

Amanda H. Fey, ND Integrative Medicine Center
301 West State Street Ithaca, NY 14850 Ph.(607) 275-9697

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 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,
Dr. Amanda 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: _____

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	_____
Celiac Disease	_____	Hypertension	_____
Depression/Anxiety	_____	Arthritis	_____
Mental Illness	_____	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

HEAD

Headaches	Y	P	Migraines	Y	P
Head Injury	Y	P	Jaw/TMJ problems	Y	P

EYES

Eye pain/strain	Y	P	Spots in eyes	Y	P
Tearing or dryness	Y	P	Glaucoma	Y	P
Cataracts	Y	P	Visual Disturbances	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 period or flow (days)?	_____	Length of cycle (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
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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: _____

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: _____

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: _____