Print all information clearly and mark anything you don't understand with a question mark. All information contained in these pages is completely confidential and it will never be shared with any other party. Your email address will only be used to contact you in regard to your health care.

Name _____ Preferred Name _____

Age _____ Date of Birth ____/____/____ Female Male Social Security Number _____-____-_____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Phone (Day) _____ (Evening) _____ (Cell) _____

Is it OK to leave messages? Yes No Only here _____

Email address (only for purposes of contacting you in regard to your health care, if necessary)

Preferred contact Day phone Evening phone Cell phone Email

Emergency contact Name _____

Relationship _____ Daytime Phone _____

Who may we thank for your referral? Friend or family AANP
 Wisdom magazine Naturopathic Gourmet Blog NYANP
 NCNM A Different Kind of Doctor Blog AHMA
 Other _____

What are your current conditions and concerns (in order of priority)? _____ Date of onset _____

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

How do these conditions affect your life? _____

Do you have a primary care physician? No Yes

Name _____ Clinic _____

Phone _____ Address _____

Diagnosis / treatment / results _____

Have you been to a Naturopathic Doctor before? No Yes

Name _____ City _____

Phone _____ Dates of treatment _____

Diagnosis / treatment / results _____

Please check "C" for therapies you currently use and "P" for those you have used in the past:

- | | | | | |
|--------------------------|--------------------------|----------------|--------------------------|--------------------------|
| C | P | | C | P |
| <input type="checkbox"/> | <input type="checkbox"/> | Acupuncture | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Chiropractic | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Counseling | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Detoxification | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Fasting | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Homeopathy | _____ |
| | | | Colon Hydrotherapy | _____ |
| | | | Physical Therapy | _____ |
| | | | Supplements | _____ |
| | | | Other | _____ |

Please list any known allergies:

Drug _____

Environmental _____

Food _____

Other _____

Do you know your family history? No Yes

Mother Health problems: _____

Alive, age ____ Deceased at age ____ Cause of death _____

Father Health problems: _____

Alive, age ____ Deceased at age ____ Cause of death _____

Please list any major illness experienced by your immediate family members (parents, sisters, brothers, children). Also indicate their age at diagnosis and their relationship to you.

Please indicate if you have ever had the following conditions or symptoms by marking “C” for current, “P” for past, or “N” for never:

- | C | P | N | | C | P | N | |
|--------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acne | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety or nervousness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIV or AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Atherosclerosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowel Syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood pressure problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer of _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lyme disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Memory loss |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic inflammation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mononucleosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mood swings |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Circulatory problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cold sores | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neurological disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Numbness / tingling |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Debilitating fatigue | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dental problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pancreas problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Panic attacks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Type _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Parasites |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physical abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty breathing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty sleeping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or fainting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Substance abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feel unsafe at home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent antibiotic use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent colds or flu | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Urinary tract infection |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vaccinations |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Head injury | | | | |

Please describe your sexual activity:

- I have never been sexually active
- I am not currently sexually active but I have been in the past
- I am sexually active with Men Women Men and women

Methods to prevent sexually transmitted infections and/or pregnancy:

Present _____
 Past _____

WOMEN:

Are you? Pregnant now Nursing Preparing for pregnancy Preventing pregnancy

If you are still having periods: Cycles are Regular Irregular
 Average number of days in cycle _____ Periods are Light Medium
 Average number of days of bleeding _____ Heavy Painful

<u>Number of</u>	<u>Year(s)</u>	<u>Date of last</u>	Normal	Abnormal
_____ Pregnancies _____		Period _____	<input type="checkbox"/>	<input type="checkbox"/>
_____ Vaginal births _____		Pap smear _____	<input type="checkbox"/>	<input type="checkbox"/>
_____ C-sections _____		Mammogram _____	<input type="checkbox"/>	<input type="checkbox"/>
_____ Miscarriages _____		Bone scan _____	<input type="checkbox"/>	<input type="checkbox"/>
_____ Abortions _____				

Please indicate if you have had the following conditions or symptoms by marking “C” for current or “P” for past or “N” for never:

- | | | | | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------------|
| C | P | N | | C | P | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal pap smear | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nipple discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breast pain or lump | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ovarian Cysts / PCOS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Changes in sex drive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful intercourse |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Changes in memory | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pelvic inflammatory disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Changes in mood | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Desire pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexual abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry skin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexual difficulties |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted infection |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Facial hair | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Spotting between periods |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent/chronic yeast infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Urinary incontinence |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hair loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Urinary tract infections |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hormone replacement therapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Uterine fibroids |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal dryness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hysterectomy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Impaired fertility | | | | |

MEN:

Date of last prostate exam _____ / _____ / _____

Please indicate if you have had the following conditions or symptoms by marking “C” for current or “P” for past or “N” for never:

- | | | | | | | | |
|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------------|
| C | P | N | | C | P | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Changes in mood | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prostate problem |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Erectile dysfunction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Regular self testicular exam |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hair loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexual abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Impaired fertility | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexual difficulties |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain or lump in scrotum | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted infection |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful intercourse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Urinary tract infection |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Problems with urination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: |

Do you take prescription medications? Yes No

Please list all medications, over-the-counter medicines, natural medicines, vitamins, and supplements you are currently taking. Use a separate page if necessary.

Name	Dosage	Dates Taken	Reason for taking

Briefly discuss any medications or supplements you are not taking now but have taken in the past year:

- See reverse
- See attached page

Height _____ Weight _____

Weight 3 months ago _____ Weight one year ago _____ Maximum weight _____ When? _____

What do you regularly eat and drink? Note the typical time of day and describe all that apply:

Breakfast _____

Mid-morning snack _____

Lunch _____

Mid-afternoon snack _____

Dinner _____

Late-night snack _____

Current dietary restrictions _____

Why? _____

Past dietary restrictions _____

When? Why? _____

Where do you eat? Check all that apply:

- Table
- Desk
- Bed
- In front of the TV
- Car
- Standing
- Walking

Other _____

Do you drink the following regularly? If so, how much?

Coffee or espresso _____ cups or _____ shots per day

Alcohol (wine, beer, spirits) _____ glasses/bottles/shots per week

Soda or sweetened beverages _____ per week

Diet soda or artificially sweetened beverages? No Yes _____ drinks per week

If you have daily bowel movements, how many per day? _____

If you do NOT have daily bowel movements, how many per week? _____

How would you describe them? Color _____

Check all that apply: Easy Difficult Painful Soft Dry and hard

Loose Explosive Blood Mucus Undigested food Floats Sinks

Do you exercise regularly? No Yes

Aerobic exercise _____ minutes _____ times per week

Activities _____

Strengthening exercise _____ minutes _____ times per week

Activities _____

Stretching _____ minutes _____ times per week

Activities _____

Other: _____

Do you smoke? No Yes

How much do you sleep each night, on average? _____ hours Is this enough? No Yes

Do you awaken well rested? No Yes

How do you rate your quality of sleep? Place an "X" on the scale:

Great ----- Poor

Are you employed? No Yes - Occupation: _____

Employer _____

Do you enjoy your work? No Yes _____ hours per week

Do you commute? No Yes _____ hours per week

Are you engaged in at least one activity you feel passionate about? Yes No

What do you do for fun? _____

Have you had a major life change in last year? No Yes _____

What is your overall level of stress? Place an "X" on the scale:

Low ----- High

Identify stressors _____

Do you feel loved and well supported in your life? Yes No

What is your level of commitment to change your current routines to improve your health?

I would change anything to get better

I am willing to make any change except _____

I am only willing to change _____

I don't want to change anything

Is there anything else you would like the doctor to know? _____

The above information is true to the best of my knowledge.

_____/_____/_____
Signature Date

Informed Consent

I, _____ (please print your name clearly), hereby certify by my signature at the bottom of this page that:

I understand Sarah Cimperman is a Doctor of Naturopathic Medicine and the state of New York does not recognize naturopathic doctors as licensed medical doctors. I understand that Dr. Cimperman functions as a health consultant and that she is not licensed to diagnose or treat specific diseases, prescribe drugs, or perform surgery in New York.

I understand that any assessment performed by Dr. Cimperman and any natural remedy recommended by Dr. Cimperman is for the purpose of optimizing my health, body function, and overall wellness, not for purposes of diagnosis, treatment, or replacement of prescription medication.

I understand that Dr. Cimperman's services are not a replacement for care by licensed medical providers. I understand that Dr. Cimperman advises me to maintain contact with a primary care physician and seek treatment for any symptoms, complaints, and conditions that I feel require such care. I take responsibility for informing other medical providers of any natural remedy I choose to consume. I take responsibility for informing Dr. Cimperman of any changes in my health, medications and supplements while seeking her services.

I take full responsibility for taking any natural remedy Dr. Cimperman may recommend. I do not hold Dr. Cimperman accountable or liable for any adverse effects or complications from the natural remedies that I consume. I understand that results are not guaranteed.

I understand that Dr. Cimperman does not bill insurance and I agree to pay for her services at each visit, unless we have specified a different financial agreement prior to the appointment. I understand that there is a \$50 fee for missed appointments and those canceled or rescheduled with less than 24 hours notice (48 hours for Monday appointments).

I understand that the internet is an open network and provides no inherent protection for confidential information. If I use email to communicate with Dr. Cimperman I understand that it may pose risks to the confidentiality of my health information and I accept these risks. I understand that there will be times when she does not have access to e-mail and that I must contact her by telephone regarding critical or time-sensitive issues.

I sign this informed consent to express that I voluntarily seek naturopathic consultation from Dr. Cimperman. I understand that I am free to withdraw my consent and to discontinue participation at any time.

I have read this consent form and fully understand its contents.

Patient signature: _____

Date: _____