HOPE ND

Today's Date _____ Date/Time of appointment _____

This is a confidential record of your medical information and will not be released, except under the guidelines of the Notices of Privacy Practices.

Please complete all areas to the best of your ability

Name: _____ Date of Birth: _____Age: _____

Sex:_____Birth sex (if different from current):_____

Address: _____
City:_____ State: _____ Zip: _____

Telephone: Home _____ Work _____ Cell _____

Please circle the phone number you prefer to be reached at.

Is it okay to leave messages regarding your medical care at: Email [ ] Home [ ] Work [ ] Cell [ ]

Email: _____ Occupation: _____

Employer _____

Emergency Contact: _____ Relationship_____

Phone _____

Other current health care providers: _____
_____

How did you hear about Hope ND? _____

Health History Portion:

Please list your most important health concerns in order of their significance. Have you received a prior diagnosis of this problem/concern? If so, please list it on the same line.

1.

2.

3.

4.

What health goals do you have for your visit today? _____
_____
_____

HOPE ND

Name: _____Date:_____Age:_____

Have you ever consulted a Naturopathic Doctor or other alternative medicine provider before?

_____

Do you have any allergies (medications, foods, dust, dander, pollen, topical agents, etc)? Please list, if yes: YES NO

If yes, please describe: _____

Personal Habits:

HABITS/SUBSTANCE

	Current	Past	Never
Alcohol			
Caffeine			
Tobacco			
Marijuana			
Other Recreational Drugs			

Hours work/ week: _____

Do you feel overly stressed in your daily life? Yes No

Are you currently experiencing any feeling of depression? Yes No

Have you recently experienced any events that increase your stress level? Please describe:

_____

_____

Are you having difficulty sleeping? Yes No

Is stress in your life causing you to lose sleep? Yes No

Have your sleeping habits changed recently? Yes No

Hours sleep/night? _____

Trouble falling asleep? _____ Staying asleep?_____ Do you wake feeling rested? _____

Do you exercise regularly? YES NO

If yes - What type? _____

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Name: _____Date:_____Age:_____

How long? _____ How often? _____

Past Medical History: Hospitalizations/surgeries (please list reason and date):

_____
_____
_____
_____
_____
_____

Serious injuries/ chronic illnesses (please list dates, as well):

_____
_____
_____
_____
_____
_____
_____

Date of last physical/annual exam: _____ Date of last blood tests: _____
_____ Date: _____Age_____

Personal and Family History **Please write "Self"** next to each condition that applies to you and please **list closest family members** who have each of the following conditions. Please note whether the condition applied in the **past (P)** or is **currently applicable (C)**

Alcohol/Drug Addiction	
Headaches	
Allergies	
Heart Disease	
Anemia	
Hepatitis	
Arthritis	
High Blood Pressure	

HOPE ND

Name: _____Date:_____Age:_____

Asthma	
Kidney Disease	
Cancer	
Mental Illness	
Depression	
STDs	
Diabetes	
Stroke	
Eczema	
Tuberculosis	
Epilepsy	
Numbness/Tingling hands/feet	
Painful or frequent urination	
Diarrhea	
Constipation	
PMS/Irregular menses	
Difficulty becoming pregnant	
Miscarriage	
Osteoporosis	
Thyroid Issues	

Other Social History Please circle those that apply: Single Married

Do you have any children? YES NO (please circle)

Please list their age(s)

_____

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Name: _____Date:_____Age:_____

Please list all medication/supplements that you are taking (include doses, date started, and **reason for taking):**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

HOPE ND

Name: _____Date:_____Age:_____

Sexual History

Please circle one: (Women)

- Premenopause (typical menstruating years)
- Perimenopause (when periods become sporadic/unpredictable before stopping altogether)
- Postmenopause (after periods have ceased for at least one year, not due to pregnancy or other methods – aside from surgical/planned menopause)

Which of the following contraceptive methods are you using: (please circle)

None _____ Natural Family Planning_____ Foam _____

Condoms ____ Partner Vasectomy/hysterectomy _____ Birth control pills (list name and type)____

Tubal ligation ____ Other ____

Diaphragm IUD: type_____

How long have you been with your current sex partner, if applicable?

_____ Have you ever been raped or abused sexually? Yes No

Eating Habits

Have you gained or lost a significant amount of weight recently? Yes (circle - gained/or lost) No

If yes, how much? _____

Are you concerned about your current eating habits? Yes No

Please describe your diet:

_____
_____
_____
_____

Do you follow any particular diet regimens or restrictions? If yes, please describe in detail:

_____
_____
_____
_____
_____
_____

HOPE ND

Name: _____Date:_____Age:_____

Are you having problems with over-eating? Yes No

Current weight?_____Height_____

Daily water intake (approximate ounces. Please note, a typical Poland spring water bottle is 16.9 ounces): _____ Source _____

Menstrual/Pregnancy History

Age of first period: _____ Usual length of period: _____

Usual interval between periods: _____

Describe your menstrual flow:_____

Number of:

Total Pregnancies: _____ Abortion:_____

Still births: _____ Full term deliveries:_____

Miscarriage:_____

Preterm deliveries: _____

Ectopic pregnancies:_____

Have you had any of the following: (please circle): __Ovarian cyst___Abnormal pap smear___Infertility

If abnormal pap smear, were you tested for HPV?_____HPV positive?_____
Any procedure performed in regard to the abnormal pap smear?_____

HOPE ND

We are currently in network with Anthem BCBS and Harvard Pilgrim Healthcare only. It is your responsibility to contact your insurance to inquire as to whether Hope ND LLC and Dr. Bonfanti are covered under **your plan** prior to your appointment. It is your responsibility to **see if your plan requires you to have a referral** to see Dr. Bonfanti. If a referral is needed and not provided to Dr. Bonfanti prior to your appointment; the payment is your responsibility. Dr. Bonfanti **being in-network does not mean that your specific plan covers Naturopathic Medical Services**. Patient is responsible for services not covered by their insurance company. By signing this document, I give my authorization for Hope ND LLC to bill my insurance company for services rendered. I understand that it is my responsibility to make Hope ND LLC aware at the time of service of any insurance changes I may have. • Upon request, an invoice can be produced at the time of service which may be submitted by the patient to their insurance company for potential reimbursement, if paying out-of-pocket. Please ask for this invoice at time of the appointment. • Hope ND, LLC does not guarantee reimbursement by the patient's insurance company. •. I understand it is not the responsibility of Hope ND, LLC to research whether reimbursement may occur, to submit forms for out-of-network reimbursement, or to follow up with insurance regarding reimbursement. Cancellation Policy: Hope ND, LLC requires **at least 48 hours' notice of cancellation** in advance of the scheduled appointment time. Missed appointments without notification, cancellations after appointment start time, or showing up more than 15 minutes late will be charged $100.00. Cancellations with less than 48 hours' (weekends excluded) notice will be charged $50.00. • I agree to pay for services rendered at time of service. Payment is expected in full at time of service. I acknowledge that I may request the fees for various procedures (although, these cannot always be guaranteed not to change) before they occur and include that information in my decision regarding healthcare. Hope ND LLC is not responsible for any price changes that may occur unexpectedly by labs without notice• I am aware that my practitioner will charge for telephone consultations. I consent to treatment by Hope ND, LLC and use of my medical records as provided by law. Any therapy will proceed only with our mutual consent, and I understand that any and all results of treatment are not guaranteed. I agree to discuss any problems/concerns in my care with the practitioner. I consent that I am aware that if I supplement with anything new outside of what is instructed for me to do so on my treatment plan, I risk interactions. This includes medication to which you do not make Dr. Bonfanti aware. An appointment will be required to discuss new medications/supplements, as Dr. Bonfanti cannot review this without an appointment.

Declaration: I state that I am over 18 years of age and am here in my private capacity and not on behalf of any private, local, county, state, or federal agency or organization of the United States, without so stating. **I have read, understand, acknowledge and agree to the above statements.**

Printed name of patient _____

Signature of Patient or Authorized Representative _____

Date _____