Adult Intake Form

Name_____ Date_____

Address_____City_____State_____Zip_____

Phone (H) _____ (W)_____Email_____

Date of Birth _____Age_____Sex_____Occupation_____

Employer_____Hrs per week_____Past Occupation_____

Marital Status (please circle) married single divorced common law re-married

Emergency Contact_____Phone_____

How did you hear about Dr. Laura Sleggs? _____

Family Doctor (name)_____(address)_____

Are you under the care of a specialist (name, number)? _____
_____

Are you under the care of an alternative healthcare provider (ie acupuncturist, chiropractor, massage therapist)?_____
_____

What is your primary reason for attending this clinic? Please list the first time you noticed the condition and describe any factors that you suspect may have a role in its onset and course.
1. _____
_____

When did it start_____Has this condition been diagnosed? Yes no _____

Are you receiving any kind of treatment for this condition? Please describe:
_____

Have any of these brought you relief? _____
_____

Please list any other health concerns:

2. _____

3. _____

4. _____

5. _____

Please list past health problems and dates:

1._____

2._____

3._____

General Information

Height_____Weight_____Weight 1 yr ago_____Maximum weight_____When_____

Primary interests and hobbies_____

Primary form of exercise, if any_____

How often_____

Past Medical History: List all **surgeries, hospitalizations or major injuries** you have had.

Procedure/reason/injury	Year	Outcome

Family History: Indicate if anyone in your family has or has had any of the following conditions

	Father	Mother	Brothers	Sisters	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if living)								
Health (G=good,P=poor)								
Anemia								
Asthma, Hayfever, Hives								
Cancer								
Cystic Fibrosis								
Diabetes								
Epilepsy								
Rheumatoid Arthritis								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Mental Illness								
Alcoholism								
Stroke								
Tuberculosis								
Other								
Age (at death)								
Cause of death								

Do you have any allergies (food, environmental, drug, chemical)? Please describe any adverse reactions you have had:

_____

_____

Do you have any pets? _____

Please check the immunizations you have had. If you don't know if you've had one, place a question mark beside it.

	Mumps		Measles		Scarlet Fever		German Measles
	Diptheria		Rheumatic Fever		Chicken pox		Other

Did you have a flu shot this year? _____How may times have you had it in total?____

Toxin Exposure

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home (hobbies, renovations), at work or while traveling?	Y	N
Have you ever experienced health problems after putting down new carpeting, painting your home, doing renovations or having your lawn sprayed with herbicide?	Y	N
Are you particularly sensitive to perfume, gasoline or other vapors?	Y	N
Do you have any mercury dental fillings?	Y	N
Do you have any surgical implants (cosmetic, medical)?	Y	N
Do you live near any of the following? Industry Power lines Highway Dump Airport	Y	N

How long have you lived in your home? _____

How old is your home? _____

Have you traveled outside of the United States? Where and when? _____

Rate you energy level between 1 and 10 1(extreme fatigue) 2 3 4 5 6 7 8 9 10(vital)

Rate your stress level 1(relaxed) 2 3 4 5 6 7 8 9 10(extremely stressed)

How do you deal with stress? _____

Any significant childhood trauma/grief/stress? _____

_____

Please list any medications or supplements that you are currently taking:

Pharmaceutical drugs or supplements (include brand)	How much do you take per day?	Why are you taking this medication?

How many times have you taken antibiotics? _____

Check the appropriate box	Yes	No		Yes	No
Get 6-8 hours of sleep nightly?			Take vacations?		
Sleep Well			Spend time outside?		
Awaken Rested			Watch TV? Hours daily ____		
In a supportive relationship			Read? Hours daily ___		
History of abuse			Eat 3 meals daily?		
Suffered recent (past 3 years) major life trauma			Cups of Water you drink per day_____		
Use recreational drugs			Drink tea? Cups per day ____		
Treated for drug/alcohol dependence			Drink coffee? Cups per day ___		
Drink alcohol			Drink soda? Cups per day ____		
Use tobacco? If so, how many packs daily: ____ # years: ___			Use products with Nutrasweet or Splenda?		
Enjoy your work?			Add sugar/salt to food?		

Review of Symptoms (please check current symptoms, use P if it was a problem in the past):

VITALITY		**GASTROINTESTINAL**	
Low stamina		Poor appetite	
Low ambition		Large appetite	
Fatigue		Heartburn	
Energy drop during the day		Indigestion	
Poor sleep		Belching	
Insomnia		Excessive flatulence	
Feel unrefreshed on waking		Bloating after eating	
Unexplained weight gain/loss		Nausea/vomiting	
		Excessive/diminished thirst	
RESPIRATORY		Cravings	
Chronic cough		Diarrhea or loose stool	
Shortness of breath lying down		Constipation or hard stool	
Chronic phlegm		Stomach pain/burn 1-4 hr after eat	
Pain while breathing		Ulcer	
Cough up blood		hemorrhoids	
Shortness of breath during the day		Digestive problems subside with rest/relaxation	
Wheezing		Hungry shortly after eating	
		Undigested food in stool	
SKIN/NAILS		Fatty foods cause indigestion	
Dryness/cracking		History of worms/parasites	
Itching		Anal itching	
Acne/pimples		# of bowel movements per day	
Boils		Blood on stool	
White/blotchy patches		Mucous in stool	
Hives, itching		Stool floats in bowl	

Changes in skin odor		Pain under right side of ribcage	
Changes in hair/nails			
Easy bruising		**IMMUNE**	
Eczema		Chronic infections	
Psoriasis		Frequent antibiotics	
Dandruff		Frequent colds	
Spots on nails		Cold sores	
Bite nails		Slow wound healing	
Fungal infection of nails		Sore throat	
		Coughing	
		Lumps, swollen glands	
		Swollen glands or lymph nodes	
EYES		Shingles	
Cataracts			
Color blindness		**URINATION**	
Failing vision		Pain on urination	
Poor night vision		Frequent bladder infections	
Double vision		Strong urine odor	
Dark circles under eyes		Inability to hold urine	
Watering		Kidney infections	
Burning		Increased frequency	
Redness		Wake in night to urinate	
Dryness		Unable to hold urine	
Discharge		Dribbling	
Sensitive to light		Difficult urination	
Blurring			
Glaucoma		**For Males**	
Frequent conjunctivitis/styes		Weak/delayed urinary stream	
Spots in front of eyes		Dripping after urination	
		Lack of sex drive	
		Impotence	
EARS		Difficulty attain/ maintain erection	
Ringing in ears		Testicular pain	
Loss of hearing		Prostate health, last exam?	
Wax build up		Genital rash	
Frequent earaches		Low sperm count	
		Low sperm mobility	
MOUTH/LIPS		Sexual orientation?	
Jaw clicks		Are you sexually active?	
Cold sores		Last prostate exam?	
Lips cracking			
Impaired taste/smell		**FEMALE REPRODUCTION**	
Peculiar taste in mouth		Age of first period	
Bad breath		Age of last period/menopause	
		How long is your cycle in days?	
		How many days is your period?	
TEETH		Irregular periods	

Cavities		Bleeding between periods	
Loose teeth		Menstrual clots	
Dentures/bridges		Breast tenderness	
Root canal		Irritability/mood swings	
Sensitivity to hot/cold		Bloating during period	
Bleeding gums		Vaginal discharge	
Gum disease		Ovarian cysts	
Grinding teeth		Uterine fibroids	
Braces			
		GYNECOLOGICAL HEALTH	
NOSE		Discharge	
Itching		Itching	
Loss of smell		Vaginal dryness	
Discharge/post nasal drip		Sexual difficulties	
Sneezing		Odor	
Sinusitis		Use tampons	
Polyps		Low sex drive	
Prone to nosebleeds		Abortions	
Breath through your mouth		Venereal disease	
		Sexual orientation?	
NEUROLOGICAL		Sexually active?	
Headaches		What birth control do you use?	
Migraine headaches		Number of pregnancies?	
Forgetful		Number of live births	
Convulsions/seizures		Are you pregnant?	
Vertigo or dizziness		Are you trying to conceive?	
Loss of balance			
Tingling/numbness		**BREAST HEALTH**	
Paralysis		Fibrocystic breasts	
Muscle weakness		Puckering of skin	
		Nipple discharge	
CIRCULATION/BLOOD		Tenderness	
Dizziness		Breast lump	
Cold hands /feet		Self breast exams?	
Swelling hands/feet		Regular mammograms?	
Varicose veins			
Low/high blood pressures		**MUSCLOSKELETAL**	
Anemia		Weakness	
Fainting		Stiffness	
		Aches	
CARDIOVASCULAR		Twitching	
Chest/heart palpitations		Cramps	
Fainting		Prone to sprains	
heart murmurs		Joint pain	
Heart disease			
Chest pain/heaviness			

Is there anything else you would like to add that you feel may be relevant to your case?

_____

_____

Thank you for completing this form as accurately and completely as possible. It will greatly help me to obtain a more complete understating of your health concern.

Informed Consent and Agreement

I voluntarily consent to the procedures and treatments by Dr. Laura Sleggs, ND and/or Dr. Estella Verdouw, ND. I understand and am informed that, as in the practice of other medicine, there are some risks to naturopathic therapies. I do not expect the naturopath to be able to anticipate and explain all risks and the complications, and I wish to rely on Dr. Sleggs and/or Dr. Verdouw to exercise judgment during the course of procedures and therapies which Dr. Sleggs and/or Dr. Verdouw feels at the time, based upon the facts then known, is in my best interests. I understand that homeopathic, nutritional and herbal therapy is administered in an attempt to improve body function, to strengthen health, and thus increase resistance to environmental stresses and diseases. I have been informed that Dr. Sleggs, ND and/or Dr. Verdouw strives to provide and or recommend only the highest quality products for her clients. I will not hold Dr. Sleggs or Dr. Verdouw responsible for any adverse reactions due to the quality or manufacturing of any products prescribed by her to me. I understand that no guarantee has been made to me as to the result or cures that may be obtained from suggestions given by this clinic. I intend this consent form to cover the entire course of treatment form my present condition and for any future condition (s) for which I may seek care.

Dr. Sleggs and Dr. Verdouw graduated from the Canadian College of Naturopathic Medicine (CCNM) in Toronto, Canada with a doctoral diploma in Naturopathic Medicine (ND). She is licensed as a naturopathic physician in the state of Connecticut and maintains that license with continuing education and standards of practice. New York does not license naturopathic physicians at this time. Dr. Sleggs or Dr. Verdouw is not a medical or osteopathic physician (MD or DO) and is not licensed to practice those forms of medicine. Dr. Sleggs and Dr. Verdouw have been trained as a primary care physician, able to use modern diagnostic methods with time honored natural remedies to achieve and maintain health.

I understand that my medical records will be kept confidential and will not be released to anyone without my consent, unless required by law. I use chart information for research and educational purposes in order to help further naturopathic care. It will be done anonymously, with no names or personally identifiable information attached. I am responsible for informing Dr. Sleggs and Dr. Verdouw if my condition or medications change as treatments may be contraindicated in some conditions (such as pregnancy). By signing here I agree to these policies and I give permission for Dr. Laura Sleggs to work with me as my health care provider.

Signature: _____Date: _____

Payment Policy Agreement

Full payment for all services and products is due at the time of service. There is a $30 return check fee. If canceling an appointment please provide us with notice at least 24 hours prior to your scheduled appointment. There is a $40 fee for no shows of less than 24 hours notice of cancellation.

I have read and understood the payment and cancellation policy above. By signing here I agree to these policies and that my credit card will be charged $40 in the case of a cancellation of less than 24 hours.

Patient's Signature:_____Date:_____