INTAKE PAPERWORK

Please complete this form as thoroughly as possible in order to aid your doctor in her diagnosis and treatment. This information will become part of your confidential medical record and will not be shared unless you expressly authorize its release. Please return the completed form 24 hours prior to your appointment.

Today's Date: ____________________

PATIENT PROFILE

Last Name: ______________________________ First Name: ________________________________ MI: _____

SSN: _______-_____-_______ Date of Birth: _________________ Age: ____ Sex: ☐ F ☐ M ☐ Other: __________________

Address: __________________________________ City: _____________________ State: ____ Zip: ___________

Email: ____________________________________ May we add you to our email list? ☐ Yes ☐ No

Home Phone: __________________ Work Phone: ___________________ Cell Phone: ___________________

I would like to receive appointment reminders via ☐ Email ☐ Text ☐ Both

May we leave confidential voicemail messages for you at any of the above numbers? ☐ No ☐ Yes

If yes, please indicate which ones: ☐ Home ☐ Work ☐ Cell

Occupation: ______________________________________ Employer: ____________________________________

Domestic Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact: ____________________________ Phone: ________________ Relation: ___________________

How did you hear of us? ☐ Physician: Dr. _________________ ☐ Friend ☐ Flyer ☐ Internet Search ☐ MAPS

Please the list the main reason(s) for your visit today in order of importance:

(1) _______________________ (2)________________________ (3) ________________________

Additional information: ____

____

____

CURRENT HEALTH

Current Primary Care Physician? ____ Phone: _________________________

Clinic Name: ____ Date of Last Visit: ___________________

Address, City, State, Zip: ____

Height: _______ Current Weight: _______ lbs

How do you describe your health in general? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

PAST MEDICAL HISTORY

Did your mother have any problems during her pregnancy with you such as illness, stress, use of alcohol, tobacco or recreational drugs, took medications, or had a traumatic delivery? ☐ No ☐ Yes

If yes, please explain:____

Were you born via Caesarean Section? ☐ No ☐ Yes

Were you breast fed as an infant? ☐ No ☐ Yes If yes, for how long? ____________________________________

During childhood and adolescence, was your home-life loving and supportive or were there significant stresses?

☐ Loving ☐ Stressful If stressful, please explain: ____

____

Please indicate if you had any of the following illnesses as a child:

☐ Eczema ☐ Recurrent colds ☐ Meningitis

☐ Asthma ☐ Bronchitis ☐ Frequent earaches

☐ Chronic runny nose ☐ Pneumonia ☐ Other (specify): __________________________

Were you ever on frequent or prolonged antibiotics? ☐ No ☐ Yes If yes, please specify: ______________________

____

Did you receive standard immunizations? ☐ No ☐ Yes If no, please elaborate: __________________________________

Did you ever have a concussion as a child? ☐ No ☐ Yes If yes, please explain: ____________________________________

Major Injuries: Please include auto accidents, sports injuries, and other injuries.

Injury	Age	Outcome

Hospitalizations

Reason	Age	Outcome

Surgeries

Type/Reason	Age	Outcome

Serious Illnesses

Type/Reason	Age	Outcome

HEALTH MAINTENANCE

Indicate the most recent date and result of the following testing. Please bring any test results with you to your appointment. (F= female, M=male)

Physical/annual exam: ___________________________ Blood Work: ____

Dental Exam: ____________________________________ Eye Exam: ____

Chest X-ray: _____________________________________ Prostate Exam (M): ____________________________________

DEXA Scan (F, 50+): ______________________________ Colonoscopy/Sigmoidoscopy (50+):______________________

Fecal Occult Blood: ______________________________ HIV Test: ____

EKG: ____

MEDICATIONS + SUPPLEMENTS

Medication Include both prescription medications, supplements, herbs, and homeopathics	**Dosage + Frequency**	**Route** e.g. oral, sublingual, injection, IV, vaginal, rectal	**Prescribed By?**	**Date Started**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

FAMILY HISTORY

Please indicate any health problems your family members have experienced. Examples include Alzheimer's disease, allergies/hay fever, asthma, arthritis, autoimmune conditions, cancer, diabetes, digestive concerns, heart disease, high blood pressure, high cholesterol, kidney disease, liver disease, lung disease, Lyme disease, mental illness, migraines, obesity, osteoporosis, Parkinson's disease, stroke, substance abuse, thyroid disorder, ulcer, uterine issues, etc.

Mother: ____

____

Father: ____

____

Siblings: ____

____

Children: ____

____

Maternal Grandparents: ____

____

Paternal Grandparents: ____

____

REVIEW OF SYSTEMS

Indicate with a C any conditions you currently have or a P for conditions you've had in the past that have since resolved.

Constitutional
___ Fevers
___ Chills
___ Night sweats
___ Fatigue
___ Loss of appetite
___ Unintended weight loss
___ Unintended weight gain

Neurological
___ Headaches
___ Migraines
___ Lightheadedness
___ Dizziness/Vertigo
___ Cognitive concerns
___ Brain fog
___ Balance issues
___ Numbness
___ Tingling

Eyes and Ears
___ Double vision
___ Recent vision change
___ Itchy/watery eyes
___ Dry eyes
___ Floaters
___ Hearing loss
___ Ringing in the ear(s)
___ Earache
___ Excessive ear wax

Nose and Throat
___ Nasal congestion
___ Post-nasal drip
___ Frequent sinus infections
___ Nasal polyps
___ Loss of smell
___ Dental concerns
___ Metallic taste in mouth
___ Canker sores
___ Loss of taste
___ Sore throat/tonsillitis
___ Difficulty swallowing

Respiratory
___ Difficulty breathing
___ Asthma
___ Chronic cough
___ Wheezing
___ Bronchitis
___ Pneumonia
___ Frequent colds/flus

Cardiovascular
___ Chest pain
___ Palpitations
___ Irregular heartbeat
___ Swelling of extremities
___ Poor circulation
___ Fainting
___ Easy bruising

Gastrointestinal
___ Food sensitivities
___ Nausea/Vomiting
___ Heartburn
___ Stomach ulcers
___ Abdominal pain
___ Gas/bloating
___ Constipation
___ Diarrhea
___ Blood, mucus, undigested food in stool

Genitourinary
___ Urinary urgency or frequency
___ Blood in urine
___ Burning with urination
___ Kidney stones
___ Frequent UTIs
___ Low libido
___ Pain with intercourse
___ Erectile dysfunction
___ Prostate enlargement

Gynecological
___ Menstrual irregularity
___ Heavy menstrual flow
___ Menstrual cramps
___ PMS
___ Hot flashes
___ Vaginal discharge
___ Breast discharge
___ Other breast issues

Endocrine
___ Thyroid disorder
___ Enlarged thyroid
___ Diabetes
___ Excessive hunger/thirst
___ Infertility
___ Excessive hair growth

Immune System
___ Cancer
___ Autoimmunity
___ Allergies
___ Hay fever
___ Enlarged lymph node
___ Frequent illnesses

Musculoskeletal
___ Arthritis
___ Back pain
___ Joint pain
___ Stiffness
___ Bursitis
___ Muscle weakness
___ Muscle cramping
___ Strain/spain//fracture

Skin + Integumentary
___ Color changes
___ Eczema
___ Psoriasis
___ Rash
___ Sores
___ Hives
___ Moles
___ Hair loss
___ Nail problems

Psychological
___ Anxiety
___ Depression
___ Suicidal ideation
___ Eating disorder
___ Mood swings
___ Anger outbursts
___ Addiction
___ Substance abuse
___ Hallucinations

Other (write-in)

HEALTH HABITS

Do you currently or did you ever use tobacco products? ☐ No ☐ Yes

Do you consume alcoholic beverages? ☐ No ☐ Yes

If yes, please indicate type and how much:

Beer	____ 12 oz can/wk
Wine	____ 5 oz glass/wk
Hard Alcohol	____ 1.5 oz/wk
Other	____/wk, specify: ____________________

Do you consume caffeinated beverages? ☐ No ☐ Yes

If yes, please indicate type and how much:

Coffee	____ oz/day
Black Tea	____ oz/day
Soda	____ oz/day

Do you use recreational drugs? ☐ No ☐ Yes

If yes, please indicate type and how often:

Marijuana ____/wk
Amphetamine ____/wk
Cocaine ____/wk
Crack ____/wk
Injectable ____/wk, specify: ______________________
Other ____/wk, specify: ______________________

LIFESTYLE

SLEEP

Time you go to sleep: __________ Time you awaken: __________ Time you get out of bed: __________

What is the quality of your sleep? ☐ Wake well rested ☐ Wake tired ☐ Sleep does not refresh me

Do you wake at night? ☐ No ☐ Yes If yes, how many times? ____

What causes you to wake up? ____

Do you have trouble falling back to sleep? ☐ No ☐ Yes ☐Sometimes

Do you sleep in total darkness? ☐ No ☐ Yes If no, indicate source of light: ___________________________________

Do you take naps during the day: ☐ No ☐ Yes ☐ No, but I would like to

If yes, at what time? ______________

For how long? _____ minutes

If you would like to take a nap but don't, at what time do you have this feeling? ___________________________

DIET

Do you follow a particular diet? ☐ No ☐ Yes If yes, what do you call it? _____________________________________

Do you avoid any foods? ☐ No ☐ Yes If yes, which ones? ____

Do you crave any foods? ☐ No ☐ Yes If yes, which ones? ____

How often do you eat out? ____ /week How often do you eat fast food? ____ /week

Please describe what you typically eat for the following meals. If you don't have a typical meal, please describe your last meal. Include beverages.

Breakfast: ____

Snack: ____

Lunch: ____

Snack: ____

Dinner: ____

Dessert: ____

How much water do you drink per day? ____ ounces (Note: a one cup measuring cup is 8 ounces.)

MOVEMENT

Do you exercise? ☐ No ☐ Yes

If yes, please indicate what you do, for how long, and how many days per week:

Activity	Minutes per session	Days per week

Please list any other exercises you enjoy but are not currently participating in:
____
____

SEXUAL ACTIVITY

Are you currently sexually active? ☐ No ☐ Yes

Sexually active with? ☐ Men ☐ Women ☐ Both

Do you use protection? ☐ No ☐ Yes ☐ Sometimes

If yes, what type of protection do you use? ____

Do you have a need for birth control? ☐ No ☐ Yes

If yes, what method of birth control is currently used and how frequently is it used? _____________________

____

Have you ever had sexual difficulties? ☐ No ☐ Yes

If yes, please describe: ____

Have you ever had a sexually transmitted disease? ☐ No ☐ Yes

If yes, please indicate type(s): ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Syphilis ☐ HIV/AIDS ☐Genital Warts

If sexually active, is your present sex life satisfactory? ☐ No ☐ Yes

If no, please describe: ____

CONSENT TO LEAVE MESSAGES

CONSENT TO LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY AND FRIENDS

I understand that my healthcare information with Leena Pandya, ND is protected and I have received a copy of their Notice of Health Information Privacy Practices.

CONSENT TO TEXT + LEAVE MESSAGES (please check box) ◻ YES ◻ NO

I consent to information regarding myself (or my child's/under the age of 18) test results or detailed appointment reminders/instructions to be texted to me or left on my voicemail or answering machine.

If yes, allowed phone numbers (circle type): __________________________ cell, home, work, other

_________________________cell, home, work, other _______________________cell, home, work, other

CONSENT FOR SHARED INFORMATION WITH FAMILY AND FRIENDS

I wish family or friends to have access to my health care information. The name(s) listed below are family or friends to whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem is minimally necessary. I understand that information is limited to verbal discussions and that no paper copies of my protected health information will be provided without my signature on a Release of Protected Health Information Form.

	NAME	RELATIONSHIP
1.	______________________________________	____________________________
2.	______________________________________	____________________________
3.	______________________________________	____________________________
4.	______________________________________	____________________________

____ ____________________________

Patient Name Date of Birth

____ ____________________________

Patient/Parent Signature Date

If signature is not by the patient, please indicate Name and Relationship:

____

This consent will be considered valid until such time as I cancel it in writing. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. I understand that any cancellation can only be applied to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

CONSENT TO RECEIVE NATUROPATHIC CARE

I understand that naturopathic evaluation and treatment may include, but is not limited to:

- Physical exam (general and female)
- Common diagnostic procedures (pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Dietary advice and therapeutic nutrition (use of foods, diet plans, nutritional supplements, and intravenous/ intramuscular vitamin injections)
- Herbs/natural medicines (prescribing of various therapeutic substances including plant, mineral and animal materials). Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, topical creams or other forms.
- Homeopathic remedies (often highly diluted quantities of natural occurring substances)
- Over the counter and prescription medications

I understand and I am informed that in the practice of Naturopathic Medicine there are some risks and benefits with evaluation and treatment including, but not limited to the following:

- Potential risks: allergic reaction to prescribed herbs, supplements, prescription medications; and aggravation of pre-existing symptoms.
- Potential benefits: restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.
- Notice to pregnant women: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explains therapies and procedures to my satisfaction. I further acknowledge that no guarantees or services have been made to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

Patient's Name: ____

Patient's Signature: ____ Date: ____________________

Parent's (Guardian's) Name: ____

Parent's (Guardian's) Signature: ____ Date: ____________________

CONSENT FOR INTRAVENOUS/INJECTION THERAPY

Patient: ____ Date: ______________

Intravenous (IV) and intramuscular injection (IM) therapies are used in this office is a means to deliver nutrient substances, and other medications, to your body while avoiding the digestive process. This is helpful in many cases where patients are depleted of certain nutrients, or when the substance can have more medicinal value through the IV or IM route.

It is important for you to understand that this type of therapy, although common, is considered by some physicians to be unconventional and not the standard of medical care for most conditions. Our professional experience with this type of therapy allows us to offer it for your condition as a viable alternative or addition to other (more standard) medical treatments.

Most patients have no adverse effects from the type of IV and IM therapy we offer. Some common effects that may come and go but are generally safe MAY be:

- A warm / tired or relaxed feeling from the minerals in the IV
- Slight to moderate light headedness
- Short term blood sugar changes
- Discomfort at the IV or IM site during or after the treatment
- Thirst
- Nausea

These effects are best dealt with as they arise, and we will give you specific instructions to help avoid or shorten them. **It is your responsibility to inform us immediately if you feel any discomfort or sensation that is unusual.**

Infiltration of the IV (the fluid leaking out of the vein and in to the surrounding tissues) is an occasional occurrence in all IV therapy. It can cause pain, swelling, and bruising on occasion. This is rare in our office practice as the IV time is relatively short (as compared with IV duration in the hospital setting). If this occurs, we will treat it as necessary. The effects of infiltration can be uncomfortable, but do go away. **If you notice pain, swelling or bruising around your IV site please let us know. Immediately apply ice as well.**

Similar to infiltration, the vein may become sore or slightly swollen or warm after an IV. This is typically irritating but not dangerous, and the vein may feel firm for one to five weeks. **Notify us of this immediately as well.**

Although materials injected in this clinic are generally safe and well tolerated by the body it is important for you to understand that all injections may cause **very rare but potentially serious or even life-threatening reactions.** We will and do take necessary precautions to avoid serious complications – but you need to know that they exist, however rare the risk may be.

I HAVE READ, UNDERSTAND, AND HAD ALL MY QUESTIONS ANSWERED ABOUT THIS PROCEDURE AND ITS RISKS AND BENEFITS TO ME.

Date: _______________________ Time: _______________________

Patient Name: ____

Signature: ____
Patient/Representative

If signed by representative, indicate relationship: ____