



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?

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

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Patient (18 years or older)

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Date

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Parent, Guardian, Responsible Party

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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:

554A Main Street  
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.

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Patient (18 years or older)

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Date

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Parent, Guardian, Responsible Party

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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, 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.

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Signature of patient or patient's responsible party

Date