

New Patient Health History

*Naturopathic doctors care for the whole person, primarily by finding patterns in each person's story.
Thank you for taking the time to fill out this form as completely as possible before your visit.*

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (home): _____ (work): _____ (cell): _____

E-mail address: _____

How would you prefer to be contacted? home work cell email

May we leave a message? home work cell email

Age: _____ Date of birth: _____ Gender: F M

Married: _____ Separated: _____ Divorced: _____ Widowed: _____ Single: _____ Partnership: _____

Live with: Spouse: _____ Partner: _____ Parents: _____ Children: _____ Friends: _____ Alone: _____

Occupation: _____ Hours per week: _____

Emergency contact: _____

Relationship: _____ Phone: _____

Name of current general practitioner _____

GP's contact information _____

Are you currently under the care of any other health practitioners? _____

Have you seen a naturopathic doctor before? _____ When? _____

How did you hear about Dr. Caron? _____

* Would you like to be listed as a supporter of Naturopathic medicine for our ongoing legislative effort? Checking "yes" gives Dr. Caron permission to put you on the CoAND legislative alert email list. Yes _____ No _____

What are your most important health concerns?

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Are you willing to change your lifestyle habits to improve your health? _____

What are your goals pertaining to your health, both short- and long-term? _____

Lorraine Caron, ND

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Allergies

Are you allergic or hypersensitive to:

any drugs? _____

any foods? _____

any environmental or chemical agents? _____

General

Height: _____ Weight: _____ Weight one year ago: _____ Maximum weight: _____ When: _____

What time of day is your energy the best? _____ worst? _____

What is your average energy level? (1-10, 10=high) _____

Interests and hobbies: _____

Do you exercise? _____ If yes, what kind? _____ How often? _____

Do you watch TV? _____ If yes, how many hours per day: _____ Do you read? _____

Do you have a religious or spiritual practice? _____ If yes, what kind? _____

Do you eat three meals a day? _____ Diet often? _____ Eat out often? _____

Enjoy your work? _____ Take vacations? _____ Spend time outside? _____

Smoke? _____ How many packs per day? _____ How many years? _____

Use other forms of tobacco? _____ Use recreational drugs? _____

Have you been treated for drug or alcohol dependence? _____

Family History

Does anyone in your family have a history of any of the following?

cancer _____ epilepsy _____ diabetes _____ arthritis _____ asthma _____ hay fever _____ anemia _____

heart disease _____ glaucoma _____ hives _____ stroke _____ alcoholism _____ mental illness _____

osteoporosis _____ kidney disease _____ high blood pressure _____ tuberculosis _____ high cholesterol _____

Mother's age or age at death: _____ Present health: _____

Father's age or age at death: _____ Present health: _____

Any other relevant family history? _____

Were you adopted? _____ What is your ethnic heritage? _____

Childhood Illnesses

Have you ever had any of the following childhood illnesses?

measles _____ chicken pox _____ mumps _____ rheumatic fever _____

diphtheria _____ scarlet fever _____ german measles _____

Immunizations

Polio _____ Pertussis _____ Diphtheria _____ Influenza _____

Measles/Mumps/Rubella _____ Tetanus (when?) _____ Other _____

Hospitalizations/surgeries/special tests

Please list any surgical procedures, hospitalizations, X-Rays, CAT scans, MRIs, EKGs, EEGs you have had:

_____ year _____	_____ year _____
_____ year _____	_____ year _____
_____ year _____	_____ year _____

Current medications

Do you use any of the following? (please circle)

- | | | | | |
|-----------|-------------|----------------|--------------------|---------------------|
| laxatives | antacids | tranquilizers | pain relievers | birth control pills |
| cortisone | antibiotics | sleeping pills | thyroid medication | hormone replacement |

Please list any *prescription medications, over-the-counter medications, vitamins, or other supplements* you are taking:

Typical diet

breakfast: _____

lunch: _____

dinner: _____

snacks: _____

drinks: _____

Dietary habits

Do you follow a particular dietary regimen? _____

How often do you consume the following items:

Pop/soft drinks _____

Coffee _____

Artificial sweeteners (including diet soda) _____

Pastries, doughnuts, cookies, cake _____

Pasta and/or bread _____

Tea (caffeinated) _____

Preserved meats (bacon, hot dogs, lunch meats, etc.) _____

How many 8 ounce glasses of water do you drink per day? _____

Do you drink filtered water, bottled water, or water from the tap? _____

Review of Systems:

For the following, please circle only those that apply:

c = a condition you currently have p = a significant problem in the past

<p>Eyes</p> <p>impaired vision..... c p glasses or contacts..... c p cataracts..... c p spots in vision..... c p glaucoma..... c p color blindness..... c p eye pain or strain..... c p double vision..... c p tearing or dryness..... c p</p>	<p>Ears</p> <p>impaired hearing..... c p ringing in ears..... c p earaches..... c p dizziness..... c p</p>	<p>Mouth</p> <p>jaw or tmj problems..... c p teeth grinding..... c p dental cavities..... c p gum problems..... c p sore tongue or lips..... c p</p>
<p>Nose and Throat</p> <p>stiffness..... c p sinus problems..... c p nosebleeds..... c p hayfever..... c p loss of smell..... c p frequent colds..... c p frequent sore throats..... c p hoarseness..... c p lumps in neck..... c p difficulty swallowing..... c p</p>	<p>Head and Neck</p> <p>headaches..... c p migraines..... c p head injury..... c p goiter..... c p swollen glands..... c p pain or stiffness..... c p</p>	<p>Neurological</p> <p>loss of memory..... c p loss of balance..... c p vertigo or dizziness..... c p fainting..... c p tremors..... c p seizures..... c p numbness or tingling..... c p muscle weakness..... c p paralysis..... c p</p>
<p>Gastrointestinal</p> <p>change in appetite..... c p change in thirst..... c p difficulty swallowing..... c p heartburn/reflux..... c p nausea/vomiting..... c p vomiting blood..... c p abdominal pain..... c p belching..... c p gas/bloating..... c p constipation..... c p diarrhea..... c p ulcer..... c p irritable bowel syndrome..... c p Crohn's disease..... c p pancreatitis..... c p gallbladder disease..... c p liver disease..... c p jaundice (yellow skin)..... c p hemorrhoids..... c p colon polyps..... c p blood or mucus in stool..... c p black stools..... c p bowel movements: how often? _____ is this a change? _____ change in shape? _____</p>	<p>Women's health</p> <p>irregular cycles..... c p bleeding between cycles..... c p heavy flow..... c p scant flow..... c p clotting..... c p painful menses..... c p pms..... c p endometriosis..... c p ovarian cysts..... c p uterine fibroids..... c p breast pain/tenderness..... c p breast lumps..... c p nipple discharge..... c p sexually transmitted infections..... c p sexual difficulties..... c p pain during intercourse..... c p difficulty conceiving..... c p birth control..... c p hot flashes..... c p vaginal dryness..... c p vaginal pain..... c p vaginal itching..... c p vaginal discharge..... c p yeast infections..... c p cervical dysplasia..... c p</p>	<p>Endocrine</p> <p>diabetes..... c p hypoglycemia..... c p hypothyroid..... c p hyperthyroid..... c p excessive hunger..... c p excessive thirst..... c p easy weight gain..... c p heat or cold intolerance..... c p fatigue..... c p hair loss..... c p change in hair distribution..... c p</p>

<p>Cardiovascular</p> <p>heart disease..... c p heart murmurs..... c p palpitations..... c p chest pain..... c p angina..... c p high blood pressure..... c p low blood pressure..... c p high cholesterol..... c p thrombophlebitis..... c p blood clots..... c p deep leg pain..... c p varicose veins..... c p cold hands or feet..... c p swelling of ankles..... c p</p>	<p>Respiratory</p> <p>cough..... c p sputum..... c p wheezing..... c p painful breathing..... c p difficulty breathing..... c p shortness of breath..... c p asthma..... c p bronchitis..... c p emphysema..... c p pleurisy..... c p pneumonia..... c p coughing up blood..... c p tuberculosis..... c p</p>	<p>Skin</p> <p>itching..... c p rashes..... c p eczema..... c p psoriasis..... c p hives..... c p acne/boils..... c p warts..... c p lumps/growths..... c p change in skin color..... c p change in skin texture..... c p changes in hair..... c p changes in nails..... c p skin cancer..... c p what type? _____</p>
<p>Men's health</p> <p>hernias..... c p testicular pain..... c p testicular masses..... c p sexually transmitted infections... c p lesions or sores..... c p discharge..... c p prostate disease..... c p sexual difficulties..... c p</p>	<p>Urinary</p> <p>increased frequency..... c p frequency at night..... c p urgency/inability to hold urine... c p difficulty starting urination..... c p pain on urination..... c p frequent infections..... c p kidney stones..... c p</p>	<p>Immune and Blood</p> <p>slow wound healing..... c p chronic infections..... c p chronically swollen glands..... c p chronic fatigue..... c p night sweats..... c p reaction to vaccines..... c p anemia..... c p easy bleeding or bruising..... c p</p>
<p>Sleep</p> <p>Hours of sleep per night _____ Do you wake rested? _____ Sleep position _____ _____</p> <p>trouble falling asleep..... c p waking in the night..... c p difficulty returning to sleep..... c p nightmares..... c p</p> <p>Do you remember your dreams?.. y n</p>	<p>Mental/emotional</p> <p>poor concentration..... c p memory problems..... c p tension..... c p anxiety or nervousness..... c p panic attacks..... c p depression..... c p mood swings..... c p frequent crying..... c p considered or attempted suicide.. c p eating disorders..... c p insomnia..... c p abuse (of any kind)..... c p</p>	<p>Musculoskeletal</p> <p>joint pain or stiffness..... c p muscle pain or cramps..... c p neck/shoulder pain..... c p upper back pain..... c p lower back pain..... c p arm/wrist pain..... c p leg pain..... c p arthritis..... c p osteoporosis..... c p osteopenia..... c p broken bones..... c p</p>

Women's health

age of first menses _____ date of last menses _____ length of cycle _____ duration of menses _____
are your cycles regular? _____ date of last pap _____ abnormal pap? _____ when? _____
have you had a hysterectomy? _____ if yes, at what age? _____
do you do self breast exams? _____ are you sexually active? _____
are you currently pregnant? _____ type of birth control (if used) _____
number of pregnancies _____ live births _____ miscarriages _____ abortions _____
sexual orientation: heterosexual _____ bisexual _____ homosexual _____

Men's health

do you do self testicular exams? _____ are you sexually active? _____
do you use birth control? _____ what type? _____
sexual orientation: heterosexual _____ bisexual _____ homosexual _____

Is there anything else you would like to share? _____

DISCLOSURE STATEMENT

Lorraine Caron, ND was trained in naturopathic medicine at the National College of Naturopathic Medicine (NCNM) in Portland, Oregon. She received her ND (Naturopathic Doctor) degree in 2004, after four years of post-graduate clinical and academic training.

Dr. Caron holds an active ND license in the state of Oregon as well as an active registration in the state of Colorado. The Oregon Board of Naturopathic Examiners (OBNE) is the regulatory board for all naturopathic physicians licensed in Oregon. No license or certification issued to Dr. Caron has ever been revoked or suspended.

OBNE
800 NE Oregon St., Suite 407
Portland, OR 97232
(503) 731-4045

Office of Naturopathic Doctor Registration
(303) 894-7414

http://www.dora.state.co.us/reg_investigations/file_complaint.htm

Naturopathic Doctors are registered by the state of Colorado to practice naturopathic medicine under the “Naturopathic Doctor Act.” They are not permitted to perform the following acts:

- Prescribe, dispense, administer or inject any prescription medications or devices other than epinephrine for anaphylaxis and barrier contraceptives (not including IUDs).
- Perform surgical procedures, including surgical procedures using a laser device. Certain in-office procedures are permitted.
- Use general or spinal anesthetics, other than topical anesthetics.
- Administer ionizing radioactive substances for therapeutic purposes.
- Treat a child who is less than two years old, unless (1) a collaborative agreement with a pediatrician or family practice physician is on file with DORA, (2)) this form is fully completed and signed; (3) the most recent immunizations schedule recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services is provided to the parent or guardian with this form; and (4) a release of information is provided to the parent or guardian requesting permission to exchange information with the child’s licensed pediatric health care provider, if the child has one.
- Treat a child who is two years of age or older, but less than eight years of age, unless: (1) this form is fully completed and signed; (2) the most recent immunizations schedule recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services is provided to the parent or guardian with this form; and (3) a release of information is provided to the parent or guardian requesting permission to exchange information with the child’s licensed pediatric health care provider, if the child has one.
- Practice medicine, surgery, obstetrics, or any other form of healing other than Naturopathic Medicine.
- Perform chiropractic services (spinal adjustments, manipulation, or mobilization). Physical medicine, as described in § 12-37.3-102(12)(b), C.R.S., is permitted.
- Recommend the discontinuation or counsel against a course of care, including a prescription drug that was recommended by another health care practitioner licensed in Colorado, unless the Naturopathic Doctor consults with the health care practitioner.

In the professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the OBNE or to the Director of Naturopathic Doctor Registration using the contact information above.

The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. The patient may seek a second opinion from another health care professional or may terminate therapy at any time.

Consultations are payable at the time of the visit. Any additional services, laboratory tests, or medicinal products are individually priced. A fee schedule is available upon request.

Patient Name

Signature of patient or parent/guardian

Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

Acknowledgement form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's name _____

Birthdate _____

Signature of patient or parent/guardian _____

Date _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice takes effect on August 1st, 2006 and remains in effect until we replace it.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. **We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization.** Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

NOTICE OF PRIVACY PRACTICES

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You must make your request in writing using a medical release form obtained from the clinic. You may also request your records by sending a letter to the doctor who provided your care. If you request copies, we will charge you \$0.15 for each page, and postage if you want the copies mailed to you.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to your doctor at this clinic.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have that right.

QUESTIONS

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights.

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.