

Amanda H. Fey, ND

301 West State Street, Ithaca, NY 14850 (607) 275-9697

27 Jenison Avenue, Johnson City, NY 13790 (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 about an 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 _____

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/where did you last receive medical or health care? Reason?

Previous Hospitalizations/Surgeries Reason Date

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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	_____
Heart Disease	_____	Asthma/Allergies	_____
Diabetes	_____	Alcoholism/Addictions	_____
Celiac Disease	_____	Birth Defects	_____
Depression/Anxiety	_____	Hypertension	_____
Mental Illness	_____	Bleeding disorders	_____
Arthritis	_____	Kidney Disease	_____
Epilepsy	_____	Stroke	_____
Osteoporosis	_____	Alzheimer's Disease	_____

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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
Ringling	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	

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	Y	P	Low blood pressure	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 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:	_____

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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: _____

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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? _____

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!**

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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 \$25.00 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 and the doctor 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: _____