Date ___________

PATIENT PROFILE

A note to our patients: Please complete this *three-sided* questionnaire as thoroughly as possible. This is a confidential record of your medical information and will not be released, except under the guidelines of the Notices of Privacy Practices.

Name: ___________________________ Date of Birth: _____________Age: ______
Nickname: _______________________

Address: _________________________ City:___________ State: _____ Zip: ______

Telephone: Home _____________ Work ______________ Cell _______________
Please circle the phone number you prefer to be reached at.

Is it okay to leave messages regarding your medical care at: Home [ ] Work [ ] Cell [ ]

Email: _________________________ I would like to receive quarterly E-newsletters [ ]

Occupation: _______________________ Employer ___________________________

Emergency Contact: ______________ Relationship____________ Phone __________

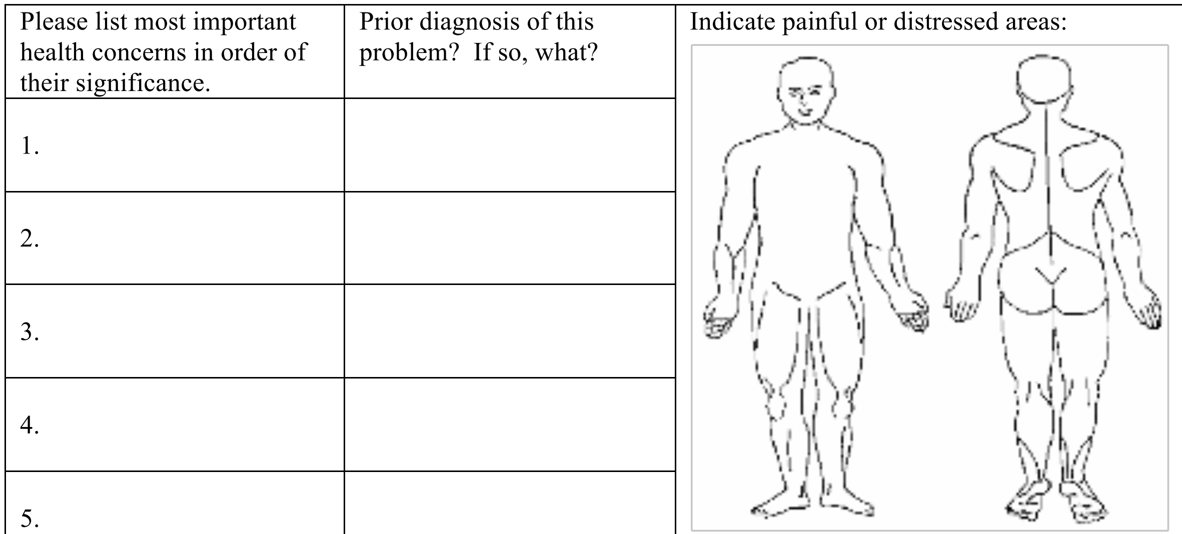
Other current health care providers: ____

____

How did you hear about the Northeast Center for Holistic Medicine? _______________

Please continue on the following pages with your health history and information.

PRESENT HEALTH CONCERNS

Please list most important health concerns in order of their significance.	Prior diagnosis of this problem? If so, what?	Indicate painful or distressed areas:
1.		
2.		
3.		
4.		
5.		

What goals do you have for your visit at the Northeast Center for Holistic Medicine today? ____________

____

Have you ever consulted a Naturopathic Doctor, Nutritionist, or other alternative medicine provider before?

____

Current Medications: Herbs, vitamins, pharmaceuticals (Rx and Over the counter), contraceptives			
Medication/supplement name	Dose	Frequency	How long?

Do you have any allergies (medications, foods, topicals, etc) that are severe or life threatening: **YES** **NO**
If yes, please describe: ____

Personal Habits:

HABITS				
SUBSTANCE	**Current**	**Past**	**Never**	**Frequency**
Alcohol				
Caffeine				
Tobacco				
Marijuana				
Other recreational drugs				

Do you follow any particular diet regimens of restrictions? If yes, please describe in detail: ____________

____

____

Daily water intake: ______________________________ Source _________________________________

Hours work/ week: ____________________

Hours sleep/night? __________________ Trouble falling asleep? ________ Staying asleep? ___________

Do you exercise regularly? **YES NO** What type? ____

How long? ________________________ How often? ____

Past Medical History:
Hospitalizations: ____

____

Serious injuries/ chronic illnesses: ____

____

Date of last physical/annual exam: ______________ Date of last blood tests: ______________________

Personal and Family History
Please check the "Self" box next to each condition that applies to you and please list closest family members who have each of the following conditions. Please note whether the condition applied in the past (P) or is currently applicable (C).

	Self	P/C	Relation	P/C		Self	P/C	Relation	P/C
Alcohol/Drug Addiction					Headaches				
Allergies					Heart Disease				
Anemia					Hepatitis				
Arthritis					High Blood Pressure				
Asthma					Kidney Disease				
Cancer					Mental Illness				
Depression					STDs				
Diabetes					Stroke				
Eczema					Tuberculosis				
Epilepsy					Other				

Social History

Please circle those that apply: Single Married Significant Other

Partner's name _________________________________

Do you have any children? YES NO Please list their age(s) ______________________________

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Consent for Purposes of Treatment, Payment, and Health Care Operation

I consent to the use of disclosure of my identifiable health information by the Northeast Center for Holistic Medicine, LLC for the purposes of diagnosis or provising treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that my diagnosis or treatment by the practitioners at Northeast Center for Holistic Medicine, LLC may be conditioned upon my consent as by my signature on this document.

Practitioner means a Naturopathic Doctor, Acupuncturist, Medical Doctor, Chiropractic Doctor, Osteopathic Doctor, Massage Therapist or other healthcare worker employed by or under contract with the Northeast Center for Holistic Medicine, LLC.

Patient means any person seeking the health care advice and/or treatment of a practitioner at the Northeast Center for Holistic Medicine, LLC through consultation by phone or in person.

My *identifiable health information* means health information collected from me and created or received by my practitioner, another health care provider, a health plan, and my employer. This *identifiable health information* relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Northeast Center for Holistic Medicine, LLC is not required to agree to the restrictions that I may request. However, if the Northeast Center for Holistic Medicine, LLC agrees to a restriction that I request, the restriction is binding upon the Northeast Center for Holistic Medicine, LLC.

I have the right to revoke this consent, in writing, at any time except to the extent that the Northeast Center for Holistic Medicine, LLC has taken action in reliance of this consent.

I understand that I have the right to review the Northeast Center for Holistic Medicine, LLC Notice of Privacy Practices prior to signing this document. This notice describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Northeast Center for Holistic Medicine, LLC.

Northeast Center for Holistic Medicine, LLC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices at any time by requesting the most current notice in writing or in person at the time of my office visit.

Emergency Care: Our clinic does not administer emergency medical care. In the case of an emergency, please see your family physician or the emergency room of the nearest hospital. After emergency care has been administered, patients often respond well to Naturopathic care to accelerate the healing process.

Payment:

Payment is expected in full at time of service. We accept personal checks, cash, Visa, Mastercard, and American Express.

We are currently unable to bill insurance in the states of New Hampshire and Massachusetts.

- Upon request, an invoice can be produced which may be submitted to insurance companies for reimbursement by the patient. Please ask for this invoice at time of payment.
- The Northeast Center for Holistic Medicine, LLC does not guarantee reimbursement by the patient's insurance company.
- I understand that it is not the responsibility of the Northeast Center for Holistic Medicine, LLC to research whether reimbursement may occur, to submit forms for reimbursement, or to follow up with my insurance company regarding reimbursement.

Cancellation Policy:

The Northeast Center for Holistic Medicine, LLC requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. Missed appointments without notification will be charged the full visit fee. Cancellations with less than 24 hours notice will be billed 50% of the visit fee.

- I agree to pay for services rendered at time of service. I acknowledge that I may request the fees for various procedures before they occur and include that information in my decision regarding healthcare.
- I am aware that my practitioner may charge for telephone consultations.
- I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- I consent to treatment as agreed upon between the practitioner and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the practitioner.

____ ________________

Signature of Patient or Authorized Representative Date

____

Printed name and relationship to patient