New Patient Intake

Dr. Jessica Renfer, ND Naturopathic Doctor 808.443.7590 ritualnature.com <u>drjrenfer.nd@gmail.com</u> Today's Date:

PATIENT INFORMATION				
Last Name:		First Name:		
Middle Name:		Date of Birth: Age:		Age:
Cell Phone:	Work/Home:		E-mail:	
May we leave confidential voice messages for you at any of the above numbers? No Yes: Home Work Cell				
Home Address:				
City: State:		Zip code:		
Mailing Address (if different from above):				
City: State:			Zip code:	
Relationship Status:				
Live With: Alone Spouse/Partner Children Parents Pet Friends Others:				
Occupation:	Employer:		Phone:	

EMERGENCY CONTACT	
Name:	Relationship:
Phone #:	Alternative Phone #:

PRIMARY CARE PHYSICIAN	
Name:	Address:
Phone #:	Email/Fax

What is your purpose and/or intention for working with Dr. Renfer? What are you hoping to accomplish or work through?

PRESENT HEALTH CONCERNS		
Please list your present health concerns in order of importance to you:	How long has this been an issue for you?	
1.		
2.		
3.		
4.		
5.		

Please list any treatments/therapies you are currently receiving or have received in the past that have worked for you.

GENERAL HISTORY			
Height:	Current Weight:	t: Is this a comfortable weight for you? Yes No	
Please list any Hospitalizations, surgeries, serious illnesses, injuries, motor vehicle accidents:			
Were you a natural birth?: Yes No (C-section or other)		Yes No (C-section or other)	
Did you receive childhood vaccinations:		All None Some:	
Known food or drug	g allergies:		
Date of last physica	l exam:	Date of last dental visit:	
Date of last blood to	est:	Date of last eye examination:	

Condition	Relation/ Self	C = Current $P = Past$	Condition	Relation/ Self	C = Current P = Past
Alcoholism			Drug addiction		
Allergies			Epilepsy/ seizures		
Alzheimer's			Glaucoma		
Anemia			Gout		
Arthritis			Headaches		
Asthma			Heart Disease		
Attention deficit			Kidney Disease		
Bleeding disorders			Liver Issues		
Blood pressure ↑/↓			Lung Issues		
Cancer			Mental Illness		
Cholesterol ↑/↓			Neural Tube Defect		
Chronic fatigue			Parkinson's		
Crohn's disease			Skin issues		
Depression			Tuberculosis		
Diabetes			Ulcerative colitis		
Obesity			STDS		
Other medical condition	ons or symptoms	s that run in your	family?		1

GYNECOLOGICAL HISTORY		
Date of Last Menstrual Period		
Cycle Frequency & Duration		
PMS or other Symptoms prior or duri	ng cycle	
Birth Control Method (Past and Prese	nt)	
Last Pap Smear:	Mammography/Breast Exam:	Bone Density Test:
Number of Pregnancies & Outcomes:	1	1

NUTRITION			
Number of meals you eat out per day,	/week:		
How many meals do you eat a day:			
How often do you snack per day:			
What are your normal snacks:			
Foods you crave:			
Diet type (ex: omnivore, vegan, etc):			
Diet restrictions/food sensitivites (ex: beef, dairy, gluten, salt, etc):			
Typical Breakfast:	Lunch:		Dinner:
Fluids (water, coffee, green tea, black tea, soda, juice, etc): (type and amount per day):			

SOCIAL AND PREVENTIVE HEALTH		
What is your heritage:		
Religion and spirituality:		
Exercise (type, how often, for how long):		
Highest degree of education:		
Recreational drug use:		
IV drug use:	Never Once or more	
Smoking history: Current Past Never	For how long: How many per day:	
Number and types of alcoholic beverages per week:		

MENTAL/ EMOTIONA	L
Do you have a sense that your health condition may have a connec- tion to your mental/emotional state?	
Have you ever been diagnosed with or currently struggle with a mental health issue? (ADD, Depression, Anxiety, OCD, ect.)	
What are some limiting beliefs that you have about yourself? (for example, I am not enough)	

ENVIRONMENTAL EXPOSURE		
Do you currently live, or have you every lived, within 20 miles of a refinery, chemical treatment facility or other industrial compound?		
How are you affected by the odor of gasoline/diesel, perfumes, con- ventional cleaning and laundry supplies? What happens? (headache, lightheaded, fatigue, etc.)		
Do you have mercury fillings/amalgams? How many and for how long?		
Do you have any tattoos and/or body piercings?		

SLEEP AND ENERGY		
What time do you go to bed?	What time do you wake up?	
Difficulty falling asleep or stay- ing asleep?	Do you wake feeling refreshed?	
Need sleep aids?	Hours of sleep per night?	
Afternoon fatigue?	Do you wake feeling refreshed?	
How many times do you wake during the night?	Tired all day? Need coffee to stay awake?	

Name of Product	Brand	Dose/Frequency	How long?
Example: Vitamin C	Thorne	1,000 mg a day	1 year

INFORMED CONSENT

Dr. Jessica Renfer is a Naturopathic Doctor. She graduated from the Southwest College of Naturopathic Medicine in Tempe, AZ, a 4-year post-graduate medical school accredited by the US Department of Education. She carries a license to practice medicine in the State of Hawaii. In the state of Hawaii, Naturopathic Medicine is regulated by the Hawaii Department of Commerce and Consumer Affairs. For those patients who are residents of the State of Hawaii, or attend a retreat in Hawaii, Dr. Renfer is licensed to practice medicine, as in may diagnose and treat disease. For all other clients, Dr. Renfer functions as a Wellness Consultant, thus does not intend to diagnose or treat disease. The focus in these cases is on education and supporting a healthy lifestyle, and recommendations are intended to complement, not replace, the care of a primary care physician.

I understand the above statement. I further understand that Dr. Jessica Renfer, ND is not a medical doctor and is not attempting to conduct the activities of a medical doctor.

Patient or Responsible Party Signature:

Printed Name: _____ Date: _____