Dr. Amanda Fey, ND
Complementary Medicine & Healing Arts 27 Jenison Ave, Johnson City, NY 13790 ph.607-729-0591

Hello and Welcome!

Attached you will find patient intake forms. Before your scheduled appointment, please fill out the forms as thoroughly as possible. I know your time is valuable and by bringing your completed intake forms you will maximize the time spent at your health visit.

Your first visit will consist of a thorough assessment of your health history lasting between 1 hour. *Please bring copies of any recent lab work, as well as any supplements or medications you are currently taking with you.*

If you are unable to keep your scheduled appointment for any reason please let us know so we can reschedule your visit at a more convenient time. A 24-hour notice is greatly appreciated.

I truly look forward to supporting you on your journey towards optimal health.

Warmly,
Amanda H. Fey, ND

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New Patient Intake Form (Adult)

Date___________ Name____

Date of Birth____________ Age______ Gender: Male or Female

Address:____

STREET OR PO BOX CITY, STATE, ZIP

Phone: Home__________________________ Work/Cell_____________________________

Email: _______________________________ SSN: ________________________________

Your occupation: _______________ Employer:_____________________________

Marital Status (please circle): Single Married Separated Divorced

Widowed Partnership Other__________________

Emergency contact-name, phone, relationship

____

How did you hear about our clinic?____

HEALTH HISTORY

What are your most important health concerns? List them in order of importance

1.____________________________________ Date of Onset___________________________

2.____________________________________ Date of Onset___________________________

3.____________________________________ Date of Onset___________________________

4.____________________________________ Date of Onset___________________________

5.____________________________________ Date of Onset___________________________

What do you think is happening?____

What do you feel needs to happen for you to get better?

____

Are you currently receiving healthcare for his/her concerns? □ Yes □ No

If yes, where and from who?____

If no, when and where did you last receive medical or health care? What was the reason?

____

Previous Hospitalizations/Surgeries Reason Date

____

____

____

____

What blood work, Xrays, CT scans, MRI's, EKG's, EEG's or other studies have you had pertaining to your current complaint(s), within the past year?

____

____

____

ALLERGIES

Do you have any allergies to drugs, food, or to the environment (animals, dust, mold, etc)

□ No □ Yes

If yes, please indicate what allergies and how you were tested

____

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VACCINATIONS

□ Diptheria	□ Measles/Mumps/Rubella	□ Pertussis	□ Chicken Pox
□ Tetanus	□ Hepatitis B	□ Polio	□ Pneumococcal
□ HiB	□ Influenza	□ Other____________________	

AVERAGE ENERGY LEVEL

0 1 2 3 4 5 6 7 8 9 10
Lowest Highest

When during the day is your energy the best?__________ the worst?__________________

AVERAGE STRESS LEVEL

0 1 2 3 4 5 6 7 8 9 10
Lowest Highest

CURRENT MEDICATIONS

Please list all current prescription medications and over the counter medications:

1. ______________________________Dose________________Indication___________________
2. ______________________________Dose________________Indication___________________
3. ______________________________Dose________________Indication___________________
4. ______________________________Dose________________Indication___________________

Are you currently taking any of the following:

□ Diet Pills	□ Birth Control Pills	□ Pain Relievers (Aspirin, Tylenol, etc)
□ Cortisone	□ Thyroid Medications	□ Sleeping pills
□ Laxatives	□ Tranquilizer	□ Antacids (Tums, etc)

How many courses of antibiotics have you had in the past 10 years? ____________________________

CURRENT SUPPLEMENTS

Please list all current supplements including herbs, vitamins, and/or other supplements:

1. ______________________________Dose________________Indication___________________
2. ______________________________Dose________________Indication___________________
3. ______________________________Dose________________Indication___________________
4. ______________________________Dose________________Indication___________________
5. ______________________________Dose________________Indication___________________
6. ______________________________Dose________________Indication___________________
7. ______________________________Dose________________Indication___________________

FAMILY HISTORY

FATHER: Age _________ □ Good Health □ Poor Health □ Deceased: Cause___________________
MOTHER: Age _________ □ Good Health □ Poor Health □ Deceased: Cause___________________

Please indicate if any family member (including spouse/partner) has/had any of the following:

	Family member		Family member
Cancer	____________________	Autoimmune Disease	____________________
Heart Disease	____________________	Asthma/Allergies	____________________
Diabetes	____________________	Alcoholism/Addictions	____________________
Depression/Anxiety	____________________	Celiac Disease	____________________
Arthritis	____________________	Bleeding disorders	____________________
Osteoporosis	____________________	Alzheimer's Disease	____________________

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REVIEW OF SYSTEMS N = Now P = Past

SKIN					
Rashes	Y	P	Acne or Boils	Y	P
Itching	Y	P	Night Sweats	Y	P
Eczema/Hives	Y	P	Perpetual Hair Loss	Y	P
Unusual Lumps	Y	P	Unusual moles	Y	P
HEAD					
Headaches	Y	P	Migraines	Y	P
Head Injury	Y	P	Jaw/TMJ problems	Y	P
EYES					
Eye pain/strain	Y	P	Glasses or contacts	Y	P
Tearing or dryness	Y	P	Glaucoma	Y	P
Cataracts	Y	P	Visual Disturbances	Y	P
Spots in eyes	Y	P	Blurriness	Y	P
EAR					
Impaired hearing	Y	P	Earaches	Y	P
Ringing	Y	P	Dizziness	Y	P
NOSE & SINUSES					
Frequent colds	Y	P	Nose bleeds	Y	P
Hay fever	Y	P	Congestion/postnasal drip	Y	P
Sinus problems	Y	P	Loss of smell	Y	P
MOUTH & THROAT					
Frequent sore throat	Y	P	Bleeding gums	Y	P
Dental cavities	Y	P	Canker sores	Y	P
NECK					
Unusual lumps	Y	P	Swollen glands	Y	P
Goiter	Y	P	Pain/stiffness	Y	P
RESPIRATORY					
Cough	Y	P	Asthma	Y	P
Wheezing	Y	P	Bronchitis	Y	P
Pneumonia	Y	P	Shortness of breath	Y	P
Sputum	Y	P	Spitting up blood	Y	P
CARDIOVASCULAR					
Heart Disease	Y	P	Chest pain	Y	P
High cholesterol	Y	P	Murmurs	Y	P
Blood clot history	Y	P	High blood pressure	Y	P
Stroke	Y	P	Ankle swelling	Y	P
Palpitations/fluttering	Y	P	Low blood pressure	Y	P
URINARY					
Pain on urination	Y	P	Frequency	Y	P
Urgency	Y	P	Inability to hold urine	Y	P
Kidney stones	Y	P	Frequent infections	Y	P

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GASTROINTESTINAL

Heartburn	Y	P	Nausea/vomiting	Y	P
Pain/cramping	Y	P	Blood in stool	Y	P
Belching/gas	Y	P	Parasites	Y	P
Gallbladder problems	Y	P	Hemorrhoids	Y	P
Ulcer	Y	P	Liver disease	Y	P
Constipation	Y	P	Diarrhea	Y	P

Bowel Movements: How many/day?______ Is this a change?________

MEN'S HEALTH

Prostate problems Y P Date of last prostate exam:______________

Hernia	Y	P	Testicular masses	Y	P
Testicular pain	Y	P	Any discharge/sores	Y	P
Are you sexually active	Y	P	Sexual difficulties	Y	P

Birth control Y N If yes, what type:______________________

Sexually transmitted diseases Y P Impaired fertility Y P

WOMEN'S HEALTH

Age menstruation began _______ Age/date of last menses _______

Date of last pap smear _______ Number of pregnancies _______

Number of live births _______ Number of miscarriages _______

Birth control Y P If yes, what type:______________________

Hysterectomy Y P If yes, what date:______________________

Abnormal pap smear Y P If yes, what date:______________________

Self breast exams	Y	P	Breast lumps	Y	P
Breast pain	Y	P	Nipple discharge	Y	P
Endometriosis	Y	P	Ovarian cysts	Y	P
Fibroid tumors	Y	P	Frequent yeast infections	Y	P
Impaired fertility	Y	P	Sexual difficulties	Y	P

Sexually transmitted disease Y P If so, specify________________________________

IF YOU ARE STILL MENSTRUATING, FILL THIS BOX:

Length of cycle (days)? _______ Length of period or flow (days)?___________

Regular cycles	Y	P	Painful menses	Y	P
Bleeding between periods	Y	P	Heavy or excessive flow	Y	P

PMS Y P If yes, what are your symptoms:_______________________________________

____

IF YOU ARE NO LONGER MENSTRUATING, FILL THIS BOX:

Hot flashes	Y	P	Vaginal dryness	Y	P
Changes in memory	Y	P	Dry skin	Y	P
Spotting	Y	P	Changes in libido	Y	P
Mood changes	Y	P	Hair loss	Y	P
Incontinence	Y	P	Urinary Tract Infections	Y	P

Hormone Replacement Therapy Y P If yes, please specify:_____________________________

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MUSCULOSKELETAL

Joint pain/stiffness	Y	P	Arthritis	Y	P
Muscle spasm/cramps	Y	P	Osteopenia/porosis	Y	P
BLOOD/PERIPHERAL VASCULAR					
Easy bruising/bleeding	Y	P	Anemia	Y	P
Varicose veins	Y	P	Cold hands/feet	Y	P
NEUROLOGICAL					
Muscle weakness	Y	P	Numbness/tingling	Y	P
Memory loss	Y	P	Dizziness	Y	P
MENTAL/EMOTIONAL					
Depression	Y	P	Mood swings	Y	P
Anxiety/nervousness	Y	P	Tension	Y	P
Poor concentration	Y	P	Considered suicide	Y	P
ENDOCRINE					
Thyroid Condition	Y	P	Blood Sugar Imbalance	Y	P
Heat/cold intolerance	Y	P	Chronic fatigue	Y	P
Excessive thirst	Y	P	Excessive hunger	Y	P

LIFESTYLE HISTORY

Weight ________lbs. Height______Weight one year ago?_____Max. Weight___lbs, When?____________

Do you exercise? □ Y □ N If yes, how many days a week?________________________

What do you do and for how long?____

Do you use tobacco? □ Y □ N If yes, how many packs/day?________________________

Smoked previously? □ Y □ N If yes, how many years?____________________________

Drink alcohol? □ Y □ N If yes, how many drinks/week?__________________________

Recreational drug use? Y P Treated for drug/alcohol addiction? Y P

Sleep:_________hours/night Sleep well? □ Y □ N Awake rested? □ Y □ N

Enjoy your work? □ Y □ N Take vacations? □ Y □ N

History of abuse? □ Y □ N Any major traumas? □ Y □ N

What are your interests and hobbies?____

TYPICAL FOOD INTAKE

Breakfast:____

Lunch:____

Dinner:____

Snacks:____

Beverages:____

How many glasses of water do you drink a day?___________________

Do you eat 3 meals/day? □ Y □ N Do you eat out often? □ Y □ N

Do you drink coffee/black tea? □ Y □ N If yes, how many/day?___________

Do you drink soda? □ Y □ N If yes, how many/day?___________

How much change are you willing to make for improving your health? (circle) MINIMAL SOME COMPLETE

Is there any information about your health that you would like to add?_______________________________

____

THANK YOU FOR TAKING THE TIME TO ANSWER THE ABOVE QUESTIONS!

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Payment Policy Agreement, Consent Form, & Agreement

By signing below, you understand that full payment for all services and products you receive from Amanda H. Fey, ND is required at the time of service. MasterCard, VISA, Debit cards, checks, and cash are accepted. You understand that there will be a $20.00 charge for each returned check. You understand that you will be charged a fee of $50 for any missed appointments or any cancellations less than 24 hours ahead of your scheduled visit.

By signing below, you recognize and understand that Amanda H. Fey, ND is a Doctor of Naturopathic Medicine licensed in the state of Oregon; and therefore, is not licensed to practice medicine in the state of New York. Further, you recognize and understand that she does not diagnose, write, or change pharmaceutical prescriptions. Nutrition and natural health services do not replace the role of a conventional physician. Amanda H. Fey, ND is using her education and experience to give you suggestions about your health. You assume the responsibility for the decision to use a natural remedy. If you feel that you are experiencing any adverse reactions then you understand to stop all supplements immediately.

Signature of Patient or Guardian:____Date:_________

Printed Name:____

Notice of Privacy Practices

By signing below, you give permission to the staff at Complementary Medicine and Healing Arts to contact you by telephone and they may leave a message that may contain appointment or medical information if you are not available. You understand that you have the right to inspect and/or copy your health information. Requests to disclose your health information to another health care provider should be provided in writing, unless it is an emergency situation.

Signature of Patient or Guardian:____Date:_________

Printed Name:____