The Naturopathic Approach – Healing Within LLC

Phone (203)260-0078

Fax (855)293-2286

***PRINT, FILL OUT AND BRING TO FIRST OFFICE* VISIT**
**** IF TELECOMMUNICATING APPOINTMENT, SEND BY FAX****
**** 24 HR CANCELLATION NOTICE REQUIRED OR $25.00 FEE WILL BE BILLED**

Date:_____/_____/_____

How did you hear about The Naturopathic Approach??_____

Patient _____ **DOB**_____/_____/_____

Weight_____**Height**_____**Circle One: Male/Female Age:**_____

Mailing Address_____**City**_____**State**_____**Zip Code**_____

Email Address _____**Can you receive correspondence? Y / N**

Home Phone _____ **Cell Phone** _____

Occupation _____ **Full Time Y/N**

In the event of an emergency, who would you like us to contact:

Name_____ **cell phone**_____

Relationship to patient_____

Marital Status: Single / Married / Divorced / Widowed / Widower

Name of Spouse / Partner / Parent: _____

Cell phone: _____**Email:** _____

Current Health Care Team:

Primary Care Physician _____ **Dr. Phone Number** _____

Specialist(s) Physician _____ **Dr. Phone Number** _____

Specialist(s) Physician _____ **Dr. Phone Number** _____

List ALL medications and supplements.

Medication _____ Date & Dr. prescribed_____

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Medication _____ Date & Dr. prescribed_____

Medication_____ Date & Dr. prescribed_____

Rx/Supplement/Vitamin_____ Date started_____

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Are you allergic/have you had a bad reaction to any medications to other substances? ____ Yes ____ No

If yes, please specify drug(s) and type of reaction:

_____

***Primary* goals for this visit?** _____

_____

_____

List chronologically, other concerns you want to address: Onset frequency/Severity

1. _____ _____

2. _____ _____

3. _____ _____

What prior experiences have you had with alternative or complementary medicine?

With whom do you live? (Include roommates, friends, partner, spouse, children, parents, relatives, pets)

Name	Age	Relationship

Are there major stressors in your life?

_____

_____

What do you do to relax/relieve stress? What interests/hobbies do you have?

_____

_____

What physical activity do you participate in, and how often?

_____

Past Occupation(s): _____

Spiritual beliefs/religious affiliations – past and present:

_____

Describe sleep pattern.

Typical time you wake up? _____

Typical bedtime? _____

<u>NUTRITION</u>

How many meals do you generally eat per day? _____ **Do you skip meals?** _____

How many servings of fruit per day? (Svgs: 1 medium fruit) _____

How many servings of vegetables do you consume each day?

_____

Are you currently on a special diet? Food allergies? Foods you avoid? Vegetarian?

_____

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Please list the foods you CANNOT eat and the reason:

Food	**Reason Can't Eat**
_____	_____
_____	_____
_____	_____
_____	_____

What and how much do you drink on a typical day? (water, caffeinated drinks, soda)

_____

Tobacco use – current or past use
Type: _____**Amount per day (or week):** _____

Recreational drugs – current or past use
Type: _____**Amount per day (or week):** _____

Alcohol – current or past use:
Type: _____**Amount per day (or week):** _____

Have you ever had to cut down on your drinking? _____ **Yes** _____ **No**

Do you get annoyed when someone asks about your drinking? _____ **Yes** _____ **No**

Do you ever feel guilty about your drinking? _____ **Yes** _____ **No**

ENVIRONMENT

Do you react adversely when you consume caffeinated beverages? _____ **Yes** _____**No**

In your work or home environment, are you exposed to chemicals, cigarette smoke, Pesticides, or Radiation exposure? _____**Yes** _____**No**

PERSONAL MEDICAL HISTORY

Please **check** all the following conditions that apply to **YOU**
If a choice is given, please **circle** the appropriate one.

Family History: Write the appropriate letter next to all that apply to your **Family members:** **M = Mother, F = Father, S = Sibling, G = Grandparent**

_____ **Alcoholism or Substance Abuse**
_____ **Anemia (Iron deficiency, etc)**
_____ **Arthritis/Joint Disease**
_____ **Blood Clots/Phlebitis**
_____ **Cancer, Type: _____**
_____ **Seizures, Epilepsy**
_____ **Digestive (UC, Crohns, IBS, Celiac)**
_____ **Sexually Transmitted Disease**
_____ **Gall Bladder**
_____ **Hay Fever, Allergy, Eczema**
_____ **Hearing Loss**
_____ **Heart Attack/Disease/Failure**
_____ **Urinary Difficulties (Incontinence, UTI)**
_____ **Vision/Eye Problems**
_____ **Liver Dis (Hepatitis A/B/C, Cirrhosis)**
_____ **Kidney Infection/Stones**
_____ **Other _____**

_____ **Lung Disease (Asthma, COPD, TB)**
_____ **Mental Trouble/Depression/Anxiety**
_____ **Pneumonia/Bronchitis/Emphysema**
_____ **History of Infertility**
_____ **Rheumatic Fever**
_____ **Diabetes (Type 1 & 2)**
_____ **Easy Bleeding**
_____ **Frequent Sinusitis**
_____ **Skin Disease(s)_____**
_____ **Stroke, TIA**
_____ **Thyroid Disease**
_____ **Heart Murmur**
_____ **Headaches (Migraines, etc)**
_____ **High Blood Pressure**
_____ **High Cholesterol**
_____ **Gout**

Please list any operations/surgical procedures/blood transfusions/major injuries (with dates):

_____

_____

Immunizations/vaccinations:

_____

WOMEN ONLY:

Reproductive History

Age of 1st menstrual period _____ First day of most recent menstrual period _____

Typical Flow: _____ Light _____ Moderate _____ Heavy

Length of period in days: _____

Circle all that apply:

_____ Painful Periods _____ Missed Periods _____ Spotting Between Periods

_____ Unusual Discharge _____ Recurring Vaginal Infections

If you have gone through menopause, have you had any post-menopausal bleeding?

_____

Date of last pap _____ History of abnormal paps? _____

Number of: Pregnancies _____ Live Births _____ Abortions _____ Miscarriages _____

Have you experienced complications during pregnancy/delivery/other problems?

_____

Please circle the method of contraception you are currently using:

Birth Control: type _____ Date started_____

Hysterectomy/Tubal Ligation/ Norplant/Condom Date: _____

Partner /vasectomy_____ Date: _____

<u>MEN ONLY:</u>

Check all that apply:

_____ Prostate Problems _____Testicular Cancer _____Vasectomy

_____ Sexual Dysfunction specify _____

<u>PAST PSYCHOTHERAPY:</u>

Have you seen a psychotherapist in the past? _____ Yes _____ No

If so, please explain: _____

Please feel free to use the remaining space to discuss anything else you wish me to know about your life, health, emotions, the kind of person you are, goals, concerns, etc.

_____

Thank you for taking the time to complete! Looking forward to meeting you!

Dr. Karenmarie LaConte ND

Business Address:
Reservoir Corporate Centre
4 Research Drive
Suite 402 (Regus Offices)
Shelton, CT

Mailing Address:
Dr. K. LaConte ND
720 Hilltop Dr.
Stratford, CT 06614
***ALL CORRESPONDENCE SHOULD BE MAILED TO THIS ADDRESS**

<u>First Office visit</u> – no insurance **$200.00**
**** Patients with a *valid insurance card* (presented at time of appointment) $25.00 off FOV**
- Please allow 1 ½ hr

<u>Follow – up appointments</u> **$125.00**

<u>Optional testing</u>
Allergy tests: IgG 208 food panel **$304.00**
Environmental test **$ 89.00 by itself**
$ 69.00m with/another allergy test
Other specific functional tests available upon request

****IN ORDER TO AVOID A CANCELLATION FEE, 24 HOUR CANCELLATION NOTICE IS REQUIRED.**

Payments accepted: Cash, HSA, Visa, MC, Discover OR Cashier's Check