Hopewell Nutrition Center
Mind, body & spiritual nutrition for medical issues

129 Clove Branch Road
Hopewell Junction, NY 12533

www.hopewellnutrition.com
info@hopewellnutrition.com
tel 845 223 5940 / fax 845 223 5350

DISCLAIMER
Your answers on this form will be interpreted for educational purposes only and should not be construed as medical or health advice.

A. IDENTIFICATION

DATE: _____

NAME: _____AGE: _____ BIRTHDATE: ____/____/____ SEX: M/F

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

PHONE (H): _____ (W) _____ (C) _____

EMAIL: _____ TEXT: Y / N

OCCUPATION: _____ SOCIAL SECURITY: _____

FAMILY STATUS: SINGLE / DIVORCED / MARRIED / WIDOW (ER) / SIGNIFICANT OTHER

EMERGENCY CONTACT: _____ PHONE #: _____

PARENT OR GUARDIAN (IF UNDER 18): _____

HOW DID YOU HEAR ABOUT US? _____ REFERRED BY: _____

PHYSICIAN NAME: _____

PHYSICIAN ADDRESS: _____PHONE #: _____

REASON FOR VISIT: _____

CANCELLATION POLICY
As a courtesy to our staff and other patients, we ask that our office receive notice of an appointment cancellation within 24-hours. Failure to cancel and/or no shows will be charged $75.

SIGNATURE: _____ **DATE:** _____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received a copy of your Notice of Privacy Practice containing a more complete description of the use and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions but if you do agree then you are bound to abide my such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

NAME: _____DATE: _____

MEDICAL HISTORY: Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible health care to you (or your child), it is necessary to have the following information.

B. CHIEF COMPLAINT

Please list your major problems and/or symptoms and the approximate date it began. (If none please write the reason for seeking this consultation.) Please rank in order of importance to you.

When problem began

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

What are your expectations regarding what you would like our office to provide for you?

_____

_____

_____

If you have seen other practitioners for these problems, indicate the results of these evaluations:

_____

_____

_____

C. HAVE YOU EVER HAD OR HAVE?	**YES**	**NO**
1. Asthma, hay fever, sinusitis or other allergies		
2. Allergy to penicillin, aspirin, local or general anesthetic or other drugs; specify		
3. Blood pressure or heart problems		
4. Rheumatic fever or heart murmur		
5. A pacemaker or open heart surgery		
6. Diabetes, liver, kidney, thyroid or lung problems		
7. Ulcers or stomach problems		
8. Hepatitis or jaundice		
9. Epilepsy or nervous disorders		
10. Bleeding or clotting disorders		
11. Arthritis, autoimmune diseases, bone disorders, joint replacement		
12. Venereal Disease, herpes, sexual transmitted disease		
13. Acquired Immune Deficiency Syndrome (AIDS)		
14. Any other illness		
15. Do any wounds heal slowly or present complications?		

16. Are you presently taking any medicine? Specify:		
17. Are you presently under the care of a physician?		
18. When was your last physical exam?		
19. Have you ever been hospitalized?		
20. Have you had X-ray treatments or chemotherapy?		
21. Are you presently on a diet?		
22. Women – Are you pregnant?		
23. What is your tobacco history?		

D. YOUR PAST MEDICAL HISTORY

Please indicate if you have had any of the following problems in the past. Please note years affected.

Alcoholism _____
Allergies _____
Anemia _____
Arthritis _____
Asthma _____
Bleeding / Bruising _____
Cancer _____
Crohn's Disease / Colitis _____
Depression _____
Diabetes _____
Digestive Disease _____
Drug Problems _____
Eating Disorder _____
Heart Disease _____
Herpes _____
HIV _____
Hypoglycemia _____
Hepatitis _____
High Cholesterol _____
High Blood Pressure _____
Irritable Bowel _____
Kidney Disease _____
Lupus _____
Lyme Disease _____
Mental Illness _____
Migraine Headache _____
Multiple Sclerosis _____
Pneumonia _____
Polio _____
Rheumatic Fever _____
Stroke / TIA _____
Seizures _____
Stomach / Intestinal Ulcers _____
Tuberculosis _____
Thyroid Disease _____
Venereal Disease _____

Do you have a primary care provider?
Yes [ ] No [ ]

If Yes, please complete provider's information:
Name: _____
Address: _____
_____
Phone: _____

Your Tests: Specify when & if known
Last Physical Exam: _____
Chest X-Ray: _____
EKG: _____
Blood Tests: _____
Urine Tests: _____
Rectal Exam: _____
PAP Smear: _____
Breast Exam: _____

Immunizations: Specify when & if known
Small Pox: _____
Polio: _____
Measles/Mumps/Rubella: _____
Pertussis: _____
Diphtheria: _____
Tetanus: _____
Influenza: _____
Hepatitis B: _____
Chicken Pox: _____
Other: _____

Hospitalization and Surgeries (dates / type)
_____
_____
_____
_____
_____
_____
_____

E. FAMILY HISTORY

For each family member, write age or if deceased – age at death and any medical problems they have or had.

Mother: _____
Grandmother: _____
Grandfather: _____
Father: _____
Grandmother: _____
Grandfather: _____
Siblings:

_____
_____
_____
_____
_____

Children:

_____
_____
_____
_____
_____

F. CURRENT MEDICATIONS

Please write name, dosage and how often taken.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Please list any medications you may have an allergy to and the type of reaction.

_____
_____
_____

G. LIFESTYLE AND HABITS

Tobacco:
Do you currently smoke? _____
Do you currently chew? _____

If yes:
How much per day? _____
For how long? _____
If no:
Did you ever smoke? _____
For how long? _____
When did you stop? _____

Alcohol
(Include wine, beer and liquor)
How often do you drink?
[ ] Never
[ ] Less than 1 times per week
[ ] 2 -3 times per week
[ ] At least once daily
What do you drink? _____
Was drinking ever a problem? _____

Caffeine
How many cups of the following do you consume daily?
Coffee_____
Black Tea _____
Green Tea _____
Cola _____
Diet Cola _____
Chocolate _____

Recreational Drug Use
(type/frequency) _____
_____

Over the Counter Medications
(type / frequency)

_____
_____
_____

NAME: _____DATE: _____

SYMPTOMS AND SYSTEMS REVIEW: Write all of the appropriate letters in the left hand columns. DO NOT fill in anything if the problem does not apply to you.

Write "C" for a current problem **"I" if it is an intermittent problem** **"P" for a past problem**

_____ headaches
_____ neck lumps or swelling
_____ loss of balance
_____ dizzy spells
_____ vertigo
_____ blackouts or fainting
_____ blurry vision
_____ double vision
_____ cataracts
_____ eye pain or itching
_____ watering eyes or redness
_____ hearing difficulties
_____ earaches
_____noises or ringing in ears
_____ recurrent ear infections
_____ dental problems / decay
_____sore or bleeding gums
_____ sore tongue
_____coated tongue
_____ loss of taste or smell
_____ sores in or around mouth
_____difficulty swallowing
_____ cold sores or fever blisters
_____ sinus or nasal congestion
_____ runny nose
_____ frequent colds
_____ nasal polyps
_____ sore throats
_____ swollen glands
_____recurrent fevers or chills
_____ hoarse voice
_____ shortness of breath
_____ wheezing or gasping
_____ coughing
_____ coughing blood
_____ chest colds or pneumonia
_____ heart murmur

_____ high blood pressure
_____ skipped heartbeats
_____ racing heart
_____ chest pain or pressure
_____ swollen feet or ankles
_____ difficulty breathing at night
_____ varicose veins or phlebitis
_____ recurring indigestions
_____ nausea or vomiting
_____ intestinal gas / flatulence
_____ belching
_____ bloating
_____ abdominal pain or cramps
_____ constipation
_____ diarrhea or loose stools
_____ rectal itching
_____ blood with stools
_____ black stools
_____ pain in rectum
_____ jaundice
_____ hepatitis / pancreatitis
_____ colitis
_____ Crohn's Disease
_____ diverticulitis / diverticulosis
_____ frequent urination
_____ brown or red urine
_____ decreased force of urine
_____ continual urge to urinate
_____ involuntary escape of urine
_____difficulty starting urination
_____ kidney or bladder infections
_____ venereal disease
_____ osteoporosis
_____ aching muscles or joints
_____ arthritis
_____ joint stiffness
_____ back or neck pain

_____ weakness
_____ painful feet
_____ leg cramps
_____ trembling or tremors
_____ seizures or epilepsy
_____ numbness or tingling
_____ skin tumors
_____ dry skin
_____ acne
_____ eczema
_____ skin rashes
_____ psoriasis
_____ dandruff or seborrhea
_____ hives
_____ itching or burning skin
_____ easy bruising
_____ hypothyroid (low)
_____ hyperthyroid (high)
_____ weight gain
_____ weight loss
_____ feel excessively warm
_____ feel excessively cold
_____ loss of appetite
_____ constant hunger
_____ fatigue or weariness
_____ night sweats
_____ diabetes
_____ low blood sugar
_____ nervousness or anxiety
_____ depression
_____ suicidal thoughts
_____ sought psychological help

MEN ONLY
_____ painful testicles
_____ hernia
_____ prostate problems
_____ sexual dysfunction

NAME: _____DATE: _____

DIET SURVEY

Please check all the following statements, being careful to use the appropriate box related to the frequency of your personal habits.

"FREQUENT" = at least once per day; "OFTEN" = several times per week; "OCCASSIONAL" = once a week or less; "SELDOM" = once or twice per month or less; "NEVER" = almost total avoidance

Frequent	Often	Occasional	Seldom	Never	
					1. alcoholic beverages
					2. eat at restaurants
					3. eat at fast food restaurants
					4. pastries, cookies, candies, ice cream, other sweets
					5. add sugar to coffee, tea, cereals or other foods
					6. colas or other soft drinks
					7. instant breakfasts, pop tarts, doughnuts, muffins
					8. cold breakfast cereals
					9. caffeine drink (coffee, tea, cola, chocolate)
					10. deep fried foods
					11. margarine of any type
					12. whole grain hot cereals (oatmeal, wheatena, etc.)
					13.meat (beef or veal, pork or ham, lamb, liver)
					14. chicken or turkey – circle: regular or free range
					15. fresh fish
					16. processed meat (bologna, turkey roll, sausage, etc.)
					17. fresh raw fruit
					18. fresh vegetables, raw or cooked
					19. salads
					20. whole grains or whole grain breads
					21. white bread or white flour products
					22.beans and legumes (lentil, kidney, chickpea, etc.)
					23. yogurt-- circle: whole or low fat, plain or flavored
					24. milk – circle: whole, low fat or skimmed
					25. cheese
					26. eggs – circle: regular or free range
					27. salt
					28. herbs, fresh and dried, or spices
					29. drink adequate water – circle: tap, filtered, bottled
					30. eat excessively if bored or depressed
					31. swallow food before chewing well
					32. hurried or rushed meals
					33. stuff yourself
					34. read and understand food labels
					35. sneak or hide food
					36. adequate fiber or roughage in the diet
					37. artificial sweeteners (saccharin, NutraSweet, etc.)
					38. shop at health food stores

NAME: _____DATE: _____

STRESS INDEX

This index, developed by Drs. Holmes and Rahe, indicates degrees of stress related to changes in life. Even enjoyable events can be stressful. Life change scores that are high are related to more illness. In studies, many people who scored over 300 became ill within a three to six month period. If am event has been true for you in the past year, or is about to happen, circle the associated point value, If an unlisted event has occurred, add it to the bottom of the list and assign it a point value. Add up the points.

Death of spouse or partner…….....100
Divorce…….73
Separation from spouse or partner……..65
Jail term……...63
Death of close family member……63
Personal injury or illness……..53
Marriage / commitment to a partner…….50
Fired at work…….....…..47
Reconciliation with spouse/partner……...45
Retirement……..45
Change in health of family member……..….44
Pregnancy……...40
Sex difficulties.....…39
Addition of new family member……..…39
Business readjustment……..…39
Change in financial state……..…38
Death of close friend…….37
Change to a different line of work……..36
More arguments with spouse/partner……..35
Mortgage over $50,000……..31
Foreclosure of mortgage or loan……..…30
Change in work responsibilities……..…29
Child leaving home……..…..29
Trouble with in-laws…….....29
Outstanding personal achievement……....28
Spouse / partner begins/stops work……..…26
Begin or end school……...26
Change in living conditions…….……25
Revision of personal habits…….……....24
Trouble with boss or employee…….……..23
Change in work hours or conditions…….……20
Change in residence…….……20
Change in schools…….……....20
Change in recreation…….……....19
Change in church activities……..…19
Change in social activities……18
Mortgage or loan under $50,000……..17
Change in sleeping habits…….……16
Change in eating habits……15
Vacation……...13
Christmas approaching……....12
Minor violations of the law.....11
Other ……._____

TOTAL ALL THE POINTS: _____

VITAMINS, MINERALS & SUPPLEMENTS

If you are taking vitamins, minerals or other supplements, please list them below. Be sure to indicate the dose in milligrams or units, the brands and the number of pills taken per day. Try to bring label of any multiple or combination formulas. Use a separate sheet if necessary.

NAME: _____ **DATE:** _____