

# 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 about 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.

Please be advised an informed consent is included for you to review, however, please do not sign till you are at the visit with Dr. Jennifer Orłowski, ND

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

Warmly,  
Jennifer Orłowski, ND



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?

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### 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

Diphtheria  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**

<b>Y = Now</b>	<b>P = Past</b>
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**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
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Dental cavities	Y	P	Canker sores	Y	P
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**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? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how many days a week? _____	
What do you do and for how long? _____		
Do you use tobacco? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how many packs/day? _____	
Smoked previously? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how many years? _____	
Drink alcohol? <input type="checkbox"/> Y <input type="checkbox"/> 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: \_\_\_\_\_

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**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? \_\_\_\_\_

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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 \_\_\_\_\_

**Jennifer Orlowski, ND**      The Center  
 1 Hoffman St, Suite B Auburn, NY 13021 Ph. (315) 704-0319

<b>ADULT</b>	
FIRST HEALTH VISIT (usually 90 minutes)	\$150
RETURN HEALTH VISITS:	
ACUTE HEALTH VISIT (30 minutes)	\$50
<b>PEDIATRICS (0-12 years old)</b>	
FIRST HEALTH VISIT:	
60 Minutes	\$100
RETURN HEALTH VISITS:	
20 minutes	\$50
PHONE CONSULT - 15 min	\$25
These a phone calls with extra questions from your visit	
<b>PHONE CONSULTATIONS</b>	
SAME AS ABOVE	
<b>HOMOEOPATHY</b>	
FIRST VISIT - adult (2.5 hour)	\$250
FIRST VISIT - peds (0-12years old) (1.5 hour)	\$150
RETURN HEALTH VISITS (30 minutes)	\$50

**Payment Policy Agreement**

By signing below, you understand that full payment for all services and products you receive from Jennifer Orlowski, 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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**INFORMED CONSENT**

**I, \_\_\_\_\_, a mature adult of sound mind, came to Jennifer Orłowski, ND for a consultation of my own will.**

**I understand that although Jennifer Orłowski, ND is a licensed Naturopathic Doctor in Vermont State, the state of New York does not recognize Naturopathic Doctors as primary care physicians. Therefore, Jennifer Orłowski cannot diagnose, treat, operate, or prescribe for my health condition. Jennifer Orłowski obtained a degree of Doctor of Naturopathic Medicine from Southwest College of Naturopathic Medicine in the state of Arizona, which is a four-year doctorate program recognized by the United States Department of Education.**

**I understand that the herbs, nutritional supplement, and homeopathic remedies are not a treatment for my condition-rather a natural substance to support my body systems and prevent disease. I agree to inform Jennifer Orłowski immediately if any adverse reactions develop while I am taking these substances. I understand that naturopathic care requires my active participation in my own health through diet and lifestyle modification. I understand that all recommendations for natural substances should be reviewed with my medical doctor before starting them.**

**I understand that in all circumstances I should continue to consult with my Medical Doctor (MD) in regard to all medical concerns that I may have. I understand that Jennifer Orłowski cannot and will not advise the discontinuation of any pharmaceutical medications prescribed by a physician and that discontinuation of such medicines must be directed by the prescribing physician.**

**I consent in signing this document to contact Jennifer Orłowski if I determine her services are no longer needed. I will contact her office by phone stating that I will cease visits to her office, even if temporary, and stop using the supplements she has suggested.**

**If I am from a regulatory organization, I have identified myself as required by law**

**Client Name: \_\_\_\_\_**

**Signature of Client: \_\_\_\_\_**

**Date: \_\_\_\_\_**



**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: \_\_\_\_\_