Dr. Jenna Dye
naturopathic physician

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480-448-8888

New Patient Adult Intake Form
Date ___ / ___ / ___

PERSONAL INFORMATION

Name _____ **DOB** ___ / ___ / ___

☐ Male ☐ Female ☐ Other

Address _____ **City** _____ **State** _____ **Zip** _____

Phones (check preferred) ☐ **Home** _____ ☐ **Cell** _____ **Work** _____

E-mail _____ ☐ **e-mail me discounts and announcements**

Occupation _____ **How many hours a week?** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

How did you hear about us?

☐ Referral *who?* _____ ☐ Internet Search(search engine)_____

☐ Advertisement _____ ☐ Returning patient ☐ Other _____

MEDICAL HISTORY

Who is your general physician? _____

Address: _____ **Phone** _____

Have you ever been treated by the following: ☐ Naturopathic Doctor ☐ Acupuncturist ☐ Chiropractor ☐ Massage Therapist

On a scale of 1 to 10, how healthy do you think you are right now? 1 2 3 4 5 6 7 8 9 10

How committed are you to making a change? 1 2 3 4 5 6 7 8 9 10

What is your primary health concern? How long has this been impacting you?

_____

What additional concerns would you like to address?

_____

What expectations do you have for your first visit with me?

_____

List all allergies (food / environmental / drug) ☐ None Known _____

_____

List and date all surgeries, hospitalizations and accidents _____

_____

PATIENT NAME _____ DOB ____/____/____

MEDICATIONS/SUPPLEMENTS (Prescribed and over-the-counter) *Please provide attachment if needed.*

MEDICATIONS	SUPPLEMENTS

Please check if you have taken any of the following:
□ Accutane *when?*_____ □ Retin-A *when?*_____

□ Antibiotics How many times in the last year? _____ Last 5 years? _____

IMAGING: (X-Rays, CT Scans, MRI, etc.) *Please list reason and date*
Reason **When**

_____

_____

Height _____ **Weight** _____ **Maximum Weight** _____ **When?** _____

Exercise: ☐ **YES** ☐ **NO** **If so, what, frequency/week?** _____

☐ Caffeine ____ # **oz** per day ☐ Alcohol ____ # (12oz beer – 6oz wine – 1.5oz liquor) per (day – week – month)
☐ Water _____ # **oz** per day ☐ Tobacco _____ # (cigarettes – cigars – pipes – dips) per day.
☐ Recreational Drug Use _____

FAMILY HISTORY

Please list familial relation and diseases: (Diabetes, Cancer, High blood pressure, Stroke, Mental Illness, etc)

_____

_____

_____

PERSONAL MEDICAL HISTORY

Please list all current health conditions: _____

_____

Please list all past health conditions: _____

_____

PATIENT NAME _____ DOB ____/____/____

MEDICAL HISTORY

Please circle one for each condition Y(yes), P (past), N (never)

SKIN			
Rashes	Y	P	N
Eczema, hives	Y	P	N
Acne, boils	Y	P	N
Itching	Y	P	N
Night sweats	Y	P	N
Melanoma	Y	P	N
HEAD - NECK - EARS – EYES - NOSE			
Headache	Y	P	N
Migraine	Y	P	N
Head injury	Y	P	N
Swollen glands	Y	P	N
Lumps/ goiter	Y	P	N
Ear ringing	Y	P	N
Earache	Y	P	N
Dizziness	Y	P	N
Impaired vision	Y	P	N
Glasses/ contacts	Y	P	N
Double vision	Y	P	N
Eye pain	Y	P	N
Tearing, dryness	Y	P	N
Glaucoma/cataracts	Y	P	N
Frequent colds	Y	P	N
Allergies/ hay fever	Y	P	N
Sinus problems	Y	P	N
MOUTH & THROAT			
Frequent sore throat	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Dental cavities	Y	P	N
CHEST/ LUNGS			
Asthma	Y	P	N
Bronchitis	Y	P	N
Pneumonia	Y	P	N
Emphysema	Y	P	N
Difficulty breathing	Y	P	N
Tuberculosis	Y	P	N
Cough	Y	P	N
Wheezing	Y	P	N

CARDIOVASCULAR			
Heart Disease	Y	P	N
High blood pressure	Y	P	N
Murmur Y	P	N	
High Cholesterol	Y	P	N
Rheumatic fever	Y	P	N
Chest pain	Y	P	N
Palpitations	Y	P	N
Swollen ankles	Y	P	N
PERIPHERAL VASCULAR & BLOOD			
Bleeding disorder	Y	P	N
Deep leg pain	Y	P	N
Cold hands/feet Y	P	N	
Varicose veins	Y	P	N
Anemia	Y	P	N
Easy bruising	Y	P	N
URINARY			
Pain on urination	Y	P	N
Increased frequency	Y	P	N
Frequency at night	Y	P	N
Kidney disease	Y	P	N
Kidney stones	Y	P	N
Weak urine stream	Y	P	N
Incontinence/leakage	Y	P	N
NEUROLOGICAL			
Dizziness	Y	P	N
Fainting	Y	P	N
Seizures	Y	P	N
Muscle weakness	Y	P	N
Numbness/tingling	Y	P	N
Memory loss	Y	P	N
MUSCULOSKELETAL			
Joint pain/ stiffness	Y	P	N
Arthritis	Y	P	N
Broken bones	Y	P	N
Muscle spasm	Y	P	N
Gout	Y	P	N

PATIENT NAME _____ DOB ____/____/____

ENDOCRINE			
Diabetes	Y	P	N
Thyroid disorder	Y	P	N
Type: _____			
Goiter	Y	P	N
Heat/cold intolerance	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
MENTAL/OTHER			
Depression	Y	P	N
Mood swings	Y	P	N
Anxiety	Y	P	N
Tension	Y	P	N
Alcoholism	Y	P	N
Chemical dependency	Y	P	N
Sleep disturbances	Y	P	N
BREAST			
Self exams	Y	P	N
Lumps	Y	P	N
Tenderness/Pain	Y	P	N
Nipple discharge	Y	P	N
GASTROINTESTINAL			
Number of bowel movements? _____(Day or week)			
Is this a change?	YES	NO	
Trouble swallowing	Y	P	N
Heartburn	Y	P	N
Change in thirst	Y	P	N
Change in appetite	Y	P	N
Nausea/vomiting	Y	P	N
Gas/bloating/belching	Y	P	N
Liver disease	Y	P	N
Gall bladder disease	Y	P	N
Ulcer	Y	P	N
Hemorrhoids	Y	P	N

FEMALE REPRODUCTION			
Bleeding between periods	Y	P	N
Irregular cycles	Y	P	N
Painful menses	Y	P	N
Excessive flow	Y	P	N
# days of bleeding_____			
Length of cycle *(example 28 days)*_____			
Birth control	Y	P	N
What type? _____			
How long? _____			
Sexually active	Y	P	N
Pain with intercourse	Y	P	N
Sexual difficulties	Y	P	N
Sexually transmitted diseases	Y	P	N
Menopause Symptoms:			
Hot flashes	Y	P	N
Night Sweats	Y	P	N
Vaginal Dryness	Y	P	N
Brain Fog	Y	P	N
Pregnancy History:			
Could you be pregnant?	Y	N	
# of pregnancies _____			
# of miscarriages _____			
# of abortions _____			
Difficulty conceiving	Y	P	N
MALE REPRODUCTIVE			
Hernias	Y	P	N
Testicular masses	Y	P	N
Prostate disease	Y	P	N
Discharge	Y	P	N
Sores	Y	P	N
Sexually active	Y	P	N
Sexual difficulties	Y	P	N
Sexually transmitted diseases	Y	P	N

INFORMED CONSENT FOR TREATMENT

I, _____, voluntarily consent to be treated with Naturopathic Medicine by Dr. Jenna Dye, NMD. I understand that I am free to withdraw my consent and to discontinue participation in treatment at any time. I authorize the use of any of the following as necessary to give proper assessments, determine treatment approaches or otherwise address my health concerns:

DIAGNOSTIC PROCEDURES: Including but not limited to general physical exams, gynecological exams, PAP smears and venipuncture, lab testing (including referrals for x-ray, MRI/CT, mammography or other imaging).
THERAPEUTIC NUTRITION: Including but not limited to dietary counseling, supplementation and diet plans. Supplementation may include oral and intramuscular vitamins or other injections.
BOTANICAL MEDICINE/HOMEOPATHY: Including but not limited to use of plants, minerals, vitamins, homeopathic remedies in the form of; teas, tinctures (glycerite/alcohol), capsules, tablets, creams or suppositories.
LIFESTYLE COUNSELING & EXERCISE PRESCRIPTION: Including but not limited to promotion of wellness, psychological counseling and recommendations for exercise, sleep and stress reduction.
NATUROPATHIC MANIPULATION: Including but not limited to specific manipulation of muscles, joints or soft tissue using massage, neuro-muscular techniques, stretching, visceral manipulation, manual manipulation, traction and/or craniosacral.
PRESCRIPTION MEDICATION: Including but not limited to prescribing pharmaceuticals, bio-identical hormones, compounded medications or chelation products within the scope of naturopathic medicine.
POTENTIAL RISKS: including but not limited to allergic reactions (rash, hives, nausea, vomiting, itching lip, and tongue swelling and/or impaired breathing), gastrointestinal upset due to prescribed medication (pharmaceutical, herbal or vitamin supplement). Therapies may also cause pain, discomfort or soreness. Topical applications may cause discoloration of skin. Soft tissue or bone injury may occur from physical manipulations and/or aggravations of pre-existing condition. *I will immediately contact my doctor if I experience any of these adverse symptoms. Herbs, homeopathic and nutritional supplements may become toxic if misused. I understand all products should be taken as prescribed.*
NOTICE TO PREGNANT WOMEN: Female patients must alert the doctor if they know or suspect that they are pregnant as some therapies and treatment recommendations may pose a risk to pregnant women.

By signing below, I consent to evaluation and/or treatment of my condition by Jenna Dye, NMD. I have been advised of risks of treatment and I fully understand these risks. I understand the nature and the purpose of the procedures, evaluation and course of my treatment. I realize that no guarantees have been given to me regarding cure or improvement of my condition.

I have been given the opportunity to ask questions, and my questions have been answered to my satisfaction. I certify that I have read, fully understand and agree to the terms of this consent form.

Patient Name: _____ **Guardian:**_____

Patient or Guardian Signature: _____ **Date:** _____

AUTHORIZATION AND DISCLOSURE

- I have fully and accurately disclosed my medical history. INITIAL_____
- I will notify my doctor of any changes to my health, medications and/or lifestyle as they occur. INITIAL _____
- I am undergoing treatment(s) of my own free will. INITIAL_____
  I understand that despite precautions, complications may occur.
- I understand that results of treatments and procedures may vary INITIAL_____
  and that no guarantees can be made regarding treatment results.
- I give my authorization for lab results and other private health information relating to my treatment to be left on voicemail.
  ☐ **Yes**, a *message may be left at the following number* ____-____-_____
  ☐ **No**, *I understand that only instructions to call Dr. Jenna Dye will be left on voicemail.*
- I understand & agree to all payment & office policies. My questions regarding these policies have been satisfactorily answered.

Signature _____ **Date** _____

FINANCIAL AGREEMENT AND OFFICE POLICIES

PAYMENT INFORMATION: Payment is due at the time of service. **Cash, check, debit, HSA, FSA and credit card (VISA or MasterCard)** are accepted. A superbill with procedure and diagnosis codes may be requested for you to submit to your insurance company for reimbursement as your insurance allows. A credit card back up is required for personal checks. In the case of returned check, the card will be charged a $35 fee in addition to the returned amount.

***LABS: It is your responsibility to determine lab coverage with your insurance carrier. Insurance companies generally have a preference for Labcorp **or** SonoraQuest. Obtaining lab work from the wrong lab may result in a large patient bill. Cash pay labs are also available through Lab Xpress. Naturopathic doctors CANNOT order under Medicare or AHCCCS plans. It is your responsibility to notify your doctor if you have either of these plans. The patient will be responsible for any bills accrued due to lack of insurance coverage.

TEST RESULTS: Routine calls for lab work results are not common practice. Do not assume that because you have not been contacted, your report was normal. Results will be reviewed at the follow up visit.

POST VISIT QUESTIONS: Your questions are important and will be answered in a timely manner via phone. If the questions result in changes to treatment or warrants a physical exam, you may be asked to schedule an appointment. Non-urgent questions left on voicemail will be answered within 24 – 72 hours. More urgent matters will be addressed as soon as possible and at the doctor's discretion. In the case of a medical emergency or acute medical concern, please present to urgent care or dial 911 as appropriate.

PRESCRIPTIONS: PLEASE CONTACT YOUR PHARMACY FOR ALL PRESCRIPTION REFILLS. Prescription refills will be handled via fax. For any new prescriptions or prescription refills, you must have at least one in-person visit with the doctor within the last 3-12 months. More frequent in person visits may be necessary per doctor's discretion.

CANCELLATION & NO SHOW POLICY: Please cancel **24 hours** before your appointment time to avoid a **$50 fee** for missed appointments. Unforeseen emergencies do occur, thus one late cancellation or missed appointment will be waived each year. Please note that arriving more than 10 minutes late to your appointment may result in rescheduling.

CHILDREN must be with you at all times. Please also be aware that many professionals practice in the building and appreciate your consideration.

COUPONS must be presented at the time of service and prior to expiration to receive discount. Coupons cannot be combined with other discounts or specials.

REFUNDS: All supplements sales are final. Payment for rendered services is also non-refundable. Patient response and treatment may vary.

Patient Name: _____ **Guardian:** _____

Patient or Guardian Signature: _____ **Date:** _____