Turshá Hamilton, N.D.
Naturopathic Primary Care Physician

www.DrTursha.com

*True Vitality Naturopathic Medical Care*
PO Box 26863 | Tempe, Arizona 85285
Tel: 480.415.9622 | Fax: 480.287.8559

# New Patient Intake Form

**OUR PRIVACY POLICY**

All health information in our office is treated as confidential, and we are careful in how we use it. This policy describes how your health information may be used and how you can get access to this information.

We will only report a patient's health information in three kinds of situations:

1) if the patient makes a written request to us for his or her health care records to be shared with himself or herself, or another health care provider; or
2) if the patient arrives to our office in a state requiring emergency care, in which case we would contact 911; or
3) in cases of victims of abuse or threatened homicide or threatened suicide, or threatened harm to others, and in such cases, only to law enforcement agencies, 911 services and/or other emergency services.

Other than these special situations, we always honor your right to privacy and your control over who sees your information, as well as federal and state privacy laws and regulations in order to assure you complete confidentiality regarding your health care information.

Please indicate your acceptance of this policy with your signature on the line below.

**X**________________________________________ Date: ____________________

**CANCELATION POLICY**

Appointments may be canceled with no penalty up to 24 hours before a scheduled visit. When less than 24 hours notice is given or if an appointment is missed, a $30 fee may be charged. Please note, this fee must be paid by your next appointment.

**X**________________________________________ Date: ____________________

**LATE ARRIVALS**

I will make every effort to remain on schedule so that you are not inconvenienced. Please be on time. If you are late, the visit will be shortened or may have to be rescheduled.

**X**________________________________________ Date: ____________________

Print Patient Name: ___________________________________________________

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## Patient – Provider E-Mail Agreement

E-mail offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember, there are important differences. E-mail is not the same as calling the office; there is no person at the other end of the e-mail – just a computer. You can't tell for sure when your message will be read or even if the doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us via e-mail.

- E-mail is never appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Room for emergencies.
- E-mail is great for asking those little questions that don't require a lot of discussion.
- E-mail should not be used to communicate sensitive medical information, such as that regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- **E-mail is not confidential!** It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he/she chooses.
- E-mail may become part of the medical record when we use is; a copy may be printed and placed in your chart
- **E-mail is not a substitute for seeing your physician**. If you think that you need to be seen, please call and schedule an appointment!
- E-mails may be forwarded to staff for handling, if appropriate.

Finally, either party can revoke permission to use the e-mail system at any time.

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- ☐ I **DO** want to communicate with my doctor electronically. I have read the above information and understand the limitations of security on information transmitted.
- ☐ I **DO NOT** want to communicate with my doctor electronically

Patient Name: ______________________________ Date: ____________
Patient / Guardian Signature: ______________________________
Email address: ______________________________

Print Patient Name: ______________________________

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**Patient contact information**

| **Last name:** | | **First name:** | ♀ ♂ |
|---|---|---|---|
| Age: | Date of birth: | SSN: | |
| Address: | | | |
| City, state, zip: | | | |
| Telephone: | | Cell or work phone: | |
| Emergency contact:<br>Telephone: | | Relationship: | |
| Referring physician: | | | |
| How did you hear about us? | | | |

**Lifestyle and habits**

| **Activity and exercise** | |
|---|---|
| How many hours/day do you ride in a vehicle? | |
| How many hours/day do you watch TV? | |
| Is your work sedentary, active or in-between? | |
| How many times/week do you exercise? | Hrs each session? |
| What kind of exercise activities do you do? | |
| For how long have you been doing regular exercise? | (approx no. of years) |

| **Habits** |
|---|
| Do you smoke? **Y N** If so, how many per day? |
| How many years have you smoked? (or N/A) |
| How many glasses of alcohol/day? (or N/A) |
| How many cups of coffee/day? (or N/A) |
| How many cans of soda/day? (or N/A) |
| How many sweets or desserts/day? (or N/A) |
| Are there any chemicals, heavy metals, fumes, dust, etc. that you are regularly exposed to? |
| Bowel movements: how often? |

| **Allergies** |
|---|
| Please list any known food or drug allergies. |
| |
| |
| |
| |
| |

Print Patient Name: ____________________________________________

## Supplements and Medications

Please list all supplements, including botanicals, vitamins and minerals, as well as any medications, both prescription and over the counter. If doses known, please indicate:

## Current medical history

What is the main reason (or reasons) for this appointment?

Date of last complete check-up:

Are you willing to modify your diet or living habits, if doing so would improve your health? Y N

What is your biggest health goal?
What would you like to accomplish?

**Past medical history**

## Surgical history

Please list all surgical history, which may include removal of tonsils, appendix, gallbladder or a tooth, placement of stents, valves, implants, artificial joints or organs, or other devices, etc.

## Emergency care or other hospitalization

Please list any history of emergency care, such as stroke, heart attack, acute gallbladder or pancreas, kidney stone, ectopic pregnancy, fracture, vehicular accident, other injury or severe acute illness which resulted in hospitalization

Print Patient Name: ____________________

## Review of systems

Please circle any current problem you are having. Mark a P next to any past problem you have had.

**Head and face**

Headaches
Dizziness
Loss of balance
Blurry vision
Fainting/blackouts
Red eye/ eye pain
Cataracts/ glaucoma
Ringing in the ears
Earaches
Difficulty hearing
Loss of smell
Nose bleeds
Hoarse voice
Grinding teeth
Neck swelling or lumps
Sore throat
Dental problems
Sore/ bleeding gums
Difficulty swallowing
Canker sore/cold sore
Impaired speech

**Chest**

Wheezing
Coughing up blood
Coughing up phlegm
Shortness of breath
Chest colds
Palpitations
Chest pain
Night sweats
Unexplained fever
Rapid/skipped beats
High blood pressure
Swollen feet or ankles

**Abdomen**

Stomach pain
Indigestion
Nausea
Vomiting
Blood in vomit
Diarrhea
Constipation
Yellow skin/jaundice
Gas/bloating
Clay-colored stool
Loss of appetite
Excessive appetite
Blood in stool
Light colored stool
Rectal pain/itching

**Genitourinary**

Frequent urination
Urge to urinate
Incontinence
Difficulty urinating
Blood in urine
Kidney stones
Sexual difficulty
Pain with urination
Bladder infections
Genital sores
STDs ________________
Genital discharge

**Musculoskeletal**

Aching muscles
Numbness/tingling
Restless legs
Broken bones
Weakness
Swollen joints
Sore joints
Leg cramps
Tender points

**Skin**

Acne
Itching
Eczema / Psoriasis
Rashes
Easy bruising
Hives
Frequent bleeding
Wounds heal slowly

**Endocrine**

Always cold
Always hot
Chronic fatigue
Weakness
Carbohydrate cravings
Increased thirst
Fluid retention

**Nervous**

Anxiety
Loss of sensation
Tremor
Foggy thinking
Lack of strength
Convulsions
Loss of memory
Lack of concentration
Paralysis

**Blood, immune**

Painful lymph nodes
Anemia
Swollen glands

Print Patient Name: ___________________________________________________________

**Mental/emotional**

| | | | |
|---|---|---|---|
| Depressed mood | Shy/timid | Loneliness | Mood swings |
| Suicidal thoughts | Restlessness | Scary dreams | Frequent crying |
| Angered easily | Excessive worry | Mental confusion | Suspicious/jealous |

**Male reproductive**

| | | | |
|---|---|---|---|
| Prostate problems | Infertility | Premature ejaculation | Swelling in testicles |
| Painful erection | Discharge | Difficult ejaculation | Pain in testicles |
| Painful urination | Trouble getting / maintaining erection | | |

**Female reproductive**

| | | | |
|---|---|---|---|
| Lumps in breast(s) | Dry or delicate vagina | Pain with intercourse | Spotting btwn periods |
| Breast pain | Pelvic pain | Vaginal itching/burning | PMS |
| Missed periods | Vaginal discharge | Genital eruptions | PCOS |
| Hot flashes | Heavy periods | Ovarian or uterine problems | |

Age of first menses: ________________ Periods occur every __________ days. Regular? _____

Periods usually last __________ days. First day of last period: ___________________________

# of pregnancies: ___________ # of births: ________________ # of miscarriages: ________________

Has menopause occurred yet? _____________ If yes, when was last cycle? ______________________

Date of last Pap: _________________________ Date of last abnormal Pap, if any: _________________

## Acknowledgement of Consent

I affirm that all information within this document is complete, accurate and true to the best of my knowledge. I further give consent for medical care by Dr. Turshá Hamilton, Naturopathic Physician.

Print Name: ___________________________ Signed: ________________________ Date: _______

Print Patient Name: ______________________________________________________________