the CENTER

a sanctuary for healing...a spa for wellness.

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 and 1.5 hours. *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

Amanda H. Fey, ND The Center
1 Hoffman St, Suite B Auburn, NY 13021 Ph. (315) 704-0319

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

_____

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	
Tuberculosis		Birth Defects	
Depression/Anxiety		Hypertension	
Mental Illness		Bleeding disorders	
Arthritis		Kidney Disease	
Epilepsy		Stroke	
Osteoporosis		Alzheimer's Disease	

REVIEW OF SYSTEMS

Y = 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

EARS

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

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 diseases	Y	P			

If you are still menstruating:

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 regularly:

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:_____

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

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

Seizures	Y	P	Paralysis	Y	P
Muscle weakness	Y	P	Numbness/tingling	Y	P
Memory loss	Y	P	Fainting	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

Hypothyroid	Y	P	Hyperthyroid	Y	P
Heat/cold intolerance	Y	P	Low blood sugar	Y	P
Excessive thirst	Y	P	Excessive hunger	Y	P
Chronic fatigue	Y	P	High blood sugar	Y	P

LIFESTYLE HISTORY

Weight _____lbs. Height_____ Weight one year ago?_____
Maximum 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 If yes, please explain:_____

_____

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?_____

What are your interests and hobbies?_____

_____

How much change are you willing to make at this time for improving your health?

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!

I certify that the information that I have given above is correct and accurate to the best of my knowledge.

Signature of Patient or Guardian_____Date_____

Print name here_____

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ADULT	
FIRST HEALTH VISIT (usually 90 minutes)	$140
RETURN HEALTH VISITS:	
30 minutes	$70
45 minutes	$95
60 minutes	$125
ACUTE HEALTH VISIT (30 minutes)	$70
PEDIATRICS (0-12 years old)	
FIRST HEALTH VISIT:	
45 minutes	$105
60 minutes	$125
RETURN HEALTH VISITS:	
20 minutes	$50
30 minutes	$70
45 minutes	$95
ACUTE/WELLNESS VISITS (30 minutes)	$70
ACUTE RETURN VISITS (20 minutes)	$50
PHONE CONSULTATIONS	
SAME AS ABOVE	
PROGRAMS	
DETOXIFICATION	$200
NUTRITION/SUPPLEMENT CONSULTS (30 minutes)	$70
For each additional 15 minutes	$30

Payment Policy 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.

Signature of Patient or Guardian:_____Date:_____

Printed Name:_____

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Consent Form and Agreement

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 The Center 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 my 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:_____