The Connecticut Center for Health

New Patient Questionnaire – First Visit *Date* ______/______/______

PLEASE DO NOT MAIL QUESTIONNAIRE. BRING IT WITH YOU TO YOUR APPOINTMENT.

Last Name ______________________________ First ____________________________ Middle Initial _____ Age _______

Date of Birth _____/_____/_____ Do you have a name you prefer to be called by? ________________________

Address ____

City _________________________________ State __________________ Zip Code _________–_________

Home Phone _______________________________ Cell Phone _____________________________________

Work ______________________________________ Fax# ____

Email ____

Social Security Number ________–________–________ What is your height? __________ Weight? __________

How did you learn about the Center?____

Level of Education? (Check) ____ High School ____ College ____ Graduate School

Do you give us permission to share findings and converse with your primary doctor and other providers? ☐ Yes ☐ No

Are you employed? Yes or No If yes, what is your occupation? ____

Employer ____

Address ____

Are you covered by medical insurance? Yes or No If yes, who? ____

Is this your “**primary**” insurance coverage? Yes or No

Your Insurance ID # _________________________________ Group Name or # ____

Who’s Name is the insurance in? (the subscriber) ____________________________ ID# ________________________________

Who will be responsible for payment of services? ____

Name of spouse, parent, relative, friend, or significant other ____

What health concerns would you like to discuss in your initial visit? Please list your concerns in order of importance.

1. ____ 5. ____
2. ____ 6. ____
3. ____ 7. ____
4. ____ 8. ____

What are your thoughts on these concerns? Do you have any ideas as to what might be the underlying cause of your symptoms? Please explain. (You may attach additional pages if necessary.)

____

____

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____

When was the **last time you experienced optimal health?** ____

Please write the specific health results you would like to achieve in working with the doctor. ____________________

____

____

____

____

Have you ever been hospitalized? Yes or No If yes, please provide specifics where indicated below.
Condition Treated or Surgical Procedure Performed Date Hospital

_________________________________ ____/____/____ ____________________________________

_________________________________ ____/____/____ ____________________________________

_________________________________ ____/____/____ ____________________________________

Are you allergic to any foods, drugs or other substances? If yes, please list.

Food\Drug\Substance Allergic Reaction(s)

___________________________________ ____

___________________________________ ____

____

Date of last physical exam? ________ Date of last chest x-ray? _______ Blood work performed? Yes or No

Do you smoke cigarettes? If yes, list # of cigarettes or packs per day ____________________________________

Do you use any other tobacco products? List ____

Do you have an alcoholic family member or loved one? Yes or No If yes, who? __________________________

Do you drink alcohol? Yes or No If yes list type(s) ____

Daily or weekly amount of alcohol consumed? ____

Do you exercise? If yes, what type(s)? ____

If yes, times/week? ________________ ________________ How Long? ____________________________

Do you **use recreational drugs or marijuana**? If yes, what type? ________________ How often? ____________

Are you sexually active? Yes or No Do you use protection during sexual activity? Yes or No

Have you had any sexually transmitted diseases? If yes please list ______________________________________

How many **hours do you sleep nightly?** ______ What time do you fall asleep? ______ What time do you awake? _____

How would you characterize your sleep? (circle) Fitful Erratic Calm Restful Deep

Upon awakening, do you feel well rested and energetic? Yes or No Do you nap during the day? If yes, how long? _____

FAMILY HEALTH HISTORY

Is any blood relative or member of your immediate family presently experiencing any of the following conditions? Please use the following codes to denote the person affected. ***M*** for your Mother. ***F*** for your Father. ***B*** for your Brother. ***S*** for your Sister. ***GM*** for your Grandmother. ***GF*** for your Grandfather. ***A*** for your Aunt. ***U*** for your Uncle. ***W*** for your Wife. ***H*** for your Husband. ***SO*** for your Significant Other.

PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION
___	___	Alcoholism	___	___	Heart Disease
___	___	Anemia	___	___	Heart Murmur
___	___	Arthritis	___	___	Herpes
___	___	Asthma	___	___	High Blood Pressure
___	___	Bleeding (Excessive or Uncontrolled)	___	___	Injury (Life-Threatening)
___	___	Cancer	___	___	Kidney Disease
___	___	Colitis	___	___	Liver Disease
___	___	Constipation	___	___	Lyme Disease
___	___	Diabetes	___	___	Mononucleosis
___	___	Digestive Disorders	___	___	Osteoporosis
___	___	Eczema	___	___	Pneumonia
___	___	Emphysema	___	___	Rheumatism
___	___	Epilepsy	___	___	Seizures
___	___	Glaucoma	___	___	Sexually Transmitted Diseases
___	___	Gout	___	___	Sinusitis
___	___	Hay Fever	___	___	Stroke
___	___	Headaches	___	___	Thyroid (Hyper or Irregular)
___	___	Heart Attack	___	___	Tuberculosis

PERSONAL HEALTH HISTORY Please indicate any condition(s) of past or present concern:

PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION
___	___	Alcoholism	___	___	Heart Disease
___	___	Anemia	___	___	Heart Murmur
___	___	Arthritis	___	___	Herpes
___	___	Asthma	___	___	High Blood Pressure
___	___	Bleeding (Excessive or Uncontrolled)	___	___	Injury (Life-Threatening)
___	___	Cancer	___	___	Kidney Disease
___	___	Colitis	___	___	Liver Disease
___	___	Constipation	___	___	Lyme Disease
___	___	Diabetes	___	___	Mononucleosis
___	___	Digestive Disorders	___	___	Osteoporosis
___	___	Eczema	___	___	Pneumonia
___	___	Emphysema	___	___	Rheumatism
___	___	Epilepsy	___	___	Seizures
___	___	Glaucoma	___	___	Sexually Transmitted Diseases
___	___	Gout	___	___	Sinusitis
___	___	Hay Fever	___	___	Stroke
___	___	Headaches	___	___	Thyroid (Hyper or Irregular)
___	___	Heart Attack	___	___	Tuberculosis

OCCUPATION If presently employed, how many hours per week do you work? ________

Describe the nature of your work and the responsibilities associated with it. ____

____

____

____

What is your **stress level at work** ? (circle) Non-Existent Low Mild Moderate High Severe

What is your **satisfaction level at work?** (circle) Non-Existent Low Mild Moderate High Extremely High

Are you doing the **type of work that you would most enjoy** above all else? Yes or No

Do you work indoors? Yes or No Do you work in an office building? Yes or No

Do the windows open for ventilation? Yes or No Is there specialized air filtration in your workplace? Yes or No

Do you presently **work with chemicals or in the presence of toxic fumes?** Yes or No Have you ever? Yes or No

If Yes, list____

What are you willing to do to achieve the health results you just recorded? If your physician were to recommend the following choices which would you be able to follow and comply with or not? Please check YES or NO.

ITEM	YES	NO	ITEM	YES	NO
Make dietary modifications			Take nutritional supplements daily		
Avoid certain foods			Be compliant with the treatment		
Exercise Regularly			Stick with the program for at least 6 months		
Read books, handouts or listen to tapes for self education about health			Keep the doctor informed about what part of the program is and is not working for you		

If you are in a relationship, will your **significant other support you** in your dietary or lifestyle modification(s)? Yes or No

Do you feel you are adequately loved by others? ☐ Yes ☐ No

Can you accept love when others offer it or demonstrate it? ☐ Yes ☐ No

Do you have people in your life that you love? ☐ Yes ☐ No

Do you experience joy and happiness on a regular basis? ☐ Yes ☐ No

Are you passionate about and fulfilled by some aspect of your life, such as work, a hobby, family, some combination of, etc.?
☐ Yes ☐ No

Are you sexually satisfied? ☐ Yes ☐ No Is this important to you? ☐ Yes ☐ No

Are you a “relaxed” person? ☐ Yes ☐ No Do you know how to relax? ☐ Yes ☐ No

Please review this list of conditions, **CHECK ONLY THOSE ITEMS YOU ARE EXPERIENCING PRESENTLY.**

___ Rough, Dry or Scaly Skin
___ Psoriasis or Eczema
___ Itching Skin
___ Pimples
___ Brittle Nails
___ Burning Skin
___ Boils or Canker Sores
___ Skin Rash
___ Skin Color Change
___ Hair Color Change

___ Numbness
___ Paralysis
___ Loss of Memory
___ Lack of Coordination
___ Nervousness
___ Anxiety
___ Depression
___ Mood Swings
___ Restlessness
___ Fitful Sleep
___ Hallucinations

___ Muscle Cramps
___ Muscle Weakness
___ Joint Pain, Stiffness or Swelling
___ Neck Pain
___ Upper Back Pain
___ Lower Back Pain
___ Backache
___ Frequent Fracturing of Bones

___ Unexplained Weight Gain or Loss
___ Overweight
___ Chronic Fatigue
___ Increased Thirst
___ Night Sweats
___ Wounds Slow to Heal
___ Swelling of Neck
___ Stiff Neck

___ Neck Pain
___ Goiter
___ Unusual Growths of Hair

___ Post Nasal Drip
___ Sinusitis
___ Discharge from Nose
___ Discharge from Nose During or After Meals
___ Nose Bleeds
___ Difficulty Breathing Through Nose
___ Obstruction of Nose
___ Impairment or Loss of Sense of Smell

___ Fever or Chills
___ Intolerance to Heat
___ Intolerance to Cold
___ Excessive Hunger
___ Inability to Gain Weight
___ Change or Loss of Sensation
___ Loss of Balance
___ Seizures or Epilepsy
___ Shaking or Trembling
___ Lightheadedness upon Standing
___ Severe Headaches
___ Fainting Spells
___ Trauma or Injury to the Head

___ Unexplained Fever
___ Burst of Energy Following Exercise
___ Difficulty Concentrating
___ Difficulty Sleeping
___ Difficulty Relieving Stress

___ Dizziness
___ Pain in Ears
___ Ringing in Ears
___ Excessive Earwax
___ Frequent Ear Infections
___ Discharge from Ears
___ Loss of Hearing

___ Dry Eyes
___ Damp Eyes
___ Caked or Crusted Eyelids
___ Sensitivity to Light
___ Poor Eyesight
___ Cataracts
___ Glaucoma
___ Change in Vision

___ Double Vision
___ Blurred Vision
___ Loss of Vision
___ Eye Pain

___ Sore Gums
___ Sore Throat
___ Sore Mouth or Tongue
___ Sensitive Teeth
___ Impairment or Loss of Sense of Taste
___ Increase or Decrease of Saliva
___ Persistent Hoarseness
___ Difficulty Speaking

Please review this list of conditions, **CHECK ONLY THOSE ITEMS YOU ARE EXPERIENCING PRESENTLY.**

___ Frequent or Daily Coughs
___ Frequent Colds
___ Shortness of Breath at Rest
___ Shortness of Breath at Play
___ Wheezing
___ Asthma
___ Emphysema
___ Bronchitis
___ Tuberculosis

___ Discharge from Throat Containing Blood and/or Mucus
___ Chest Pain at Rest
___ Chest Pain at Play
___ Heart Murmur
___ Heart Palpitations
___ Swelling of Ankles
___ Rheumatic Fever
___ Sleep in an Upright Position
___ Frequently Awake at Night Short of Breath

___ Frequent Urination
___ Frequent Night Urination
___ Frequent Urgent Urination
___ Painful Urination
___ Difficulty Holding Urine
___ Difficulty Initiating Urination
___ Frequent Urinary Infections
___ Kidney Stones

___ Abdominal Bloating
___ Excessive Lower Bowel Gas
___ Stomach Pain 5 - 6 Hours After Meal (Usually at Night)
___ Symptoms Above Relieved By Drinking Milk
___ Symptoms Above Aggravated by Worry or Tension

___ Constipation
___ Diarrhea
___ Rectal Pain
___ Hemorrhoids
___ Jaundice
___ Hepatitis
___ Gallbladder Problems
___ Difficulty Swallowing
___ Vomiting
___ Vomiting Blood

___ Loss of Appetite
___ Frequently Awake at Night Hungry
___ Irritable if Late for a Meal
___ Sudden Cravings for Sweets or Alcohol
___ Headaches or Tremors Relieved by Consuming Sweets

___ Frequent Heartburn or Indigestion
___ Frequent Stomach or Abdominal Pain
___ Frequent or Excessive Belching
___ Frequent or Severe Nausea
___ Discomfort After Fatty or Greasy Meals
___ Lack of Energy After Meals
___ Black Stools
___ Yellow Stools
___ Blood in Stools
___ Malodorous Stools
___ Anal Itching

___ Discharge from Vagina
___ Difficulty Feeling Sexually Aroused
___ Lack of Lubrication When Aroused
___ Never or Seldom Experience Orgasm
___ Find Sexual Intercourse to be Painful

___ Menstrual Flow is Excessive/Decreased/Absent
___ Bleeding or Spotting Between Periods
___ Pain Before, During and/or After Periods
___ PMS (Cramping, Headaches, Water Retention)
___ Rheumatic Fever
___ Must Sleep in an Upright Position

___ Clots in Menstrual Flow
___ Mood Swings/Changes with Menstruation
___ Increased Acne, Irritability or Weight with Menstruation
___ Pelvic Pain
___ Lumps or Pain in Breasts
___ Discharge from Breasts

___ Discharge from Penis
___ Difficulty Achieving or Maintaining Erection
___ Painful Erection
___ Difficulty Ejaculating
___ Lumps, Swelling or Pain in Testicles or Groin
___ Cold Hands and/or Feet
___ Troubling Veins in Legs
___ Pain in Legs

___ Swollen or Painful Lymph Nodes
___ Easily Bruised
___ Bleeding
___ Anemia

Please Read - Patient Information and Responsibilities

IF WE PARTICIPATE WITH YOUR INSURANCE YOU MUST HAVE YOUR INSURANCE CARD WITH YOU AT THE TIME OF YOUR VISIT. If your insurance requires a **A Referral,** and you do not have one in place when you arrive for your office visit you will be required to pay for your office visit in full at the time of service.

NOTE: Please come fragrance and perfume free to your appointment. This protects our patients with chemical sensitivity. We kindly ask that you not eat or drink in our waiting room. We ask that you watch and manage your young children in our waiting room to ensure their good behavior. Thank you for your consideration.

CANCELLATION POLICY
If you do not keep an appointment or cancel without 24 hour notice you will be charged a $50.00 no show/cancellation fee. Your doctor may request that you prepay with cash or credit card before the next visit can be scheduled.

PAYMENT FOR SERVICES
Payment for physician services, nutritional supplements, diagnostic tests and all other items must be made at the time of the visit unless prior arrangements have been made. We accept cash, checks, MasterCard and Visa. The Center charges a $15 processing fee for all returned checks. Accounts with balances outstanding 30 days or more will be charged monthly interest of 1.5% of the outstanding balance. Should collection action be required a collection fee of 15% of the outstanding balance will be assessed.

INSURANCE: Please note that we do not participate with Medicare or Medicaid
The Center does not guarantee that your insurance carrier will reimburse all or part of your bill. Not all services are considered covered benefits in all contracts. If we are under contract with an insurance company we will accept their reimbursement rate. If we are not under contract with your insurance company you agree to pay our current fees in full.

The Center currently accepts and participates with some HMO's and insurance companies in the State of Connecticut. We only participate with primary insurance coverage and cannot submit to secondary coverage insurance plans. We will do all we can to insure payment of the claim within 90 days. If the claim is not paid in 90 days or there is a dispute about the claim, the responsibility will be turned back to you and payment for any unpaid claims will be requested. From that point you will be responsible to see that the insurance company pays the claim. Any duplicate payments will be refunded promptly.

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I hereby authorize the payment of medical benefits directly to my physician. I authorize my physician to release any information acquired in the course of my examination or treatment that may be required; by other medical professionals; by my insurance company and its agents to determine benefits payable for services rendered; and in a collection situation.

I understand and agree that I am ultimately responsible for the balance of my account for any and all professional services rendered on my behalf regardless of statements made by any/all insurance companies that I am/was a participating member. I understand that giving you my insurance information does not guarantee insurance approval or payment and I accept full responsibility for the payment of services if my medical insurance provider does not pay as well as late fees or service charges.

SIGNED ____ DATE _______/_______/_______
Patient, Parent or Guardian's Signature (if patient is a minor)

Rev. 11-6-10

THESE POLICIES ARE SUBJECT TO CHANGE WITHOUT NOTICE

Drug Medication(s) List

Instructions to the Patient – Please fill out this form completely. Make sure you put the required information in each column. Include all of the prescription and non-prescription medications (over the counter) you are using daily or on an as needed basis. (Please do not list Nutritional Supplements here, they will go on the back of this form)

Name ______________________________________ **Age:** __________ **Date** ____________ **Weight** ________________

Drug Allergies: ____ ☐ **NKDA**

Name of Drug or Medication	Strength or Dose Per Capsule or Tablet	# of Times Taken Per Day	How Long on This Drug?	Condition Prescribed For?	Name of Doctor That Prescribed This Drug
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Nutritional Supplement(s) List

Instructions to the Patient – Please fill out this form completely. Make sure you put the required information in each column. Include all of the nutritional supplements you are using daily.

Name ______________________________ **Age:** __________ **Date** ___________ **Weight** ________________

Drug Allergies: ____ ☐ **NKDA**

Nutritional Supplement Name	Strength or Dose Per Capsule or Tablet	# of Times Taken Per Day	How Long on This?	Name of Doctor That Prescribed? If none put NA
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				

CONNECTICUT CENTER FOR HEALTH, PC
Naturopathic Medicine ♦ 860-347-8600 ♦ 860-232-0000

INFORMED CONSENT FOR TREATMENT

Name: ____

I hereby authorize the Naturopathic physicians and other practitioners of the CT Center for Health, PC to perform the following specific procedure(s) as necessary to facilitate my diagnosis and treatment:

- **Common diagnostic procedures:** e.g., venipuncture, Pap smears, radiography, laboratory, and x-ray.
- **Minor office procedures:** e.g., dressing a wound, ear cleansing.
- **Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation of vitamins, minerals, amino acids and other nutritional or therapeutic substances.
- **Botanical medicine:** botanical substances (herbal medicines) may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
- **Lifestyle counseling and hygiene:** diet therapy, fasting, elimination diets, promotion of wellness including recommendations for exercise, sleep, stress reductions and balancing of work and social activities.
- **Psychological counseling.**
- **Physical Medicine, acupuncture and bodywork.**

Practitioners of CT Center for Health, PC have discussed and explained to my satisfaction the basic procedures of the above therapies and the risks and benefits of the care I will receive and I have been given the opportunity to ask questions about the treatment plan and procedures. I recognize certain potential risks and benefits of the procedures I am receiving, as they were described to me and as described more generally below:

POTENTIAL RISKS: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, venipuncture for diagnostic testing, and possible prescription drug interaction with prescribed natural supplements or products. Acupuncture may produce temporary numbness, tingling, bruising or redness.

POTENTIAL BENEFITS: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

ALTERNATIVES – I understand that the practitioners at the CT Center For Health, PC are not primary care physicians, and the procedures that I will receive at the CT Center For Health, PC are supplementary care to my primary care physician and/or specialist. It has been recommended to me that I consult with a primary care physician and/or a specialist to obtain information about all of the conventional medicine treatment alternatives available to me.

NOTICE TO PREGNANT WOMEN - All female patients must inform the treating doctor if they know or suspect that they are pregnant as some of the procedures and therapies described above may present a risk to the pregnancy.

CONSENT - With this knowledge, I voluntarily consent to the above procedure(s), realizing that no guarantees or warrantees have been given to me by the CT Center for Health, PC or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

TEACHING CLINIC - I understand that the CT Center for Health, PC often participates as a teaching clinic, and that faculty and students may observe or participate in the care provided, and that my case may be discussed (without identifying information) for educational purposes.

CONFIDENTIALITY - I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my lawful representative, or me or unless law permits or requires it. I understand that I may request to view my medical record and can request a copy of it by paying the appropriate copying fee.

I understand that my medical record will be kept for a minimum of seven years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that my practitioner will answer any questions I have, to the best of his/her ability.

I certify that I have read and fully understand this consent and the matters, which have been explained to me. I further certify that I have full authority and accept full responsibility to execute this consent for an on behalf of the above-named patient and that I am signing freely and voluntarily.

______________________ ____
Date Signature of Patient

____
Signature of Patient Representative or Guardian

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