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. Your email address will only be used to contact you in regard to your health care, or for Dr. Cimperman's monthly newsletter if you elect to receive it.

Personal Information

Name ______________________________ Age ______ Gender ☐ Female ☐ Male

Date of Birth ______/______/________ Social Security Number ______-____-________

Address ______________________________ Apt. # __________

City ______________________________ State ________ Zip ______________

Phone (Day) ____________________ (Evening) ____________________ (Cell) ____________________

Is it OK to leave messages? ☐ Yes ☐ No ______________________________

Email address (for purposes of contacting you in regard to your health care, if necessary)

____

Preferred contact ☐ Day phone ☐ Evening phone ☐ Cell phone ☐ Email

Emergency contact

Name ______________________________

Relationship ______________________________

Daytime Phone ______________________________

On her website, Dr. Sarah Cimperman publishes a free online newsletter, *Santé! Holistic Health News*.

Are you interested in receiving a monthly email alert once the new issue has been posted?

☐ Yes, please subscribe me at this email address ______________________________

☐ No thank you, please do NOT subscribe me

Who may we thank for your referral? ☐ AANP website ☐ NYANP website

☐ New York Naturally ☐ Wisdom Magazine ☐ NCNM

☐ Internet search ☐ Friend or family ☐ Other ____________________

Current Health Conditions

Conditions, symptoms, concerns - in order of priority — Date of onset

(1)______________________________ ______________

(2)______________________________ ______________

(3)______________________________ ______________

(4)______________________________ ______________

(5)______________________________ ______________

How do these conditions affect your life? ______________________________

____

Medical History

Do you have a Primary Care Physician? ☐ No ☐ Yes Dr. ______________________

Date of last physical exam ______________

Have you consulted your PCP about the aforementioned condition(s)? ☐ No ☐ Yes

Have you consulted another practitioner about the aforementioned condition(s)? ☐ No ☐ Yes

If so, who? ______________________

Have you been to a Naturopathic Doctor before? ☐ No ☐ Yes Dr. ______________

If so, when and under what circumstances? ______________________

____

Please state any previous diagnosis, treatment and results (any practitioner):

____

____

Please indicate which therapies have you used by marking "C" for current or "P" for past or "N" for never:

C	P	N		C	P	N	
☐	☐	☐	Acupuncture	☐	☐	☐	Herbal Medicine
☐	☐	☐	Chiropractic	☐	☐	☐	Homeopathy
☐	☐	☐	Counseling	☐	☐	☐	Hydrotherapy
☐	☐	☐	Detoxification	☐	☐	☐	Massage
☐	☐	☐	Diet modification	☐	☐	☐	Nutritional Supplements
☐	☐	☐	Fasting	☐	☐	☐	Physical Therapy
☐	☐	☐	Fertility Awareness	☐	☐	☐	Vitamins/minerals

Please indicate the date and outcome of any of the following procedures or events that apply to you. Check the box in front of any procedure that diagnosed abnormal results, where applicable:

☐ Bone scan ______________________

☐ Colonoscopy ______________________

☐ CT scan ______________________

☐ Electrocardiogram (ECG/EKG) ______________________

☐ Electroencephalogram ______________________

☐ Endoscopy ______________________

☐ MRI ______________________

☐ X-ray ______________________

Car accident ______________________

Hospitalization ______________________

Surgery ______________________

Other ______________________

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	Condition
☐	☐	☐	Anemia
☐	☐	☐	Anxiety or nervousness
☐	☐	☐	Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Atherosclerosis
☐	☐	☐	Autoimmune disease
☐	☐	☐	Blood pressure problems
☐	☐	☐	Bone disease
☐	☐	☐	Breathing problems
☐	☐	☐	Cancer ______________
☐	☐	☐	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

C	P	N	Condition
☐	☐	☐	Head injury
☐	☐	☐	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
☐	☐	☐	Panic attacks
☐	☐	☐	Pancreas problems
☐	☐	☐	Parasites
☐	☐	☐	Physical abuse
☐	☐	☐	Seizures
☐	☐	☐	Sinus problems
☐	☐	☐	Skin problems
☐	☐	☐	Stroke
☐	☐	☐	Substance abuse
☐	☐	☐	Thyroid problems
☐	☐	☐	Ulcers
☐	☐	☐	Vaccinations ☐ Routine Only
☐	☐	☐	Varicose veins
☐	☐	☐	Vomiting
☐	☐	☐	Other ______________________

Please describe your sexual activity:

- ☐ I am sexually active
- ☐ I am not currently sexually active but I have been in the past
- ☐ I have never been sexually active
- ☐ I use or have used methods to prevent sexually transmitted infections and/or pregnancy

Present ____

Past ____

For Women Only

Are you pregnant now? ☐ Yes ☐ No

Age menses began __________ Last menses ____ / ____ / _________

Number of pregnancies __________ Last pap smear ____ / ____ / _________

Number of children __________ Last mammogram ____ / ____ / _________

If you are still having periods:

Average number of days in cycle _______

Cycles are ☐ Regular ☐ Irregular

Average number of days of bleeding _______

Periods are ☐ Light ☐ Medium ☐ Heavy ☐ Painful

PMS ☐ No ☐ Yes: ______ days per month

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 yeast infections
☐	☐	☐	Hair loss
☐	☐	☐	Hormone replacement therapy
☐	☐	☐	Hot flashes
☐	☐	☐	Hysterectomy ____/_________
☐	☐	☐	Impaired fertility

C	P	N	
☐	☐	☐	Nipple discharge
☐	☐	☐	Ovarian Cysts / PCOS
☐	☐	☐	Painful intercourse
☐	☐	☐	Pelvic inflammatory disease
☐	☐	☐	Premenstrual breast tenderness
☐	☐	☐	Regular self breast exam
☐	☐	☐	Sexual abuse
☐	☐	☐	Sexual difficulties_______________
☐	☐	☐	Sexually transmitted infection
☐	☐	☐	Spotting between periods
☐	☐	☐	Urinary incontinence
☐	☐	☐	Urinary tract infections
☐	☐	☐	Uterine fibroids
☐	☐	☐	Vaginal dryness
☐	☐	☐	Other __________________________

For Men Only

Last Prostate exam ______ / ______ / ___________ PSA level, if known _________________ng/ml

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 _________________________

Please list any known allergies:

Drug ____

Environmental ____

Food ____

Other ____

Family History

☐ I do not know my family history

Mother Health problems: ____

☐ Alive, age _____ ☐ Deceased at age ____ ; Cause of death ____________________

Father Health problems: ____

☐ Alive, age _____ ☐ Deceased at age ____ ; Cause of death ____________________

Please indicate any family members who have been affected by the following conditions and the age of onset (sister, brother, child, maternal/paternal grandmother/grandfather):

Alzheimer's disease ____

Alcoholism or substance abuse ____

Allergies ____

Asthma ____

Attempted suicide ____

Autoimmune disease ____

Cancer (specify location) ____

Depression ____

Diabetes ____

Eczema ____

Genetic disorder ____

Hayfever ____

Heart disease ____

Hemophilia ____

High blood pressure ____

Obesity ____

Osteoporosis ____

Stroke ____

Thyroid problems ____

Other ____

Medications

Please indicate if you have used any of the following over-the-counter medications by marking "C" for current (at least once per month) or "P" for past or "N" for never:

C	P	N	
☐	☐	☐	Acetaminophen
☐	☐	☐	Antacid
☐	☐	☐	Anti-diarrhea medicine
☐	☐	☐	Antihistamine
☐	☐	☐	Appetite suppressants
☐	☐	☐	Aspirin

C	P	N	
☐	☐	☐	Cold Meds
☐	☐	☐	Ibuprofen
☐	☐	☐	Laxatives
☐	☐	☐	Medicine to stay awake
☐	☐	☐	Sleeping pills
☐	☐	☐	Other ______________________

Please list both pharmaceutical and natural medications (including vitamins) that you are taking or have taken in the last year. Use a separate page if necessary.

Medication	Dosage	Dates Taken	Reason for taking

☐ See attached page

Lifestyle History

Height _______ Weight ________ BMI, if known ________

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

How would you rate your weight? Place an "X" on the scale:

Underweight --- Overweight

How would you rate your diet? Place an "X" on the scale:

Healthy --- Not healthy

How would you rate your lifestyle? Place an "X" on the scale:

Healthy --- Not healthy

When and where do you feel the best? Check all that apply.

☐ Upon waking ☐ Morning ☐ Afternoon ☐ Evening ☐ No pattern
☐ Weekdays ☐ Weekends ☐ At home ☐ At work ☐ Other __________

When and where do you feel the worst? Check all that apply.

☐ Upon waking ☐ Morning ☐ Afternoon ☐ Evening ☐ No pattern
☐ Weekdays ☐ Weekends ☐ At home ☐ At work ☐ Other __________

Sleep ______ hours per night Is this enough? ☐ No ☐ Yes

Do you awaken well rested? ☐No ☐Yes Are you hungry when you wake up? ☐No ☐Yes

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

Great -- Poor

How do you rate your energy level throughout the day? Place an "X" on the scale:

Upon waking High energy --- Low energy
Morning High energy --- Low energy
Afternoon High energy --- Low energy
Evening High energy --- Low energy

For exercises that you do regularly, check the box and fill in duration, frequency and activities:

☐ Aerobic exercise _______ minutes _______ times per week

Activities ____

Do you sweat? ☐ No ☐ Yes

☐ Strengthening exercise _______ minutes _______ times per week

Activities ____

☐ Stretching _______ minutes _______ times per week

Activities ____

☐ Other ____

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? Check all that apply:

☐ Easy ☐ Difficult ☐ Loose ☐ Dry and hard ☐ Blood/mucus/undigested food

Meals per day _____ Usual times ____

Snacks per day _____ Usual times ____

Current dietary restrictions ____

Why? ____

Past dietary restrictions ____

When? Why? ____

____

Problematic foods ____

Where do you eat? Check all that apply: ☐ Table ☐ Desk ☐ Bed ☐ In front of the TV

☐ Car ☐ Standing ☐ Walking ☐ Other ____________________________

If you consume any of the following regularly (at least once per week) check the box and indicate how much by circling "day" for daily amounts or "week" for weekly amounts:

☐ Water	____ cups per day week		☐ Soda, regular	____ cans per day week
☐ Herbal tea	____ cups per day week		☐ Soda, diet	____ cans per day week
☐ Green tea	____ cups per day week		☐ Fast food	____ meals per day week
☐ Black tea	____ cups per day week		☐ Wine	____ drinks per day week
☐ Coffee	____ cups per day week		☐ Beer	____ drinks per day week
☐ Espresso	____ shots per day week		☐ Liquor	____ drinks per day week

Tobacco ☐ Never ☐ Past ☐ Present

Cigarettes: ____ pack(s) per day for ____ years

Cigars: ____ per week for ____ years

Chew: ____ times per day for ____ years

Second hand smoke ☐ Not exposed to second hand smoke on a regular basis

☐ Exposed to second hand smoke regularly

Recreational drugs ☐ Never ☐ Past ☐ Present

Substance ______________________ Frequency ____________________

Mercury amalgam fillings ☐ Never ☐ Past ☐ Present

Date of filling(s) ____

Toxic exposure (pesticides, radioactivity, solvents, paint, lead, chemicals, new or remodeled home)

☐ Never ☐ Past ☐ Present

Explain ____

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

Living location ☐ Urban ☐ Suburban ☐ Rural ☐ Coastal

Do you have pets? ☐ No ☐ Yes; animals ______________________

How much time do you spend outside per day? ______________________

Do you watch television? ☐ No ☐ Yes; hours per day ______________________

Recreational activities ______________________

Major life change in last year ☐ No ☐ Yes

If yes, please explain ______________________

Overall level of stress; place an "X" on the scale:

Low -- High

Identify stressors ______________________

How do you feel about the following areas of your life? Place an "X" on the scale:

Emotional	Satisfied	--	Not satisfied
Mental	Satisfied	--	Not satisfied
Physical	Satisfied	--	Not satisfied
Professional	Satisfied	--	Not satisfied
Social	Satisfied	--	Not satisfied
Spiritual	Satisfied	--	Not satisfied

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

____ _____ / _____ / ___________

Signature (Parent or guardian if patient is under 18 years old) *Date*