

When did you last visit a doctor's office, medical clinic, or hospital? Please explain.

What is the main reason for your visit to our clinic today?

Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold, dust)? If yes, please list and explain:

How did you hear about Bare Medicine?

May we thank the person who referred you?

Self and Family History

What hospitalizations or surgeries have you had?

What diagnostic imaging studies have you had? Bone density scan Mammogram
 Electrocardiogram Electroencephalogram X-rays CT scan MRI

Medications and/or Supplements

Do you take or use any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Pain relievers (aspirin, ibuprofen) | <input type="checkbox"/> Antacids |
| <input type="checkbox"/> Diet pills, appetite suppressants | <input type="checkbox"/> Laxatives |
| <input type="checkbox"/> Cortisone (cream or pills) | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Thyroid medication | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Sleeping pills | |

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

General

Height: _____ Weight: _____ lbs. Weight one year ago: _____ lbs.
Maximum weight: _____ lbs. When? _____
When during the day is your energy best? _____ Worst? _____

Family History

Do you have a family history of any of the following (please circle)?

- | | | | |
|-----------|----------------------|---------------------|----------------|
| Anemia | Diabetes | Hayfever/hives | Liver disease |
| Arthritis | Epilepsy | Heart disease | Mental illness |
| Asthma | Gall bladder disease | Heart murmur | Stroke |
| Cancer | Glaucoma | High blood pressure | Tuberculosis |
| Cataracts | Goiter | Kidney disease | |

Is your father still living? Yes; his age ____ No; age at time of death ____ Cause of death ____
Is your mother still living? Yes; her age ____ No; age at time of death ____ Cause of death ____

Childhood Illnesses

Please circle whether you have/had any of the following conditions as a child/ adolescent:

Diphtheria	Mumps
German measles	Rheumatic fever
Measles	Scarlet fever
Other _____	

Past Immunizations

Please circle any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diphtheria	Polio
Measles/Mumps/Rubella (MMR)	Tetanus
Pertussis	Other _____

Review of Systems

Please circle. Y= Yes, present condition. N=No, never had the condition. P=Problem of the past.

Head

Headaches	Y P N	Migraine headaches	Y P N
Head injury	Y P N	Jaw/TMJ problems	Y P N

Ears

Ringing	Y P N	Dizziness	Y P N
Earaches	Y P N	Impaired hearing	Y P N

Neck

Lumps	Y P N	Swollen glands	Y P N
Goiter	Y P N	Pain or stiffness	Y P N

Skin

Rashes	Y P N	Psoriasis	Y P N	Eczema, hives	Y P N
Lumps	Y P N	Acne, boils	Y P N	Color changes	Y P N
Itching	Y P N	Loss of hair	Y P N	Night sweats	Y P N

Musculoskeletal

Joint pain	Y P N	Muscle spasms	Y P N	Weakness	Y P N
Arthritis	Y P N	Broken bones	Y P N	Sciatica	Y P N

Eyes

Blurred vision	Y P N	Cataracts	Y P N	Glasses/contacts	Y P N
Eye pain/strain	Y P N	Glaucoma	Y P N	Tearing/dryness	Y P N
Spots in eyes	Y P N	Color blind	Y P N	Double vision	Y P N

Nose/Sinuses

Stiffness	Y P N	Loss of smell	Y P N	Sinus problems	Y P N
Hayfever	Y P N	Nose bleeds	Y P N	Frequent colds	Y P N

Mouth/Throat

Hoarseness	Y P N	Gum problems	Y P N	Freq. sore throat	Y P N
Jaw clicks	Y P N	Dental cavities	Y P N	Sore lips/tongue	Y P N

Respiratory

Asthma	Y P N	Wheezing	Y P N	Spitting up blood	Y P N
Cough	Y P N	Bronchitis	Y P N	Difficulty breathing	Y P N
Sputum	Y P N	Pneumonia	Y P N	Pain with breathing	Y P N
Pleurisy	Y P N	Emphysema	Y P N	Shortness of breath	Y P N
		Tuberculosis	Y P N	at night	Y P N
				lying down	Y P N

Cardiovascular

Angina	Y P N	Chest pain	Y P N	Blood clots	Y P N
Murmur	Y P N	Heart disease	Y P N	Rheumatic fever	Y P N
Fainting	Y P N	Ankle swelling	Y P N	Low/high blood pressure	Y P N

Gastrointestinal

Diarrhea	Y P N	Constipation	Y P N	Changes in thirst	Y P N
Ulcers	Y P N	Black stool	Y P N	Coughing up blood	Y P N
Jaundice	Y P N	Hemorrhoids	Y P N	Gall bladder disease	Y P N
Heartburn	Y P N	Abdominal pain	Y P N	Blood in stool	Y P N
Liver disease	Y P N	How many bowel movements per day? _____			

Urinary

Incontinence	Y P N	Frequent infections	Y P N	Painful urination	Y P N
Kidney stones	Y P N	Frequency at night	Y P N		

Blood/Peripheral Vascular

Anemia	Y P N	Cold hands/feet	Y P N	Thrombophlebitis	Y P N
Leg pain	Y P N	Easy bruising	Y P N	Varicose veins	Y P N

Neurological

Fainting	Y P N	Paralysis	Y P N	Numbness/tingling	Y P N
Seizures	Y P N	Loss of memory	Y P N	Muscle weakness	Y P N

Emotional

Mood swings	Y P N	Nervousness	Y P N	Tension/stressed	Y P N
Anxiety	Y P N	Depression	Y P N		

Endocrine

Hypothyroid	Y P N	Excessive thirst	Y P N	Cold intolerance	Y P N
Hyperthyroid	Y P N	Excessive hunger	Y P N	Heat intolerance	Y P N

Male Reproductive

Hernias	Y P N	Testicular masses	Y P N	Discharge or sores	Y P N
Prostate issues	Y P N	Sexual difficulty	Y P N		
Testicular pain	Y P N				
Venereal disease	Y P N	Premature ejaculation	Y P N		

Female Reproductive

Age of first menses _____ Age of last menses (if menopausal) _____
 Length of cycle _____ Duration of menses _____

Date of last annual exam	_____				
Painful menses	Y P N	Endometriosis	Y P N	Ovarian cysts	Y P N
Heavy flow	Y P N	Fertility issues	Y P N	Cervical dysplasia	Y P N
Breasts tender	Y P N	Venereal disease	Y P N	Bleeding between cycles	Y P N
Sexually active	Y P N	Cycles regular	Y P N	Menopausal symptoms	Y P N
Sexual difficulty	Y P N	Abnormal pap	Y P N	PMS	Y P N
Breast lump(s)	Y P N	Nipple discharge	Y P N	Do self breast exams	Y P N

Birth control Y P N If yes, what type? _____
 Number of pregnancies _____ Number of live births _____
 Number of miscarriages _____ Number of abortions _____

Sexual preference: Heterosexual Homosexual Bisexual

Is there anything else you would like us know in order to serve you better?

Consent for Treatment:

I understand that my care as a patient at Bare Medicine is directed by a licensed naturopathic doctor. I consent to services rendered and provided to me under the instructions of this professional assisting in my care, as well as volunteer staff practitioners who may be associated for the purpose of consulting.

I may be contacted by Bare Medicine for voluntary participation in clinical research projects. I do, however, have the right to refuse these programs without jeopardizing my future care at Bare Medicine in any way.

I understand that treatment with natural and energetic medicines and modalities including bodywork and manipulation can sometimes make symptoms worse while getting to the root of the problem and that this is a normal healing process.

I have fully read and understand the above agreements and authorizations.

Patient (18 years or older)

Date

Parent, Guardian, Responsible Party

Date

HIPAA Notice of Privacy Practices and Consent: I hereby consent to the use and disclosure of my protected health information by Bare Medicine for the purposes of **treatment, payment and healthcare operations**, or as otherwise required by law.

- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by Bare Medicine at the following address:

460 Main Street, Suite 2
Springvale, ME 04083

- I understand that while Bare Medicine may honor these requests, they are not required by law to do so.
- I am aware that Bare Medicine reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Bare Medicine will make available a revised Notice of Privacy Practice for my review.

Patient (18 years or older)

Date

Parent, Guardian, Responsible Party

Date

Statement of Financial Responsibility: I understand and agree to the following:

- ⇒ Payment for services rendered are my responsibility as the patient or patient's responsible party.
- ⇒ I am responsible for paying for all services, including lab tests and medicinary items, rendered at the time of service.
- ⇒ If I am receiving a discount of any sort, I am responsible for providing accurate and thorough documentation supporting it and I am responsible for paying in full at the time of service.
- ⇒ I understand that due to the nature of services and items sold, all sales of both services and goods are final.
- ⇒ I understand if I fail to show for my appointment or do not give at least 24 hours notice for cancellation, that I will be charged a cancellation fee equal to or less than my scheduled visit fee. The exceptions to this rule are severe weather, family / personal death or hospitalization and I will provide proof of the latter two at my next appointment.
- ⇒ I understand that Bare Medicine does not carry malpractice insurance and should there be a legitimate dispute, each side will use a board-certified or credentialed expert in Naturopathic Medicine who is a member of and follows the code of ethics for Naturopathic Medicine.

Signature of patient or patient's responsible party

Date

Please provide your email address if you would like to be reminded of appointments via email. Our electronic health records system is secure and we never share email addresses as part of our HIPAA compliance.

Email Address

Would you like to be added to our monthly e-newsletter list? Yes No