GABBERT MEDICAL
903 E. Hwy 260, Suite No: 4 – Payson, AZ 85541 – 928-472-2225

NEW PATIENT INTAKE FORM

(Patient Demographic – Please fill in as much info as possible)

Patient Name: _____

Date of Birth: _____ Age: _____ Gender: _____Male _____Female

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

Contact Phone No: _____ (Circle One) Cell: _____ Home: _____

How did you hear about the clinic? _____

Email Address: _____ (Please provide)

Marital Status: (Please circle): Single Married Separated Divorced
With Partner Widow(er)

Occupation: _____

Employer: _____ Hours Per Week: _____

Employers Phone Number: _____

Emergency Contact Name: _____ (Please Provide)

Emergency Contact Number: _____ (Please Provide)

Treating Physician Name: _____ (Please Provide)

Height: _____ Weight: _____ Nationality: _____

NATUROPATHIC INTAKE FORM

Name:

Date of Birth:

CONCERNS

Thank you for taking the time to fill out this intake form. We know it's comprehensive, but by gathering this information about your health history and goals helps give your naturopathic doctor a more complete understanding of you. We want to help you reach your optimal health.

Most important concern you would like to address?

Additional concerns?

FAMILY HISTORY

Have any blood relatives ever had any of the following?

☐ Cancer	☐ Tuberculosis
☐ Asthma	☐ Mental Illness or suicide
☐ Diabetes	☐ High Blood Pressure
☐ Allergies	☐ Autoimmune Disease
☐ Heart Attack	☐ Heart Disease
☐ Stroke	☐ Osteoporosis
☐ Other	

If YES, check appropriate box and please indicate who below (maternal aunt, paternal grandmother, father, son, sister, etc)

MEDICAL HISTORY

Who is your Primary Care Physician? Please include address, phone number, and fax number.

Please indicate the doctors or practitioners that have been involved in your care in the last three years. Provide name, date of last visit, visit reason, office number?

☐ Acupuncturist	☐ Chiropractor
☐ Gastroenterologist	☐ Hematologist/Oncologist
☐ Surgeon	☐ Endocrinologist
☐ Cardiologist	☐ Naturopathic Physician
☐ Gynecologist	☐ Other

List any significant prior illnesses, diagnoses, or injuries, including date occurred (ie. hypertension, March 2015)

List all surgeries and hospitalizations, including reason and date occurred?

Please list any major accident or illness during childhood not already indicated?

Date of last physical exam?

Date of last blood work?

Medical Imaging

X-ray: Provide date, area of body, and reason?

MRI/CAT Scan: Provide date, area of body, and reason?

Ultrasound: Provide date, area of body, and reason?

Vaccination History

Have you ever had the disease (D), been immunized (I), neither (N) or unknown (U) for the following?

	D	I	N	U	Date
Tetanus	o	o	o	o	
Whooping cough (Pertussis)	o	o	o	o	
Hemophilus (HiB)	o	o	o	o	
Hepatitis A	o	o	o	o	
Hepatitis B	o	o	o	o	
Measles	o	o	o	o	
Mumps	o	o	o	o	
German Measles (Rubella)	o	o	o	o	
Chicken Pox	o	o	o	o	
Shingles	o	o	o	o	
Human papilloma virus (HPV)	o	o	o	o	
Pneumococcal Conjugated Vaccine (PCV)	o	o	o	o	
Polio	o	o	o	o	
Meningococcal	o	o	o	o	
Pneumonia	o	o	o	o	
Influenza	o	o	o	o	
Other Vaccines	o	o	o	o	

Any adverse reactions to any vaccinations?

- ☐ No
- ☐ Yes, describe:

Medications / Supplements

Current Medications and Supplements (please include ALL prescriptions, over-the-counter drugs, vitamins, herbs, etc.). Please include daily dose and reason for taking it.

Allergies

Please indicate allergies?

- ☐ No known allergies
- ☐ Medication
- ☐ Foods
- ☐ Environmental

Please indicate allergy and describe reaction:

SOCIAL HISTORY

What is your current job?

Do you enjoy your job? ☐ Yes ☐ No

What are your hobbies?

Have you done any foreign travel within the last year?

☐ Yes, indicate where ☐ No

Please indicate your average level of energy throughout the day using the scale 1-10 (1 is the lowest and 10 is the highest)

Do you exercise? If YES, indicate type of exercise, how many days per week, and for how long? (i.e. bicycling, 3 days, 60 minutes)

☐ Yes, describe ☐ No

Sleep

How many hours of sleep do you usually get per night?

Do you wake feeling refreshed?

☐ Always ☐ Usually ☐ Rarely ☐ Never

Do you have difficulty sleeping?	☐ Yes	☐ No
Any trouble falling asleep?	☐ Yes	☐ No
Any trouble staying asleep?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Do you have nightmares?	☐ Yes	☐ No

Do you need a sleep-aid?

☐ Yes, indicate what ☐ No

Alcohol, Tobacco, and Recreational Drug Use

Do you drink alcohol?

☐ Daily ☐ Weekly ☐ Monthly ☐ No

What type of alcohol do you prefer? ☐ Liquor ☐ Wine

☐ Rarely ☐ Never

How much do you drink per sitting? Indicate amount consumed per occasion.

Do you smoke tobacco?

☐ Yes ☐ No ☐ In the past

If yes, how many cigarettes or packs per day?

If past, when did you quit smoking, number of years smoking, and packs per day?

Do you use recreational drugs?

☐ Yes ☐ No ☐ In the past

If yes, how often?

☐ Daily ☐ Weekly ☐ Monthly ☐ Other

If Yes or in the past, what kind?

Have you ever been told you have an addiction or been treated for an addiction?

☐ Yes ☐ No

Does the use of alcohol or drugs impair your activities of daily living?

☐Yes ☐No

Diet

Do you follow a special diet (ie South Beach, Paleo, Vegan, Blood-type, etc.)?

☐ Yes, indicate type ☐ No

How many ounces of water do you drink each day?

How many meals do you eat a day?

Do you drink energy drinks?

☐Daily ☐Weekly ☐Monthly ☐ No

Please indicate what kind of energy drink and how much:

Do you drink soda, juice or sports drinks?

☐Daily ☐Weekly ☐Monthly ☐ No

Please indicate what kind of soda, juice or sports and how much:

How many 8oz cups of coffee do you drink daily?

Relationship

Relationship status?

☐ Single ☐ Separated
☐ Married ☐ Divorced
☐ Domestic partner ☐ Widowed
☐ In a relationship ☐ Other

Are you satisfied with your significant relationships?

☐ Yes ☐ No

Do you find your life?

☐ Satisfactory
☐ Unsatisfactory
☐ Boring
☐ Too demanding

Do you live alone?

☐ Yes ☐ No

Do you have a support system?

☐ Strong ☐ Moderate ☐ Limited

Major stressors in the last year?

☐ Money
☐ Job
☐ Marriage/relationship
☐ Home life
☐ Children
☐ Loss
☐ Other

Do you have a history of abuse? Check all that apply.

☐ Mental abuse
☐ Physical abuse
☐ Sexual abuse
☐ Emotional abuse

If yes, by whom and at what age?

How would you define your childhood memories?

☐ Mostly happy
☐ Normal
☐ Mostly painful
☐ Denies recollection

REVIEW OF SYSTEMS

Do you have, or have you had within the past year, any of the following?

General

- ☐ weight change
- ☐ weakness
- ☐ appetite change
- ☐ fatigue
- ☐ fever/chills
- ☐ night sweats

Skin

- ☐ positive skin exam
- ☐ hair/nail changes
- ☐ color change
- ☐ psoriasis
- ☐ abnormal mole
- ☐ itchy skin
- ☐ dry skin
- ☐ rosacea
- ☐ acne
- ☐ eczema
- ☐ rash
- ☐ skin cancer
- ☐ hives
- ☐ warts

Head

- ☐ migraines
- ☐ dandruff
- ☐ headaches
- ☐ oily hair
- ☐ dizziness
- ☐ dry hair
- ☐ lightheadedness
- ☐ hair loss
- ☐ head injury

Eyes

- ☐ dryness
- ☐ styes
- ☐ watery eyes
- ☐ dark circles
- ☐ itching eyes
- ☐ discharge of the eye
- ☐ redness of the eye
- ☐ contacts/glasses
- ☐ eye strain
- ☐ problems with vision
- ☐ cataracts
- ☐ glaucoma
- ☐ Date of last eye exam:

_____

Ears

- ☐ ringing
- ☐ recurrent infections
- ☐ change in hearing
- ☐ pain
- ☐ discharge
- ☐ vertigo

Nose

- ☐ nose bleeds
- ☐ postnasal discharge
- ☐ polyps
- ☐ nasal congestion
- ☐ allergies
- ☐ nasal discharge
- ☐ frequent colds
- ☐ sinusitis
- ☐ problems smelling

Mouth/Throat/Neck

- ☐ goiter
- ☐ swollen glands
- ☐ sore throat
- ☐ problems swallowing
- ☐ problems tasting
- ☐ sores

Respiratory

- ☐ asthma
- ☐ TB
- ☐ bronchitis
- ☐ cough
- ☐ wheezing
- ☐ COPD
- ☐ pneumonia
- ☐ shortness of breath with exertion
- ☐ shortness of breath with sitting
- ☐ shortness of breath with lying down
- ☐ pain with breathing

Date of last chest x-ray (if any):

Cardiovascular

- ☐ murmurs
- ☐ congestive heart failure
- ☐ palpitations
- ☐ blue hands/feet
- ☐ heart attack
- ☐ rheumatic fever
- ☐ arrhythmias
- ☐ low blood pressure
- ☐ angina
- ☐ high blood pressure
- ☐ TIA/stroke(s)
- ☐ varicose veins
- ☐ chest pain
- ☐ edema
- ☐ leg cramps
- ☐ Date of last ECG (if any):

Gastrointestinal

- ☐ indigestion
- ☐ gas/bloating
- ☐ diarrhea
- ☐ nausea
- ☐ constipation
- ☐ vomiting
- ☐ food intolerance
- ☐ liver disease
- ☐ abdominal pain
- ☐ hernias
- ☐ heartburn
- ☐ fatty meals bothering rectal
- ☐ ulcers
- ☐ hemorrhoids
- ☐ bleeding/burning/itching

☐ How often do you have a bowel movement?

_____

☐ Date of last colonoscopy (if any):

_____

Urinary Tract

- ☐ incontinence
- ☐ frequent urination
- ☐ kidney stones
- ☐ frequent infections
- ☐ blood in urine
- ☐ pain with urination
- ☐ urgency
- ☐ waking to urinate

Musculoskeletal

- ☐ muscle weakness
- ☐ leg cramps
- ☐ muscle aches
- ☐ stiffness
- ☐ tremors
- ☐ past injury
- ☐ arthritis

Neurological

- ☐ paralysis/weakness
- ☐ numbness/tingling
- ☐ fainting/blackouts
- ☐ seizures

Endocrine

- ☐ diabetes
- ☐ thyroid disease
- ☐ anemia
- ☐ mood swings
- ☐ snacking often
- ☐ irritability
- ☐ hormone therapy
- ☐ increased urination
- ☐ increased thirst
- ☐ hot/cold intolerance
- ☐ needing to eat regularly
- ☐ easy bruising/bleeding
- ☐ change in glove/shoe size

Mental/Emotional

- ☐ anxiety
- ☐ fear/panic
- ☐ eating disorder
- ☐ anger/irritability
- ☐ feeling down/depressed
- ☐ suicidal thoughts
- ☐ psychiatric hospitalization

FEMALE SECTION

(Only females complete this section)

Menstrual Cycle

Age of first menses?

First day of last menses?

Length of menses?

Color of blood?

Clots in menses?

☐ Yes ☐ No

Number of pads/tampons used on your heaviest day?

Number of pads/tampons used on your lightest day?

Do you experience any of the following before or during your menses?

- ☐ diarrhea
- ☐ bloating
- ☐ food cravings
- ☐ menstrual cramping
- ☐ fatigue during menses
- ☐ backache during menses
- ☐ mood changes
- ☐ headaches
- ☐ heavy bleeding
- ☐ breast tenderness/swelling

Menopause

Surgically induced menopause:

☐ Total hysterectomy ☐ Partial hysterectomy

Age at menopause: Age mother entered menopause

Check all the symptoms you experience:

- ☐ hot flashes
- ☐ night sweats
- ☐ vaginal dryness
- ☐ decreased libido
- ☐ palpitations
- ☐ mood changes
- ☐ incontinence
- ☐ joint pain
- ☐ sleep disruption
- ☐ brain fog or decreased memory

Date of last DEXA scan (bone scan):
Indicate if you never had one.

Breast Health

Do you do breast self-exams monthly?

☐ Yes ☐ No

Do you know how to perform a self breast exam?

☐ Yes ☐ No

Do you have any of the following?

- ☐ breast pain
- ☐ breast discharge
- ☐ breast masses

Date of last mammogram and results:

Gynecology and PAP History

Date of last PAP smear and results:

Have you ever had an irregular PAP smear?

☐ No ☐ Yes, list date and treatment received:

Check all pelvic disease conditions that you have a history of:

- ☐ ovarian cysts
- ☐ fibroids
- ☐ endometriosis
- ☐ ectopic pregnancy
- ☐ ovarian/uterine disease
- ☐ pelvic inflammatory disease
- ☐ other

Have you had any gynecological surgeries or procedures?

☐ No ☐ Yes, indicate date and type:

Check all the pelvic symptoms you currently experience:

- ☐ vaginal itching
- ☐ vaginal odor
- ☐ pelvic pain
- ☐ abnormal discharge
- ☐ rashes or skin changes
- ☐ pain with intercourse

Pregnancy History

Number of pregnancies:

Number of miscarriages:

Number of abortions:

Any complications with pregnancy? ☐ Yes ☐ No

Any difficulty with conceiving? ☐ Yes ☐ No

Number of vaginal births:

Number of C-Sections:

Number of VBACs (vaginal birth after cesarean):

Contraception, Libido, and Sexually Transmitted Infections (STIs)

Are you currently sexually active? ☐ Yes ☐ No

Current number of sexual partners (if any):

Please indicate birth controls or other hormones previously or currently used:

Do you have sex with?

☐ Males ☐ Both males and females
☐ Females ☐ Other

Do you experience any of the following?

☐ low libido ☐ bleeding after intercourse
☐ pain with intercourse

Do you have a history of STIs?

☐ No ☐ Yes, indicate type:

How do you protect yourself from STIs?

MALE SECTION

(Only males complete this section)

Prostate / urinary symptoms?

☐ BPH ☐ incomplete urination
☐ nocturia ☐ dribbling of urine
☐ prostatitis ☐ difficulty initiating urination
☐ prostate cancer

Do you perform monthly testicular exams? ☐ Yes ☐ No

Date of your last PSA?

Date of your last prostate exam (digital rectal exam)?

Check all the pelvic symptoms you currently experience:

☐ testicular pain ☐ impotency
☐ testicular swelling ☐ decreased libido
☐ hernia ☐ prostate disease
☐ penile discharge ☐ rashes or skin changes

Contraception, Libido, and Sexually Transmitted Infections (STIs)

Are you currently sexually active? ☐ Yes ☐ No

Current number of sexual partners (if any):

Do you have sex with?

☐ Males ☐ Both males and females
☐ Females ☐ Other

Do you experience any of the following?

☐ low libido ☐ difficulty achieving an erection
☐ fertility challenges ☐ difficulty maintaining erection

Do you have a history of STIs?

☐ No ☐ Yes, indicate type:

How do you protect yourself from STIs?

Please indicate any hormones previously or currently used:

Additional Information

Is there anything else you would like your doctor to know about you?

CONSENT TO TREAT FORM

CHIROPRACTIC TREATMENT

Chiropractic care is a non-surgical, non-invasive procedure and has one of the safest records in health care. As with any healthcare specialty, we cannot promise a cure but we will give you our best care and we will discuss any questions or concerns with you.

Patients may experience temporary symptoms such as an increase in soreness following a massage, manipulation or traction. In addition, physiotherapy such as ice, heat or ultrasound may irritate the skin. There have been a few cases where adjustments may have aggravated a bulging or herniated disc or caused a rib fracture. On extremely rare occasions, adjustments to certain areas of the cervical spine have been related to a compromise of the vertebral artery and possible stroke symptomatology.

I acknowledge that I have discussed non-surgical Chiropractic care and physiological therapeutics and by signing below I authorize Gabbert Medical.

NATUROPATHIC TREATMENT

Naturopathic care focuses on holistic medical treatment and proactive prevention of diseases. By using protocols that minimize the risk of harm, naturopathic physicians help facilitate the body's inherent ability to restore and maintain optimal health.

Care provided by the doctors and staff at Gabbert Medical encompasses routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work, intravenous therapies, injection procedures, acupuncture, structural manipulation and administration of medications/supplements prescribed by the doctor.

I agree to treatment using, but not limited to, peptides, nutrition, lifestyle, homeopathy, herbs, acupuncture, aesthetic, hormones, PRP, Prolotherapy, liquid allograph, sarapin, pharmaceuticals, nutraceuticals (supplements), intravenous and injection therapies.

I understand and am informed that, as in the practice of naturopathic medicine/integrative medicine, there are some risks to treatment, including, but not limited to: pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness, allergic reactions to prescribed herbs, supplements, medications, aggravations of pre-existing symptoms.

MEDICAL RECORDS PROTOCOL

Gabbert Medical is in accordance with Arizona State Law maintains medical records for a period of at least six (6) years after the last treatment date. Minor patient's records are maintained for a period of at least three (3) years after the child's 18th birthday or for at least six (6) years after the last treatment date, whichever occurs later. Gabbert Chiropractic & Pain Treatment Center has a protocol for the secure storage, transfer, disposal and access of medical records at our office. By singing below I acknowledge that I have been provided a copy of the ***Medical Records Protocol*** for Gabbert Chiropractic & Pain Treatment Center and is available to me at any time upon request.

RECORD RELEASE

I understand that my records and X-Rays may be released for professional consultations to other health providers as necessary. Gabbert Chiropractic & Pain Treatment Center routinely sends many X-Rays and related health care information to Diagnostic X-Ray Consultation Services for interpretation. Should additional consultations be required with other HealthCare providers (i.e. Orthopedists, Neurologist, etc.) records will be provided as necessary. I also understand that my records and X-Rays may be released for payment purposes to Insurance Companies, Attorneys, and/or other third parties as necessary to obtain payment. By singing below I authorize the release of my records and X-Rays for these purposes. I understand that all my records will be kept confidential and will not be released without my written consent.

NOTICE OF PRIVACY PRACTICES

Gabbert Medical in accordance with HIPAA regulations wants to protect your rights and privacy as a patient. In addition, we will not provide your medical records to any outside third party for independent marketing purposes. All medical records are stored in compliance with Arizona State Law. Any questions regarding Privacy Practices may be directed to Dr. Brian Gabbert who serves as the Privacy Officer. By signing below I acknowledge that I have been provided a copy of the ***Notice of Privacy Practices*** for Gabbert Medical (PP-09-23-13) and is available to me at any time upon request and in no way affects the care I receive at Gabbert Medical.

By signing below I authorize Gabbert Medical to provide such care.

Patient Print Name: _____ Date: _____

Patient Signature: _____

Parent/Guardian Signature required if patient is under the age of 18.

OFFICE POLICIES

OFFICE HOURS

Our office is open Monday-Thursday 9:00 am to 6:00 pm and Friday 9:00 am to 1:00 pm. Patients are not scheduled from 1:00 pm through 2:00 pm during lunch. We are closed in observance of all major holidays.

NEW PATIENTS

For purposes of maintaining continuity of care, we ask that first time patients bring us the latest relevant records with the most recent test results, MRI / CT / XRAY/BLOOD WORK and current medications list. We do ask that you remain the sole custodian of your entire medical records from your previous healthcare providers. Should there be a need to further examine your previous records; our providers will have you bring your records back for additional review during subsequent office visits.

COURTESY

We strive to provide the best medical care for our patients. While we make every effort to provide prompt on-time service, the healthcare needs of each individual do not necessarily lend themselves to an exact schedule. We therefore appreciate your understanding and patience if you have to wait a few extra minutes. If you have any suggestions or complaints for our office, please let us know. Angry or foul language directed to our staff regardless of the issues involved will absolutely not be tolerated and will be grounds for immediate dismissal from our practice.

SUPERVISION OF CHILDREN & MINORS PRESENT WITHOUT PARENTS OR LEGAL GUARDIAN

Although we provide an area for children to entertain themselves, for safety reasons, we depend on parents to properly supervise their child(ren) at all times. Our staff cannot watch your children. Under no circumstances should a child under the age of 10 be left unattended. We also require a consent form signed by a parent or legal guardian to legally provide medical care to minors 16 and 17 years of age when the parent or legal guardian cannot be present. Minors 15 years of age or younger must be accompanied by a parent or legal guardian.

CHANGES IN ADDRESS, BILLING, OR CONTACT INFORMATION

Please notify our office in writing of any changes of address, telephone, billing or contact information. It is imperative that we have the most current information on file.

FEES & PAYMENTS

Payment in full is due at the time services are rendered. We do not except any forms of insurance. We accept credit/ debit cards, cash, personal check, cashier's checks, HSA cards. A copy of your driver's license or photo ID will be taken for your file on record. Should you require a payment plan, our office manager will be glad to discuss your options with you.

Balances over 120 DAYS due may be sent to a collection agency unless other arrangements have been made. A $50 fee may be assessed on accounts placed in collections. We may also elect to discharge you from our practice should you fail to comply with our policy.

APPOINTMENTS AND NO SHOW

We make every effort to provide prompt medical care to all of our patients. If you are unable to keep a scheduled appointment, please let us know at least 24 hours in advance. A NO SHOW is when a patient fails to keep a scheduled

appointment and does not give an appropriate amount of notice time. If you are scheduled for IV and or Injection therapy and no show, a fee may be assessed to cover the cost of wasted product if the IV or injection was pre-made. Fees will be assessed as follows, IV-$100.00 / Injection-$20.00. In the event that you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understanding of special circumstances.

If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any significant delay may require the visit to be rescheduled. Should you have more medical issues that need to be addressed, please inform our staff when calling for appointments, and we will schedule more time for you accordingly. Multiple family member appointments must be scheduled in advance. Family members who are present at the time of another member's appointment, but are not scheduled, may be required to schedule an appointment at a later time.

TELEPHONE MESSAGES & PROCESSING OF REFERRALS

We will try our best to respond to your messages as soon as possible. However, please be aware that messages may take up to 24 HOURS to process and respond. More often than not, if your questions require extensive attention, the doctor may elect to have you make an appointment and come for further evaluation for quality assurance purposes.

MEDICAL RECORDS & FORMS

All requests for medical records must be on a HIPPA approved form, which must be properly and completely filled out and signed by the patient or legal guardian. Improperly filled out forms may delay your request. Please allow at least 10 BUSINESS DAYS for processing.
Medical records released to a new provider, specialist or school: For continuity of care and as a courtesy to the patient, our office will forward records requested at no charge.
Medical records released to the patient, some insurance companies, law firm or miscellaneous requests: Records are subject to copying fees.

IN A LIFE-THREATENING SITUATION, PLEASE CALL 911 IMMEDIATELY.

Our friendly staff is committed to making your visit as pleasant as possible. Your comments or concerns are important to us. We rely on them to continue to improve our quality medical care to you and your family.

By signing below, I understand and agree to the office policies and procedures explained above. A copy of the office policies and procedures along with notice of privacy information regarding Gabbert Medical will be available to me upon request.

Patient Print Name: _____ Date: _____

Patient Signature: _____

Parent/Guardian Signature required if patient is under the age of 18.