Specialized Natural Health Care

Dr. Matthew Perchemlides, ND, FABNO, MSN, BSN
5 Park St #3C Middlebury, VT 05753
SpecializedNaturalHealthCareVT.com
802-339-4166 fax
802-989-7669 phone

New Patient Intake Form

Successful health care and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. Please take the time to carefully and thoroughly complete this health history questionnaire; you may consider making a copy for your records. Print all information and indicate areas of confusion with a question mark. Thank you.

Name: _____ Today's Date: _____

Mailing Address:_____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____

Ethnicity: Hispanic/Not Hispanic Race_____ Preferred Language_____

Phone number: _____Alternate Phone number _____

Okay to leave a message (circle):Yes No

Email: _____

Insurance Company:_____ Subscriber ID# _____ Group #_____

Primary Subscriber Name:_____ DOB_____

Emergency Contact: _____ Emergency Contact phone number _____

How did you hear about Specialized Natural Health Care?_____
_____

Please list your chief concerns in the order of their importance to you.
You may use chart to rate each of the following concerns: (minor)1..2..3..4..5..6..7..8..9..10(severe)

Chief Concern 1: _____

- Rate severity:
- When did this begin?
- What makes this worse?
- What helps this?
- What other care have you received for this concern?

Chief Concern 2: _____

- Rate severity:
- When did this begin?
- What makes this worse?
- What helps this?
- What other care have you received for this concern?

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Chief Concern 3: _____

Rate severity:
When did this begin?
What makes this worse?
What helps this?
What other care have you received for this concern?

Chief Concern 4: _____

Rate severity:
When did this begin?
What makes this worse?
What helps this?
What other care have you received for this concern?

Other Current Diagnoses:

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

Past Surgical History:

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____
4. _____ Year _____

History of past traumatic injuries (broken bones, motor vehicle accident, etc.):

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____
4. _____ Year _____

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Family Medical History:
Siblings: _____

Mother: _____

Father: _____

Mother's parents: _____

Father's parents: _____

Health Habits:
How often do you drink? Wine _____ Beer _____ Other alcohol _____ Caffeine _____

Cigarettes: packs per day _____ number of years smoking _____ Date Quit _____

Chewing tobacco: amount daily _____ number of years chewing _____ Date Quit _____

Other _____

Allergies:
Medication Allergies:
1_____ Reaction _____

2 _____Reaction _____

3 _____Reaction _____
Foods Allergies or Sensitivities:
1_____ Reaction _____

2 _____Reaction _____

3 _____Reaction _____
Environmental Allergies:
1_____ Reaction _____

2 _____Reaction _____

3 _____Reaction _____

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Medications currently prescribed:

1_____ Dosage _____Reason_____

2_____ Dosage _____Reason_____

3_____ Dosage _____Reason_____

4_____ Dosage _____Reason_____

Over the counter medicine currently or frequently taking:

1_____ Dosage _____Reason_____

2_____ Dosage _____Reason_____

3_____ Dosage _____Reason_____

4_____ Dosage _____Reason_____

Supplements:

1_____ Dosage _____Reason_____

2_____ Dosage _____Reason_____

3_____ Dosage _____Reason_____

4_____ Dosage _____Reason_____

Any regular exercise routine:

Type _____ Duration (minutes per day) _____ Frequency _____

Type _____ Duration (minutes per day) _____ Frequency _____

List all food and all beverages you have had in the last 24 hours.

Breakfast _____

Snack _____

Lunch _____

Snack _____

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Dinner _____

Water: _____

Coffee/Tea _____

Soda _____

Current Height _____feet ____ inches Current Weight _____lbs

Please use chart to rate the following concerns: (minor)1..2..3..4..5..6..7..8..9..10(severe)
Fatigue: _____ Sleep Problems: _____ Emotional Stress: _____ Physical Stress: _____

SOCIOECONOMICS:
Occupation: _____

Education completed: _ Grade school _ High school_ College _ Graduate school ___ Post grad
Years of education ____
Marital status: _____
Spouse/Partner's name: _____Number of children: _____

Who lives at home with you?_____

Check all that apply to you, either now or in the past:

Neurological:

☐	Declining memory	☐	Dizziness	☐	Foggy thinking
☐	Headaches	☐	History of head injury	☐	History of stroke
☐	History of TIA	☐	Light sensitivity	☐	Loss of balance
☐	Loss of touch sensation	☐	Migraines	☐	Peripheral neuropathy
☐	Mental focus	☐	Seizures	☐	Tremors
☐	Weakness	☐	Other_____		

Mental/Emotional:

☐	Anorexia	☐	Anxiety	☐	Bulimia
☐	Confusion	☐	Depressed mood	☐	Emotional fluctuations
☐	History of Trauma	☐	Restlessness	☐	Suicidal action
☐	Suicidal thoughts	☐	Other_____		

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Eyes, Ears, Nose, Throat:

☐ blurry vision	☐ cataracts	☐ cold or canker sore
☐ congestion	☐ dark circles	☐ dental problems
☐ difficulty hearing	☐ difficulty swallowing	☐ dizziness
☐ double vision	☐ dry eyes, throat, etc.	☐ earaches
☐ eye pain/red eye	☐ fainting/blackouts	☐ frequent colds/infections
☐ glasses/contacts	☐ glaucoma	☐ grinding teeth
☐ hair loss	☐ hay fever	☐ head injury
☐ headaches	☐ hoarse voice	☐ loss of smell
☐ neck lumps/swelling	☐ neck pain	☐ nosebleeds
☐ puffy eyes	☐ ringing in ears	☐ sensitive to light
☐ sinus problems	☐ sore throat	☐ sore tongue
☐ sore/bleeding gums	☐ tearing	

Respiratory:

☐ asthma	☐ bronchitis	☐ chest colds
☐ chest pain	☐ chest pain	☐ cough up blood
☐ coughing	☐ coughing sputum	☐ emphysema
☐ heart palpitations	☐ high blood pressure	☐ pneumonia
☐ shortness of breath	☐ swollen ankles	☐ wheezing

Cardiac:

☐ Activity intolerance	☐ Aneurysm	☐ Angina
☐ Bacterial endocarditis	☐ Congenital heart defect	☐ High blood pressure
☐ High cholesterol	☐ History chest pain	☐ History heart attack
☐ Irregular heartbeat	☐ Leg pain with activity	☐ Pacer
☐ Valve condition		

Gastrointestinal

☐ blood in stool	☐ blood in vomit	☐ constipation
☐ diarrhea	☐ difficulty swallowing	☐ excessive appetite
☐ gas/bloating	☐ hemorrhoids	☐ indigestion
☐ light colored stool	☐ loss of appetite	☐ mucous in stool
☐ nausea	☐ rectal pain/itching	☐ stomach pain
☐ undigested food in stool	☐ vomiting	☐ yellow eyes or skin

Genitourinary

☐ bladder infections	☐ blood in urine	☐ genital discharge
☐ change in urine color	☐ difficulty urinating	☐ frequent urination
☐ genital sores	☐ incontinence	☐ kidney stone

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☐ odorous urine ☐ pain with urination ☐ sexual difficulty
☐ STIs ☐ urge to urinate

Musculoskeletal

☐ Aching muscles ☐ Areas of tenderness ☐ Cramps
☐ discomfort at joints ☐ numbness/tingling ☐ restless legs
☐ swollen joints ☐ weakness

Skin

☐ acne ☐ boils ☐ color change ☐ easy bruising
☐ fungus ☐ hives ☐ itching ☐ lesions
☐ lumps ☐ moles ☐ rashes ☐ warts

Endocrine

☐ Always cold ☐ Always hot ☐ Chronic Fatigue
☐ Increased/decreased hunger ☐ Increased/decreased thirst
☐ Thyroid condition

Blood, Immune

☐ Autoimmune disorder ☐ Bruising ☐ Frequent bleeding
☐ Frequent Flu/Colds ☐ Painful lymph nodes ☐ Slow wound healing
☐ Swollen glands

Male Reproductive (Male only)

☐ Discharge
☐ Erection difficulty
☐ Hernias
☐ Infertility
☐ Painful erections
☐ Painful testicles
☐ Painful urination
☐ Premature ejaculation
☐ Prostate problems
☐ Sexual difficulties
☐ STIs
☐ Testicular mass
☐ Testicular swelling

Female Reproductive (Female only)

# of live births _____
# of pregnancies _____
# of spontaneous or missed miscarriages _____

☐ Body hair
☐ Breast pain
☐ Difficulty conceiving
☐ Facial hair
☐ Genital eruptions
☐ Heavy periods
☐ Lack of sexual desire
☐ lumps in breast(s)
☐ missed periods
☐ Nipple discharge
☐ Orgasm difficulty
☐ Pain with intercourse
☐ Painful menses
☐ Pelvic pain
☐ PMS
☐ Spotting
☐ STIs
☐ Use of birth control
☐ Vaginal discharge
☐ Vaginal dryness
☐ Vaginal itching
☐ Vaginal burning
☐ Yeast infection

Thank you for taking the time to fill out these forms. I look forward to working with you on your journey towards health.

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Cancellation Policy

As a courtesy, we email confirmation for your appointment prior to your scheduled time; ultimately it is your responsibility to keep the scheduled appointment or to reschedule. Specialized Natural Health Care has a 24-hour cancellation policy in regards to scheduled appointments. If for some reason you cannot be present for a scheduled appointment, please notify us win 24 hours prior to that appointment. If appointments are not canceled within the appropriate time frame, we reserve the right to bill the patient for 50% of the cost of the missed appointment. We strive not only to keep our patients healthy, but to keep healthy professional relationships as well. Please join us in collaboration on a healthy relationship throughout your care.

_____
initials of patient

Outpatient Laboratory and Imaging Costs

While we do our best to find the most cost effective ways to diagnose and monitor our patients, the costs associated with laboratory test, diagnostic imaging, and similar procedures are not within our control.
Please note that it is the responsibility of the patient to pay costs that are not covered by insurance. It is advisable that each patient or patient representative contact their insurance company for information concerning costs and coverage for any and all such testing.

Phone Appointments for Local, Insurance Based Patients

Should there be a time when an office visit is not possible, we are happy to set up a phone consult. Please note that this type of service is not billable to insurance, therefore we have an expected fee of $50 billed at time of service.

Please sign below to acknowledge that you have read and understand these statements.

_____ Date _____

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Patient Agreement

CONSENT TO CARE

You are the most important person on your health care team. You are entitled to receive clear and understandable information about the options for and methods of therapy, techniques used, and the duration of therapy.
I wish to be treated by Dr. Matthew Perchemlides. I understand that this care may include tests, examinations, diet and lifestyle therapies, acupuncture, nutritional counseling, therapeutic use of nutrients (including oral, intramuscular injection or intravenous infusion), herbal medicine, hormonal therapies, and prescription medication. I understand that no guarantees have been made to me about the outcome of this care. I understand that I have the right to seek a second opinion from another healthcare professional, or terminate therapy at any time. I agree that the practice may do the following unless I specifically give direction prohibiting such activity:

- Send visit reminders and routine correspondence, such as billing statements, to the address I have provided.
- Leave messages on an answering machine or voicemail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the practice on medical or billing matters.
- I agree that the practice may share billing information with my spouse and/or the person holding the insurance to secure payment.

_____ _____

Signature | Relationship to Patient if signed by someone other than patient | Date

ASSIGNMENT OF BENEFITS

I authorize payment directly to Matthew Perchemlides, ND, FABNO, MSN, BSN health insurance benefits payable to me under the terms of my policy and I agree to assist in the processing of claims for benefits. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

_____ _____

Signature | Relationship to Patient, if signed by someone other than patient | Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that Matthew Perchemlides, ND, FABNO, MSN, BSN has offered me a copy of his Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact the Privacy Contact at 802-989-7669. I also understand that I am entitled to receive updates upon request if Matthew Perchemlides, ND, FABNO, MSN, BSN. amends or changes this Notice of Privacy Practices in a material way. This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

_____ _____

Signature | Relationship to Patient, if signed by someone other than patient | Date