New Patient Intake

Welcome! Holistic health care and preventive medicine are most effective when the doctor has a complete understanding of your health history. Please fill out this questionnaire as thoroughly as possible. Print all information clearly and mark anything you don't understand with a question mark. All information contained in these pages is completely confidential and it will never be shared with any other party. Your email address will only be used to contact you in regard to your health care.

Name ____ Preferred Name ______________________

Age _____ Date of Birth _____/____/_______ ☐ Female ☐ Male

Address ____

City ________________________ State ________ Postcode _____________

Phone (Day) ____________________ Mobile____________ Email_______________________________

Is it OK to leave messages? ☐ Yes ☐ No

Preferred contact ☐ Day phone ☐ Evening phone ☐ Mobile phone ☐ Email

Emergency contact Name ____

Relationship _____________________ Daytime Phone _________________

Who may we thank for your referral? ☐ Friend or family
☐ Web search
☐ A Blog or news article
☐ Other ____

What are your current conditions and concerns (in order of priority)? Date of onset

(1)____ __________________

(2)____ __________________

(3)____ __________________

(4)____ __________________

(5)____ __________________

How do these conditions affect your life? ____

____

____

Do you have a primary care physician? ☐ No ☐ Yes

Name ______________________________________ Clinic ________________________________

Phone _________________ Address ____

Diagnosis / treatment / results ____

____

Have you been to a Natural Medicine Doctor before? ☐ No ☐ Yes

Name ____ City ___________________________

Phone _________________________ Dates of treatment _________________________________

Diagnosis / treatment / results ____

____

Please check “C” for therapies you currently use and “P” for those you have used in the past:

C	P		C	P	
☐	☐	Acupuncture	☐	☐	Homeopathy
☐	☐	Chiropractic	☐	☐	Oestopathy
☐	☐	Herbal Medicine	☐	☐	Physical Therapy
☐	☐	Detoxification	☐	☐	Jennetics
☐	☐	Mineral Therapy	☐	☐	Supplements
☐	☐	Other ______________			

Please list any known allergies:

Drug ____

Environmental ____

Food ____

Other ____

Do you know your family history? ☐ No ☐ Yes

Mother Health problems: ____

☐ Alive, age ____ ☐ Deceased at age ____ Cause of death ______________________

Father Health problems: ____

☐ Alive, age ____ ☐ Deceased at age ____ Cause of death ______________________

Please list any major illness experienced by your immediate family members (parents, sisters, brothers, children). Also indicate their age at diagnosis and their relationship to you.

____

____

____

____

Please indicate if you have ever had the following conditions or symptoms by marking “C” for current, “P” for past, or “N” for never:

C	P	N	
☐	☐	☐	Acne
☐	☐	☐	Anemia
☐	☐	☐	Anxiety or nervousness
☐	☐	☐	Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Atherosclerosis
☐	☐	☐	Autoimmune disease
☐	☐	☐	Blood pressure problems
☐	☐	☐	Bone disease
☐	☐	☐	Cancer of _____________
☐	☐	☐	Chest pain
☐	☐	☐	Chronic inflammation
☐	☐	☐	Chronic pain
☐	☐	☐	Circulatory problems
☐	☐	☐	Cold sores
☐	☐	☐	Constipation
☐	☐	☐	Debilitating fatigue
☐	☐	☐	Dental problems
☐	☐	☐	Depression
☐	☐	☐	Diabetes Type _________
☐	☐	☐	Diarrhea
☐	☐	☐	Difficulty breathing
☐	☐	☐	Difficulty sleeping
☐	☐	☐	Dizziness or fainting
☐	☐	☐	Ear infections
☐	☐	☐	Eating disorder
☐	☐	☐	Feel unsafe at home
☐	☐	☐	Frequent antibiotic use
☐	☐	☐	Frequent colds or flu
☐	☐	☐	Gallbladder disease
☐	☐	☐	Gastrointestinal disorder
☐	☐	☐	Hay fever
☐	☐	☐	Headaches
☐	☐	☐	Head injury

C	P	N	
☐	☐	☐	Heartburn
☐	☐	☐	Heart disease
☐	☐	☐	Hemorrhoids
☐	☐	☐	HIV or AIDS
☐	☐	☐	Hypoglycemia
☐	☐	☐	Irritable Bowel Syndrome
☐	☐	☐	Kidney disease
☐	☐	☐	Liver disease
☐	☐	☐	Loss of appetite
☐	☐	☐	Lyme disease
☐	☐	☐	Memory loss
☐	☐	☐	Mononucleosis
☐	☐	☐	Mood swings
☐	☐	☐	Nausea
☐	☐	☐	Neurological disease
☐	☐	☐	Numbness / tingling
☐	☐	☐	Osteoporosis
☐	☐	☐	Pancreas problems
☐	☐	☐	Panic attacks
☐	☐	☐	Parasites
☐	☐	☐	Physical abuse
☐	☐	☐	Seizures
☐	☐	☐	Sinus problems
☐	☐	☐	Skin problems
☐	☐	☐	Stroke
☐	☐	☐	Substance abuse
☐	☐	☐	Thyroid problems
☐	☐	☐	Ulcers
☐	☐	☐	Urinary tract infection
☐	☐	☐	Vaccinations
☐	☐	☐	Varicose veins
☐	☐	☐	Vomiting
☐	☐	☐	Other:

Please describe your sexual activity:

☐ I have never been sexually active
☐ I am not currently sexually active but I have been in the past
☐ I am sexually active with ☐ Men ☐ Women ☐ Men and women
Methods to prevent sexually transmitted infections and/or pregnancy:
Present ____
Past ____

WOMEN:

Are you? ☐ Pregnant now ☐ Nursing ☐ Preparing for pregnancy ☐ Preventing pregnancy

If you are still having periods:
Average number of days in cycle _______
Average number of days of bleeding _______

Cycles are ☐ Regular ☐ Irregular
Periods are ☐ Light ☐ Medium ☐ Heavy ☐ Painful

Number of		Year(s)
_____	Pregnancies	__________________
_____	Vaginal births	__________________
_____	C-sections	__________________
_____	Miscarriages	__________________
_____	Abortions	__________________

Date of last		Normal	Abnormal
Period	__________________	☐	☐
Pap smear	__________________	☐	☐
Mammogram	__________________	☐	☐
Bone scan	__________________	☐	☐

Please indicate if you have had the following conditions or symptoms by marking "C" for current or "P" for past or "N" for never:

C	P	N	
☐	☐	☐	Abnormal pap smear
☐	☐	☐	Breast pain or lump
☐	☐	☐	Changes in sex drive
☐	☐	☐	Changes in memory
☐	☐	☐	Changes in mood
☐	☐	☐	Desire pregnancy
☐	☐	☐	Dry skin
☐	☐	☐	Endometriosis
☐	☐	☐	Facial hair
☐	☐	☐	Frequent/chronic yeastinfections
☐	☐	☐	Hair loss
☐	☐	☐	Hormone replacement therapy
☐	☐	☐	Hot flashes
☐	☐	☐	Hysterectomy
☐	☐	☐	Impaired fertility

C	P	N	
☐	☐	☐	Nipple discharge
☐	☐	☐	Ovarian Cysts / PCOS
☐	☐	☐	Painful intercourse
☐	☐	☐	Pelvic inflammatory disease
☐	☐	☐	PMS
☐	☐	☐	Sexual abuse
☐	☐	☐	Sexual difficulties
☐	☐	☐	Sexually transmittedinfection
☐	☐	☐	Spotting between periods
☐	☐	☐	Urinary incontinence
☐	☐	☐	Urinary tract infections
☐	☐	☐	Uterine fibroids
☐	☐	☐	Vaginal dryness
☐	☐	☐	Other:

MEN:

Date of last prostate exam ______ / ______ / ___________

Please indicate if you have had the following conditions or symptoms by marking "C" for current or "P" for past or "N" for never:

C	P	N	
☐	☐	☐	Changes in mood
☐	☐	☐	Erectile dysfunction
☐	☐	☐	Hair loss
☐	☐	☐	Impaired fertility
☐	☐	☐	Pain or lump in scrotum
☐	☐	☐	Painful intercourse
☐	☐	☐	Problems with urination

C	P	N	
☐	☐	☐	Prostate problem
☐	☐	☐	Regular self testicular exam
☐	☐	☐	Sexual abuse
☐	☐	☐	Sexual difficulties
☐	☐	☐	Sexually transmitted infection
☐	☐	☐	Urinary tract infection
☐	☐	☐	Other:

Do you take prescription medications? ☐ Yes ☐ No

Please list all medications, over-the-counter medicines, natural medicines, vitamins, and supplements you are currently taking. Use a separate page if necessary.

Name	Dosage	Dates Taken	Reason for taking

Briefly discuss any medications or supplements you are not taking now but have taken in the past year:

☐ See reverse
☐ See attached page

Height _______ Weight ________

Weight 3 months ago _____ Weight one year ago _____ Maximum weight _____ When? __________

What do you regularly eat and drink? Note the typical time of day and describe all that apply:

Breakfast ____

Mid-morning snack ____

Lunch ____

Mid-afternoon snack ____

Dinner ____

Late-night snack ____

Current dietary restrictions ____

Why? ____

Past dietary restrictions ____

When? Why? ____

Where do you eat? Check all that apply:

☐ Table ☐ Desk ☐ Bed ☐ In front of the TV ☐ Car ☐ Standing ☐ Walking

☐ Other ____

Do you drink the following regularly? If so, how much?

☐ Coffee or espresso ______ cups or _____ shots per day

☐ Alcohol (wine, beer, spirits) ______ glasses/bottles/shots per week

☐ Soda or sweetened beverages ______ per week

☐ Diet soda or artificially sweetened beverages? ☐ No ☐ Yes ______ drinks per week

If you have daily bowel movements, how many per day? _______

If you do NOT have daily bowel movements, how many per week? _______

How would you describe them? Color ______________________

Check all that apply: ☐ Easy ☐ Difficult ☐ Painful ☐ Soft ☐ Dry and hard

☐ Loose ☐ Explosive ☐ Blood ☐ Mucus ☐ Undigested food ☐ Floats ☐ Sinks

Do you exercise regularly? ☐ No ☐ Yes

Aerobic exercise _______ minutes _______ times per week

Activities ____

Strengthening exercise _______ minutes _______ times per week

Activities ____

Stretching _______ minutes _______ times per week

Activities ____

Other:

Do you smoke? ☐ No ☐ Yes

How much do you sleep each night, on average? ______ hours Is this enough? ☐ No ☐ Yes

Do you awaken well rested? ☐ No ☐ Yes

How do you rate your quality of sleep? Place an "X" on the scale:

Great -- Poor

Are you employed? ☐ No ☐ Yes - Occupation: ______________________________

Employer ______________________________

Do you enjoy your work? ☐ No ☐ Yes __________ hours per week

Do you commute? ☐ No ☐ Yes __________ hours per week

Are you engaged in at least one activity you feel passionate about? ☐ Yes ☐ No

What do you do for fun? ______________________________

____

Have you had a major life change in last year? ☐ No ☐ Yes ______________________________

____

What is your overall level of stress? Place an "X" on the scale:

Low -- High

Identify stressors ______________________________

Do you feel loved and well supported in your life? ☐ Yes ☐ No

What is your level of commitment to change your current routines to improve your health?

☐ I would change anything to get better

☐ I am willing to make any change except ______________________________

☐ I am only willing to change ______________________________

☐ I don't want to change anything

Is there anything else you would like the doctor to know? ______________________________

____

____

____

The above information is true to the best of my knowledge.

______________________________ _____ / _____ / _________

Signature *Date*

Informed Consent

I, _______________________________ (please print your name clearly), hereby certify by my signature at the bottom of this page that:

I understand Patrick Rozanski is a Doctor of Naturopathic Medicine and Queensland does not recognize naturopathic doctors as licensed medical doctors. I understand that Dr. Rozanski functions as a health consultant and that he is not licensed to diagnose or treat specific diseases, prescribe drugs, or perform surgery in Queensland.

I understand that any assessment performed by Dr. Rozanski and any natural remedy recommended by Dr. Rozanski is for the purpose of optimizing my health, body function, and overall wellness, not for purposes of diagnosis, treatment, or replacement of prescription medication.

I understand that Dr. Rozanski's services are not a replacement for care by licensed medical providers. I understand that Dr. Rozanski advises me to maintain contact with a primary care physician and seek treatment for any symptoms, complaints, and conditions that I feel require such care. I take responsibility for informing other medical providers of any natural remedy I choose to consume. I take responsibility for informing Dr. Rozanski of any changes in my health, medications and supplements while seeking his services.

I take full responsibility for taking any natural remedy Dr. Rozanski may recommend. I do not hold Dr. Rozanski accountable or liable for any adverse effects or complications from the natural remedies that I consume. I understand that results are not guaranteed.

I understand that Dr. Rozanski does not bill insurance and I agree to pay for his services at each visit, unless we have specified a different financial agreement prior to the appointment.

I understand that the internet is an open network and provides no inherent protection for confidential information. If I use email to communicate with Dr. Rozanski I understand that it may pose risks to the confidentiality of my health information and I accept these risks. I understand that there will be times when he does not have access to email and that I must contact him by telephone regarding critical or time-sensitive issues.

I sign this informed consent to express that I voluntarily seek consultation from Dr. Rozanski. I understand that I am free to withdraw my consent and to discontinue participation at any time.

I have read this consent form and fully understand its contents.

Patient signature: ________________________________

Date: ________________________________