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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_____ Transgender Y/N

Single Married Partnership Separated Divorced Widowed

Occupation:_____

Employer: _____

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_____ High Blood Pressure _____

Heart Disease _____ Stroke_____

Kidney Disease _____ 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**