# Stephanie Wawrzyniak, ND Sage Naturopathic Health, LLC 301 River Street, Suite 201

Montpelier, VT 05602

(802) 461-7238

Date:

Patient Name: Age: Date of Birth: Address: City: State: Zip: For Pediatric Patients - Parent/Legal Guardian Names

After writing in your phone number, please circle which number (if any) is okay to leave a confidential message on

Telephone (Home): (Work): (Cell): e-mail:

Gender: Male Female Non-Binary Other

Preferred Pronoun: He She They Other Single Married Partnership Separated Divorced Widowed Occupation: Employer:

Transgender Y/N

Insurance: SS#:

Emergency Contact: Relationship: Telephone (Home): (Work): (Cell):

Are we your Primary Care Provider? Y/N If No, Who is?

How did you hear about this clinic? Please list any family members also treated at this clinic

What are your most important health concerns? Please list in order of importance

1.

2.

3.

4.

5.

Medications and/or Supplements currently taking (please include strength and frequency):

Allergies/Sensitivities (food, medication, environmental):

Please list any Hospitalizations or Surgeries and when they occurred:

Please circle any past history of Illness

Mumps Measles Rubella Chickenpox Whooping Cough Pneumonia Polio Scarlet Fever Rheumatic Fever Mononucleosis Pneumonia Frequent Colds Frequent Ear Infections Tuberculosis Tonsilitis

Other:

Please circle all immunizations received

Hep B Polio DTaP Hib PCV MMR Tetanus Influenza Chicken Pox HPV Smallpox Varicella Other:

Birth History (if known)

Gestation age at birth Weight at birth Mother’s age at birth Father’s age at birth

Length of labor Any Complications with Pregnancy or Birth

Height: Weight: Weight one year ago: Maximum Weight:

Do you exercise? Y/N How often and how much? Do you spend time outside Y/N How often? How much screen time do you have in a day? a week? Do you drink alcohol Y/N How often and how much? Do you drink caffeine Y/N How often and how much? Do you smoke tobacco Y/N How often and how much? Do you use recreational drugs Y/N What kind, how often and how much?

Are you sexually active Y/N With men, women, or both? Do you use birth control Y/N What type?

Please circle C (current) or P (past) next to the following conditions. If never had leave blank.

|  |  |  |
| --- | --- | --- |
| Headaches C/P | Migraines C/P | Head Injury C/P |
| Cataracts C/P | Glaucoma C/P | Double Vision C/P |
| Corrective Lenses C/P | Impaired Hearing C/P | Ringing in Ears C/P |
| Dizziness C/P | Nose Bleeds C/P | Nasal Congestion C/P |
| Loss of Smell C/P | Gum Disease C/P | Teeth Grinding C/P |
| Jaw Clicks (TMJ) C/P | Shortness of Breath C/P | Asthma C/P |
| Chronic Cough C/P | Wheezing C/P | Sleep Apnea C/P |
| High Blood Pressure C/P | Chest Pain C/P | Palpitations C/P |
| Heart Murmurs C/P | Difficulty Swallowing C/P | Nausea C/P |

Vomiting C/P Heartburn C/P Blood in Stool C/P

Abdominal Pain C/P Gas or Bloating C/P Undigested Food in Stool C/P Pain with Urination C/P Urinary Urgency C/P Urinary Frequency C/P

Joint Pain/Stiffness C/P Muscle Pain C/P Muscle Weakness C/P Easy Bruising C/P Anemia C/P Anxiety C/P Depression C/P Trauma C/P

**Patient's with Penis/Prostate**

Testicular Mass C/P Testicular Pain C/P Hernia C/P Prostate Disease C/P Impotence C/P

**Patient's with Ovaries/Uterus**

Painful Cycles C/P PMS C/P Endometriosis C/P Ovarian Cyst C/P Breast Lump C/P Breast Tenderness C/P Nipple Discharge C/P Mastitis C/P

Age of first menses Date of last menstrual cycle Age of Menopause

Length of Cycle Length of blood flow Are cycles regular Y/N

Date of last PAP Any irregular PAP Y/N If yes, how treated Self Breast Exam Y/N

Number of Pregnancies Number of Births Number of Miscarriages

Number of Abortions

Any other conditions past or present that have not been asked about?

Family History - Please list any immediate family members who have these conditions

Diabetes Heart Disease Kidney Disease

High Blood Pressure Stroke Thyroid Disease

AutoImmune Conditions

Cancer Mental Illness

## Terms and Conditions of Treatment

**Consent for Treatment:**

I understand that my care as a patient at Sage Naturopathic Health, LLC is directed by a Naturopathic Physician. I consent to services rendered and provided to me under the instructions of this professional assisting in my care.

## Patient (18 years or older), Parent, Guardian, Responsible Party Date

**HIPAA Notice of Privacy Practices and Consent:**

I hereby consent to the use and disclosure of my protected health information by Sage Naturopathic Health, LLC for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

## Signature of Patient, Parent, Guardian, or Responsible Party Date

**Statement of Financial Responsibility: I understand and agree to the following:**

* Payment for services rendered is my responsibility as the patient or patient’s responsible party.
* I am responsible for paying for all services, including lab tests, rendered at the time of service.
* If I am receiving a discount of any sort, I am responsible for providing accurate and thorough documentation supporting it and I am responsible for paying in full at the time of service.

## Signature of Patient, Parent, Guardian, or Responsible Party Date

**Insurance Billing: If I am billing insurance for services rendered, I understand and agree to the following:**

* I authorize Sage Naturopathic Health, LLC to release pertinent medical records related to billing directly to my insurance carrier. This release applies to support of the insurance billing process only.
* I am responsible for any and all charges that my insurance company will not cover.

## Signature of Patient, Parent, Guardian, or Responsible Party Date