Name:_____ DOB:_____ Date:_____

Naturopathic care is only possible when the physician has a complete "picture" of your physical, mental and emotional health. Please take the time to complete this questionnaire as thoroughly as possible. This information is for the doctor's use only and is confidential. Thank you.

NAME:_____ INSURANCE:_____

DOB:_____ ID#_____

SS#_____ (for lab & insurance use) GROUP#_____

ADDRESS:_____ PLAN NAME_____

CITY,ST,ZIP:_____ INSURED/SUBSCRIBER_____

PHONE:_____ INSURED/SUBSCRIBER DOB_____

PHONE:_____ INSURED/SUBSCRIBER EMPLOYER _____

EMAIL:_____ _____

Emergency Contact:_____ INSURANCE CO-PAY_____

_____ MARITAL STATUS: S M OTHER_____

Present Health Concerns	Date of Onset	Current Treatment

Childhood illnesses

- ☐ Chicken Pox
- ☐ Diphtheria
- ☐ Ear Infections
- ☐ German Measles
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pertussis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Rubella
- ☐ Tonsillitis
- ☐ Scarlet Fever
- ☐ Strep Throat
- ☐ Mononucleosis

Immunizations	Date	Adverse Reactions
☐ DTP or ☐ DTaP		
☐ MMR		
☐ Polio (☐ IPV/ ☐ OPV)		
☐ Hib		
☐ Pneumococcus (PCV)		
☐ Hep B		
☐ Varicella		
☐ TB test (pos. or neg.?)		
☐		

Other Childhood Illnesses or Trauma_____

_____

Serious Injury or Illness (year and cause)_____

_____

Hospitalizations/Surgeries (year and reason):_____

_____

Name:_____ DOB:_____ Date:_____

Current Medications (prescription, non-prescription, vitamins, herbs, etc. Include pills, tablets, liquids, ointments, suppositories, etc. **indicate dosage**)

_____

_____

_____

_____

_____

Allergies and Sensitivities (Drugs, Foods, Environmental Chemicals, Etc)	Symptoms during an allergy attack?

MEDICAL HISTORY: indicate Mother(M), Father(F), Self(S), Brother/sister(B), other(O)

☐ Anemia_____	☐ Genetic Disease_____	☐ Stomach Ulcer_____
☐ Arthritis_____	☐ Heart Disease_____	☐ Stroke_____
☐ Bleeding Disorder_____	☐ Hepatitis_____	☐ Thyroid Disorder_____
☐ Cancer/Tumor _____ (type?) _____	☐ Herpes_____	☐ Tuberculosis_____
	☐ High Blood Pressure_____	☐ Venereal Disease_____
☐ Diabetes_____	☐ Kidney or bladder _____	☐ Osteoporosis_____
☐ Epilepsia_____	☐ Depression/ Anxiety_____	☐ _____
☐ Glaucoma_____	☐ Positive TB Test____Xray___	☐ _____

SLEEP: Hrs of sleep_____ Fall asleep O.K?_____ Sleep through night? _____
What wakes you_____ Wake rested? _____

WORK: Hr/wk you work _____ Do you enjoy work?_____ Hr/day commute_____
What do you do?_____

EXERCISE: What do you do? _____
How long/often? _____ Do you warm up? _____ Do you stretch?_____

DIET: Restrictions or regimen? _____ How many meals a day? _____
Are you satisfied with your diet as it is now? _____ Cravings? _____
Breakfast:_____
_____
Lunch:_____
_____
Dinner:_____
_____
Snacks- What and when_____
_____

Name:_____ DOB:_____ Date:_____

SUBSTANCE USE: (indicate how much, how often)
Alcohol_____ Tobacco_____

Caffeine (coffee. black/green tea, soda)_____ Recreational Drugs _____

LEISURE: leisure activities/hobbies_____

_____

REVIEW OF SYSTEMS *(Y= you have now: P= you had in past)*

Height_____ Weight _____ Maximum Weight _____ When _____ Easy Weight Gain ____

Length of time for weight gain/loss if you are over/underweight _____

GENERAL: Night sweats_____ Fatigue_____ Do you tend to feel more cold/hot? _____

SKIN: Rashes ____ Infection____ Growths_____ Hair/Nail Changes_____

HEAD: Headaches_____ Head Injury_____Hair loss_____

EYES: Impaired vision____ Eye Pain____ Tearing/Dryness____ Double Vision___ Poor night vision____ floaters____ loss of vision____

EARS, NOSE, SINUS: Frequent Colds____ Nose Bleeds____ Stuffiness____ Sinus Problems____ Post Nasal Drip____ Ringing in Ears _____ Hearing loss or change _____

MOUTH, THROAT: Frequent Sore Throat_____ Sore Tongue____ Sores in mouth/on lips____ Gum Problems____ Hoarseness____ Dental Problems_____ Bad Breath_____

RESPIRATORY: Cough____ Spitting up Blood____ Difficulty Breathing_____ Pain_____

HEART/ CIRCULATION: Heart Disease_____ High Cholesterol____ High Blood Pressure_____ Chest Pain _____ Swelling in Ankles_____ Palpitations/Fluttering_____ Deep Leg Pain_____ Cold Hands/Feet_____ Varicose Veins_____ Murmurs_____ Arrhythmias_____

URINARY: Pain on Urination_____ Increased Frequency_____ Frequency at Night_____ Inability to Hold Urine____ Bladder Infections____

DIGESTION: Change in Thirst_____ Change in appetite_____ Trouble Swallowing_____ Heartburn_____ Stomach Pain_____ Nausea_____ Vomiting_____ Loose Stools_____ Gas_____ Bowel movement frequency? _____ Is this a change?____ Blood in Stools____ Pain _____

NEUROLOGICAL: Fainting____Dizziness___ Seizures____ Paralysis____ Muscle Weakness____ Ringing in ears _____ Numbness or Tingling_____ Loss of Memory_____ Loss of Focus_____ Distractibility_____

HORMONAL: Thyroid Problem_____ Heat/Cold Intolerance____ Hypoglycemia____ Other_____

Name:_____ DOB:_____ Date:_____

REVIEW OF SYSTEMS…continued *(Y= you have now: P= you had in past)*

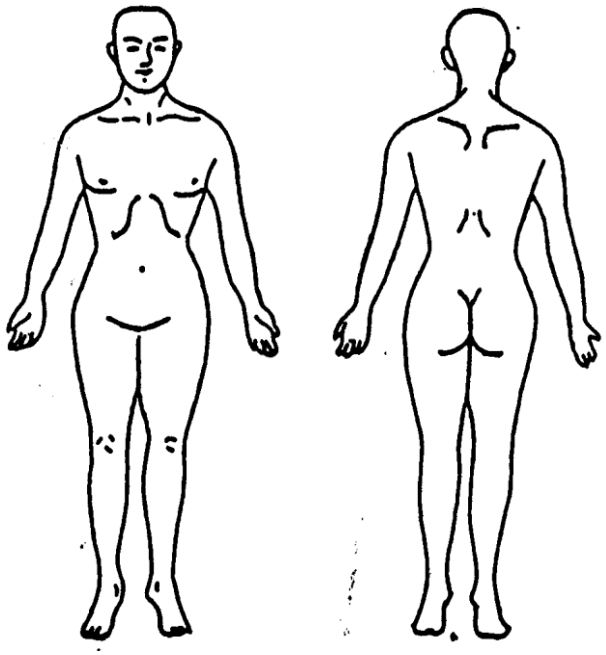
BLOOD AND LYMPH: Anemia____ Easy Bleeding or Bruising_____ Swollen Glands _____

EMOTIONAL: General status_____ Concerns_____

FEMALE REPRODUCTION: Age Menses Began_____ Date of Last Menstrual Period_____
Length of Complete Cycle ____ Number of Days Menstrual Flow____ Bleed Between Periods____
Excessive Flow_____ Are Cycles Regular____ Cramps____
Premenstrual Symptoms: _____Post menstrual or during menses symptoms_____
Abnormal Vaginal Discharge____ Date of Last Pap Smear____ Abnormal Pap Smears ____
Number of Pregnancies____ Number of Live Births____ Number of Miscarriages____
Sexually Active____ Birth Control____(Type _____) Pain During Intercourse_____
Sexual Difficulties____Difficulty Conceiving____ Sexually Transmitted Disease_____
Abortions_____(Optional) Sexual Orientation: _____(Optional)
Menopausal Symptoms_____
Regular Self-Breast Exam____ Lumps____ Pain/Tenderness____ Nipple Discharge____

MALE REPRODUCTION Regular Self-Testicular Exam?____ Testicular Mass____ Testicular Pain____ Sexually Active____ Sexual Difficulties____ Prostate Problems_____
Venereal Disease_____ Sores _____ Discharge_____ Difficulty Urinating_____
Birth Control ____ (Type) _____ Sexual Orientation_____ (Optional)

MUSCULOSKELTAL: Joint Pain/Stiffness____ Morning stiffness____ (lasts how long?_____)
Broken Bones____ Muscle Spasm/Cramp ____ Hernias ____ Weakness____
Indicate any problem areas on diagram below:



Name:_____ DOB:_____ Date:_____

A Natural Path

1037 Western Ave
Brattleboro, VT05301
802-275-5223

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that A Natural Path has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. **I understand that if I have questions or complaints I may contact the office at 802-275-5223.**

I also understand I am entitled to receive updates upon request if A Natural Path changes its Notice of Privacy Practices in a material way.

_____ _____

Signature Relationship to Patient, if signed by someone other than patient.

Date:_____

THIS SECTION IS TO BE COMPLETED BY THE OFFICE OF ANNA ABELE, ND IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (specify):

Name and title of employee_____ Date_____

Name:_____ DOB:_____ Date:_____

Mandatory Disclosure of Information and Informed Consent for Treatment by Anna Abele, ND

** You are the most important person on your health care team. You are entitled to receive clear and understandable information about the methods of therapy, techniques used, and the duration of therapy. If you have any questions about your treatment, please feel free to contact Dr. Abele. You have the right to refuse any treatment offered. You may seek a second opinion from another health care professional, or terminate therapy at any time.*

I understand that methods of treatment may include, but are not limited to: diet and lifestyle therapies, nutritional counseling, therapeutic use of nutrients, herbal medicine, soft tissue manipulation and/or joint manipulation. I further understand that Naturopaths are not licensed in the state of Massachusetts and it is recommended that I have a primary care physician who can provide the kinds of treatment that Dr. Abele is unable to provide in this state.

Naturopathic Pharmacy:

- I understand that pharmacy items need to be prepared and consumed according to the instructions provided orally and in writing.
- Herbal Medicine: I understand that some herbs may need to be prepared. I understand that herbal tinctures are usually prepared with alcohol and will inform the physician if I cannot use them.
- I understand that some pharmacy items may have an unpleasant smell, taste or texture, which is not a reason for returning an item. However, I will immediately notify Dr. Abele of any unanticipated or unpleasant effects associated with a pharmacy item.

Manual Therapy: I understand and am informed that, as in the practice of medicine, in the practice of manual therapy there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, strains and sprains. I understand that a minority of patients may notice stiffness or soreness after the first few days of treatment. I understand that the risk of more severe complications due to joint manipulation have been described as "rare", having been estimated at one in one million to one in twenty million, and is even further reduced by the use of screening procedures as used by Dr. Abele.

Photography: either conventional or digital may be utilized to record my condition. Photography of my condition may also be used to illustrate a patient's condition or an aspect of treatment for educational purposes. I understand that photographs form a part of my medical records and are protected in the same way as any other medical record and if used for medical illustration my privacy will be protected.
I do not expect Dr. Abele to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment, which the she thinks at the time is in my best interest based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and to discuss with Dr. Abele the nature, purpose, risks and benefits of treatments provided. I understand that not all of the above-named procedures may be utilized for my treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I understand that results are not guaranteed. I hereby request and consent to the treatment and use of the procedures listed above on me (or on the patient named below, for whom I am legally responsible).

_____

Patient signature (or gurardian) date

_____

Printed name (guardian and patient if applicable)

Name:_____ DOB:_____ Date:_____

AUTHORIZATION TO RELEASE INFORMATION REGARDING MY CARE

Please initial or sign where indicated

_____ I authorize the release of information regarding my care to the following Physicians:
Initials

Doctors Name: _____

Address:_____

Phone:_____

Fax:_____

Email:_____

Doctors Name: _____

Address:_____

Phone:_____

Fax:_____

Email:_____

_____ I authorize the release of information regarding my care on the voicemail or answering In
Initials machine attached to any number provided by me to ***A Natural Path LLC.***

_____ I authorize the release of information regarding my care to me by any email address
Initials provided by me to ***A Natural Path LLC.***

_____ I authorize the release of information regarding my care to the following people via any
Initials of the means provided by me to ***A Natural Path LLC.*** (___email, ___ mail, ___telephone, ___ answering machine) *please initial*

Name: _____

Name: _____

Name: _____

_____ Date_____

Signature of Patient (or his/her authorized representative, or parent or guardian)

Please specify relationship to patient/client if a minor: _____

This Authorization may be revoked in whole or part at anytime by writing to A Natural Path LLC.