Last Name_____ First Name_____

Passion for Healing New Patient Intake Form

This form is a detailed questionnaire designed to help you communicate your medical history, family risk factors, current and other health complaints, allergies, prescription/supplements list, and more, enabling Dr. Curry rapid understanding of your personal health needs. Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Ultimately it will help her serve you and make your Naturopathic House Call more productive. You can download and print one from this website or Dr Curry can send you a paper version by mail. Please have it filled out and ready for review during your first visit. You may also want to prepare your own list of any additional questions or concerns that you have for Dr. Curry. If you are unable to fill out this form, Dr Curry can assist you on the first visit.

What are your expectations from this first Naturopathic House Call?

_____

_____

_____

What expectations do you have of me personally as your physician?

_____

_____

_____

What do you know about our approach?

_____

_____

Are there any potential obstacles you foresee in addressing unhealthy lifestyle factors Naturopathically?

_____

_____

Are you currently receiving healthcare (circle)? Yes No

If yes, where and from whom: _____

_____

If no, when, where and for what reason did you last receive medical or health care? _____

_____

In order of importance please list your most important health problems: _____

_____

_____

_____

_____

_____

_____

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Please list any contagious diseases you may have at this time: _____

_____

Any major traumas, accidents, broken bones?_____

_____

Any other health complaints not listed? _____

_____

Hospitalization, Surgery, Imaging Please list dates of any hospitalizations, surgeries, procedures, X-Rays, CAT Scans, MRIs, Bone density scans, EEG, EKG's or other imaging that have you had:

_____

_____

_____

Allergies or Hypersensitivities

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

Current Medications Please circle any you take:

Pain relievers Antacids Cortisone Antibiotics Tranquilizers Thyroid medication
Sleeping pills Laxatives Appetite suppressants Inhalers Allergy pills

Please list all prescription medications and over-the-counter medications you take (attach list if necessary):

_____

_____

_____

Supplements Please list any vitamins or other supplements you take:

_____

_____

_____

Family History Do you have a family history of any of the following (please circle)?

Diabetes Heart Disease High Blood Pressure Kidney Disease Epilepsy Arthritis
Glaucoma Tuberculosis Stroke Anemia Mental Illness Cancer Asthma
Allergies/Hay fever/Hives Sickle cell anemia Hemachromatosis

Any other relevant family history? _____

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Childhood Illnesses Please circle whether you had any of these as a child:

Scarlet fever Diphtheria Rheumatic fever Mumps Measles German measles

Other: _____

General
Height: _____Weight (lbs): _____ Unexplained weight gain/loss? _____
Maximum Weight: _____When: _____ Desired Weight: _____

When during the day is your energy: Best? _____ Worst?_____

Typical Food Intake Please describe a typical days worth of meals and snacks:

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

Deserts/Candy: _____

Water (cups): _____Soda/juices/energy drinks: _____Coffee/tea: _____

Do you eat three meals a day? Yes No Do you go on diets often? Yes No

Do you eat out often? Yes No If yes, how often? _____

Do you eat refined sugars? Yes No Do you add salt? Yes No Fried foods regularly? Yes No

Habits For the following please circle

Y=Yes, a condition you have now N=No, never had P=Past problem

Main interests and hobbies:_____
Enjoy your work? Y N Take vacations? Y N Spend time outside? Y N

Do you have a religious or spiritual practice? Y N If yes, what? _____

Watch television? Y N Hours per day? _____ Video games/web surfing? Y N Hours per day? _____

Have a supportive relationship? Y N Have a history of domestic abuse? Y N

Can you read? Y N P If no, are able to access health information via audio books or DVD? Y N

Exercise Do you exercise? Y N If yes, what kind? _____ How often? _____

Sleep Average 6-8 hours sleep? Y N If no, how much? _____ Sleep well? Y N Awaken rested? Y N

Alcohol/Tobacco/Drugs Use alcoholic beverages? Y N P If yes, how much? _____

Treated for alcoholism? Y N P Use recreational drugs? Y N Treated for drug dependence? Y N P

Use tobacco? Y N P Past smoker Y N P How many years? _____ Packs per day? _____

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Review of Systems

Y=Yes, a condition you have now N=No, never had P=Past problem

Mental
Fatigue Y N P Memory loss Y N P Poor concentration Y N P Easily stressed Y N P
Alzheimer's Y N P Learning Disability Y N P Developmentally disabled Y N P
Other: _____

Emotional
Have you been treated for troubling emotions? Y N P Depression Y N P Mood Swings Y N P
Anxiety/Nerves Y N P Considered/Attempted suicide Y N P Stress Y N P Anger Y N P
Bipolar Y N P Schizophrenia Y N P Paranoia Y N P ADHD Y N P OCD Y N P
Seasonal depression Y N P
Other: _____

Neurologic
Paralysis Y N P Loss of balance Y N P Muscle weakness Y N P Numbness/tingling Y N P
Stroke Y N P Loss of speech Y N P Vertigo/dizziness Y N P Cerebral Palsy Y N P
Seizures Y N P Brain Injury Y N P Brain Tumor Y N P Sensory Loss Y N P
Other: _____

Immune
Chronic infections Y N P Frequent Flu's/Colds Y N P Swollen glands Y N P HIV/AIDS Y N
Chronic Fatigue Syndrome Y N P Slow wound healing Y N P Reactions to immunizations Y N P
Other: _____

Endocrine
Hypothyroid Y N P Hyperthyroid Y N P Heat/cold intolerance Y N P Hair Loss Y N P
Dry skin Y N P Night Sweats Y N P Hypoglycemia Y N P Diabetes Y N P
Excessive thirst Y N P Excessive hunger Y N P
Other: _____

Skin
Rashes Y N P Itching Y N P Eczema, Hives Y N P Acne, Boils Y N P Psoriasis Y N P
Lumps Y N P Lesion with Irregular Border Y N P Rapid Growing Y N P Won't heal Y N P
Color Change Y N P Ulcer Y N P Shingles Y N P Diaper rash Y N P Dry/Oily Y N P
Other: _____

Head
Headaches Y N P Migraines Y N P Jaw/TMJ problems Y N P Head Injury Y N P
Other: _____

Eyes
Impaired vision Y N P Glasses/ contacts Y N P Cataracts Y N P Glaucoma Y N P
Macular Degeneration Y N P Eye pain/strain Y N P Blurriness Y N P Spots in Eyes Y N P
Blurriness Y N P Blindness Y N P Tearing or dryness Y N P Double Vision Y N P
Other: _____

Ears
Hearing loss Y N P Ringing Y N P Earaches Y N P Infections Y N P Dizziness Y N P
Other: _____

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Nose and Sinuses
Frequent colds Y N P Nose Bleeds Y N P Stuffiness Y N P Nasal drip Y N P
Hay fever/Allergies Y N P Sinus congestion Y N P Loss of smell Y N P
Other: _____

Mouth and Throat
Frequent sore throat Y N P Dental cavities Y N P Gum problems Y N P Cold sores Y N P
Sore tongue/lips Y N P Drooling Y N P Dry mouth Y N P Hoarseness Y N P
Trouble swallowing Y N P Loss of voice/larynx Y N P Jaw clicks Y N P Teeth grinding Y N P
Other: _____

Neck
Pain or stiffness Y N P Lumps Y N P Swollen glands Y N P Goiter Y N P
Other: _____

Respiratory
Cough Y N P Spitting up mucus Y N P Spitting up blood Y N P Difficulty breathing Y N P
Pain on breathing Y N P Shortness of breath Y N P Shortness of breath lying down Y N P
Wheezing Y N P Asthma Y N P Emphysema Y N P Bronchitis Y N P Pleurisy Y N P
Pneumonia Y N P Black lung/Asbestosis Y N P Tuberculosis Y N P Lung cancer Y N P
Other: _____

Cardiovascular
High/Low Blood Pressure Y N P Heart disease Y N P Angina Y N P Chest pain Y N P
Murmurs Y N P Palpitations/Fluttering Y N P Rheumatic Fever Y N P Blood clots Y N P
Fainting Y N P Phlebitis Y N P Swelling in ankles Y N P
Other: _____

Blood / Peripheral Vascular
Deep vein thrombosis Y N P Deep leg pain Y N P Varicose veins Y N P Swollen ankles Y N P
Feeling loss in feet Y N P Hands/feet fall asleep Y N P Cold hands/feet Y N P
Hands turn white in cold weather Y N P Easy bleeding/ bruising Y N P Thrombophlebitis Y N P
Anemia Y N P Iron overload/hemachromatosis Y N P
Other: _____

Gastrointestinal
Nausea/vomiting Y N P Heartburn Y N P Abdominal pain/cramps Y N P Ulcer Y N P
Gall Bladder disease Y N P Liver Disease Y N P Jaundice (yellow skin) Y N P Belching Y N P
Change in appetite/ thirst Y N P Is this a recent change? Y N
Bowel Movements: How often?_____
Constipation Y N P Diarrhea Y N P Passing gas Y N P Hemorrhoids Y N P
Blood in stool Y N P Black stools Y N P Pale stool Y N P Intestinal parasites/worms Y N P
Irritable bowel syndrome Y N P Inflammatory bowel disease Y N P Colon cancer Y N P
Other: _____

Urinary
Increased frequency Y N P Frequency at night Y N P Inability to hold urine Y N P
Difficulty urinating Y N P Pain on urination Y N P Blood/pus in urine Y N P
Frequent infections Y N P Kidney stones Y N P Interstitial cystitis Y N P
Other: _____

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Musculoskeletal

Back pain Y N P Joint pain/stiffness/swelling Y N P Arthritis Y N P Weakness Y N P
Muscle wasting Y N P Muscle spasms or cramps Y N P Carpel Tunnel Y N P Sciatica Y N P
Osteoporosis Y N P Broken bones/trauma Y N P Dislocation Y N P
Other: _____

Male Reproduction

Hernias Y N P Testicular masses Y N P Testicular pain Y N P Prostate disease Y N P
Are you sexually active? Y N Number of partners: _____ Have you ever been tested for STIs? Y N
Sexually Transmitted disease Y N P Discharge /sores Y N P Chlamydia Y N P Gonorrhea Y N P
Syphilis Y N P Herpes Y N P Genital Warts Y N P HIV Y N P
Impotence Y N P Erectile dysfunction Y N P Premature ejaculation Y N P
Birth control? Y N Type: _____
Sexual orientation: _____
Other: _____

Female Reproduction / Breasts

Are you pregnant? Y N Due date: _____
Age of first menses: _____ Date of last annual exam/ PAP: _____
Date of last menses _____ Are cycles regular? Y N Length of cycle:_____days
Bleeding between cycles Y N P Duration of menses:_____days Pain during intercourse Y N P
Painful menses Y N P If yes, what are your symptoms?_____
Clotting Y N P Heavy/excessive flow Y N P PMS Y N P
Endometriosis Y N P Ovarian cysts Y N P Uterine fibroids Y N P Abnormal PAP Y N P
Cervical Dysplasia Y N P Cervical cancer Y N P Hysterectomy Y N Ovaries left? Y N
Do you do breast self-exams? Y N P Mammogram Y N If yes, last date: _____
Breast lumps Y N P Breast pain/tenderness Y N P Nipple discharge Y N P
Menopausal symptoms Y N P Hot Flashes Y N P Vaginal dryness Y N P Loss of libido Y N P
Prolapse Y N P Chronic Fatigue Y N P Hair changes Y N P Night sweats Y N P
Are you sexually active? Y N Number of partners: _____ Have you ever been tested for STIs? Y N
Sexually Transmitted disease Y N P Discharge /sores Y N P Chlamydia Y N P Gonorrhea Y N P
Syphilis Y N P Herpes Y N P Genital Warts Y N P HIV Y N P
Sexual orientation: _____
Birth control Y N P Type:_____
Number of pregnancies: _____ Number of live births: _____ Miscarriages: _____ Abortions: _____
Difficulty conceiving Y N P Sexual difficulties Y N P Inability to orgasm Y N P
Other: _____

Thank you for your time and effort.
Dr. Curry sincerely looks forward to meeting you and fulfilling your health care needs and goals.

Last Name_____ First Name_____

Informed Consent for Naturopathic Medical Treatment

I, _____, hereby authorize Dr. Mindy Curry or other licensed doctors of naturopathic medicine, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., laboratory, venipuncture, UA, Pap smears, radiography, allergy testing,
Minor medical procedures: e.g., ear cleansing, nail care, nasal specific, wound care, minor surgery,
Medical use of nutrition: therapeutic nutrition, nutritional supplementation, IM vitamin injections, IV therapy,
Botanical medicine: botanical substances may be prescribed fresh or as teas, alcohol tinctures, syrups, powders, capsules, tablets, troches, creams, essential oils, gels, or suppositories,
Hydrotherapy: the use of water, warm, hot or cold to stimulate circulation, immune function, and relieve pain,
Naturopathic physical medicine: e.g. naturopathic manipulation therapies, Positional release techniques, Strain/Counterstrain, Post-Isometric Relaxation stretch, Physiotherapy,
Therapeutic massage techniques: heat and cold therapies, electric stimulation, manual therapies, energywork,
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses,
Environmental counseling: identification and removal of environmental obstacles to health, e.g., toxins, allergens.
Lifestyle counseling: promotion of wellness including recommendations for exercise, sleep, stress reduction, balancing of work with social activities, art therapy and spiritual awareness,
Psychological counseling: Discussion of emotional concerns, origins thereof, and options for management,

I recognize the potential risks and benefits of these procedures as described below:

Potential benefits: restoration of health and the body's maximal capacity, relief from pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medicines, inconvenience of lifestyle changes, injury from injections, venipuncture, or physical medicine, aggravation of pre-existing conditions.
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 the naturopathic physician 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 my record of health services provided to me is confidential and that I may look at my medical record at any time and can request a copy of it (fees apply for subsequent copies).

_____	_____	_____
Printed Name of Patient	Signature	Date
_____	_____	_____
Printed Name of Legal Guardian	Signature	Date