Dr Sarah Strong, ND

PO Box 127, Hilo, HI 96721
main office: 808.933.4325, fax:808.969.9350

NEW PATIENT INTAKE FORM

Last Name: _____ First Name:_____ MI _____

Nickname: _____ Date of Birth: _____ Gender: M / F

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

SS#: _____-_____-_____ Home Ph:(_____)_____

Work Ph:(_____)_____ Cell Ph:(_____)_____

May I leave confidential voice-mail messages for you at any of the above numbers?

¦ No ¦ Yes (specify): ¦ Home ¦ Work ¦ Cell

Email:_____ (*for healthcare use only!)*

Are you currently employed? Y N Occupation_____

How did you hear about us? _____

Do you have insurance? (if Yes, what type?)_____

Ethnicity?_____

Mother's Name (minors only): _____

Father's Name (minors only): _____

Emergency Contact: _____

Relationship to Emergency Contact: _____

Contact's Phone: (_____)_____ ¦ Home ¦ Work ¦ Cell

Primary Physician_____

Financial Terms: *I understand that I am responsible for all charges at the time of service. I understand that a flat rate finance charge will be added on all accounts that are 60 days past at a rate of 100% the owed amount. This is done to offset fees accrued during collection. I further understand that excessively overdue accounts will be forwarded to an outside collection agency. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing. I also understand that all supplements ordered specifically for me will be automatically billed to me if not picked up within 14 days.*

Privacy Terms: *Records are kept of the healthcare services provided to you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the records kept. Moreover, if you believe that information in your record is inaccurate, you may also request that it be corrected. Your medical information will not be disclosed to others unless you direct us to do so or applicable laws authorize or compel us to do so.* ***Privacy Policy is available upon request.***

Signature_____ Date___/___/20___

Main Reason for today's consultation _____

Other Health Concerns

Present medications (including contraceptives), nutritional supplements, herbs, etc.

Name of product	Brand	Dosage	Duration taken	Reason(s)	Did it help?

Check any of the following that you currently use:

__laxatives __ antibiotics __sleep aids __antacids __allergy medications __pain relievers

List previous surgeries, hospitalizations, or special studies (MRI, etc):

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

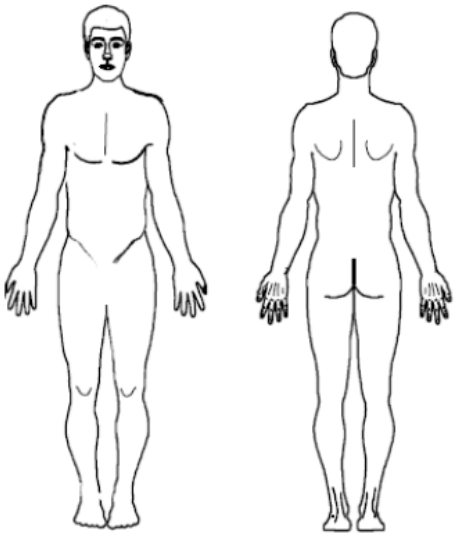
_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

REVIEW OF SYMPTOMS

Please take time to fill this out- it will help us maximize our time with you during your visit. Answer questions about symptoms/ habits experienced in the past 6 months or those that greatly affect your daily life.

Please shade in areas where you are experiencing pain on figures (if applicable).



LIFESTYLE HABITS

Interests and hobbies? _____
Exercise, what kind? _____
How often do you exercise? _____

__Y __ N Have a spiritual practice?
__Y __ N Average 6-8 hrs. of sleep?
__Y __ N Fall asleep easily?
__Y __ N Wake often in during sleep?
__Y __ N Have a supportive relationship?
__Y __ N History of abuse?
__Y __ N Major traumas?
__Y __ N Use recreational drugs?
__Y __ N Treated for drug dependence?
__Y __ N Consume caffeine? How much?_____
__Y __ N Add salt to your food?
__Y __ N Eat refined sugar?
__Y __ N Enjoy your work?
__Y __ N Take vacations?
__Y __ N Spend time outside, in nature?
__Y __ N Watch TV? How much? _____
__Y __ N Read? How often? _____
__Y __ N Consume alcohol? # per week _____
__Y __ N Use tobacco currently? # per day ____
__Y __ N Used tobacco in the past? # of yrs_____

What foods do you crave?

What foods do you dislike?

List any food sensitivities:

Describe your general mood:

How old is your house?

Circle any that apply to your home: carpeting, gas stove, laminate floors, mold issues

Check any of the following you have or have had in the past 6 months.

SKIN
___Rashes
___Eczema, Hives
___Acne, Boils
___Itching
___Fungal Infections
___Color change
___Hair Loss
___Dry skin / scalp
___Lumps
___Night Sweats
___Slow healing ulcerations
___Flushing or hot flashes

NOSE AND SINUSES
___Frequent colds
___Nose Bleeds
___Stuffiness
___Hay fever
___Sinus problems
___Loss of smell

EYES AND EARS
___Itchy eyes
___Watery eyes
___Dry eyes
___Swollen/painful eyes
___Red Eyes
___Impaired vision/blurriness
___Floaters in vision
___Cataracts
___Color blindness
___Double Vision
___Glaucoma
___Hearing difficulty
___Ringing
___Earaches/Infection

MOUTH AND THROAT
___Sore throat
___Copious saliva
___Teeth grinding
___Sore tongue/lips
___Gum problems
___Hoarseness
___Gagging/choking
___Difficulty swallowing

HEAD / NECK
___Headache/migraine
___Faintness
___Dizziness
___Jaw Pain
___Swollen Glands
___Goiter
___Pain or stiffness
___TMJ

RESPIRATORY
___Chest congestion
___Wheezing
___Asthma
___Bronchitis/Pneumonia
___Emphysema
___Difficulty/Pain breathing
___Shortness of breath
___Tuberculosis
___Cough ___Wet or ___Dry
___Coughing blood

CARDIOVASCULAR
___Heart disease
___Angina/Chest pain
___High/Low Blood Pressure
___Murmurs
___Blood clots
___Irregular heart beat
___Palpitations/Fluttering
___Swelling in ankles

CIRCULATION
___Easy bleeding or bruising
___Anemia
___Deep leg pain
___Varicose veins
___Cold hands/feet

ENDOCRINE
___Hypothyroid
___Heat or cold intolerance
___Hypoglycemia
___Diabetes Is this a change?
___Excessive thirst
___Excessive hunger
___Fatigue
___Seasonal depression

IMMUNE
___Chronic Fatigue Syndrome
___Chronic infections
___Chronically swollen glands
___Slow wound healing

MUSCLES / JOINTS/ BONES
___Joint pain
___Muscle pain
___Muscle spasms / cramps
___Restless leg Syndrome
___Sciatica
___Osteoporosis

NEUROLOGIC
___Seizures
___Paralysis
___Muscle weakness
___Numbness or tingling
___Easily stressed
___Vertigo or dizziness
___Loss of balance
___Tics

DIGESTION
___Trouble swallowing
___Heartburn / Acid Reflux
___Change in thirst/appetite
___Ulcer
___Nausea/Vomiting
___Gas/Bloating
___Belching or passing gas
___Diarrhea
___Constipation
___Pain or cramps
___Mucous in stools
___Black / Bloody stool
___Hemorrhoids
___Itchy / Burning Anus
___Rectal Pain
___Liver/Gall Bladder trouble
___Jaundice (yellow skin)
Bowel Movements:
How often?_____
Stools? ___Hard ___Firm
___Soft ___Loose

URINARY
___Pain on urination
___Increased frequency
___Frequency at night
___Frequent infections
___Inability to hold urine
___Kidney stones
___Blood in urine

MENTAL/ EMOTIONAL
___Mood Swings
___Anxiety or nervousness
___Considered/Attempted suicide
___Depression
___Poor concentration
___Poor Memory
___Other:_____

GENERAL
___Poor Sleep / Insomnia
___Dream disturbed Sleep
___Fatigue / Low Energy
___General feel Hot
___General feel Cold
___Chills
___Fevers
___Poor Appetite
___Constant Hunger
___Cravings _____
___Peculiar taste in mouth
___Low Libido
___Experience High Stress

MALE ONLY
___Hernias
___Testicular masses
___Testicular pain
___Prostate disease
___Sexually transmitted disease
___Discharge or sores
___Sexual dysfunction
Are you sexually active? Yes No
Birth control? Type? _____
Any other male difficulties? _____

FEMALE ONLY
___Irregular cycles
___Bleeding between cycles
___Pain during intercourse
___Clotting
___Heavy or excessive flow
___PMS
___Endometriosis
___Difficulty conceiving
___Painful menses
___Vaginal discharge? Color? _____
___Vaginal Odor
___Ovarian cysts
___Menopausal symptoms
___Abnormal PAP
___Sexually transmitted disease
___Breast pain/tenderness
___Nipple discharge
___Breast Lumps
Age at which menses began _____
Age of last menses (if menopausal)___
Length of Cycle (ex. 28 days)_____
Duration of Flow (ex 3-5 days) _____
Date of last period _____
Are you sexually active? Yes No

Birth control? Type? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Difficult or premature births
Do you do breast self-exams? Yes No
Date of last Pap smear _____
Date of last mammogram _____
Could be pregnant now?
Any other female difficulties?

OTHER SYMPTOMS/CONCERNS?

Do you have any allergies? ☐ **No Known Allergies**

Allergen	Reaction Caused	Severity of Reaction

Dr Sarah Strong, ND
NATUROPATHIC INFORMED CONSENT FOR TREATMENT

I, _____, understand that online consultations are not intended to replace in-person care and are to be use as a supplement to standard healthcare.

I recognize the potential risks and benefits of any recommendations as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, flare-ups in current symptoms

Potential benefits: restoration of health and the body's maximal functional 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 Dr Strong 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 Dr Strong regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these consultations at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of seven, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

_____ _____

Date Signature of Patient

_____ _____

Date Signature of Patient's Guardian/ Parent