Dr. Paloma Defuentes Naturopathic Physician 1-406-556-1209

MT Naturopathic Clinic 2050 Fairway Drive #103 Bozeman, MT 59715

Patient Profile Intake Form - Long

By completing this profile of your health history, I can offer you more complete naturopathic care. Please be assured that I keep this information confidential.

Name				Age	Birth Date	
Address		City			State	Zip
Social Security #		Hom	ne Pho	ne	Work Phone	
Email address						
MarriedPartnered	Separated _	_ Divorc	ed _	Widowed	I Single Children? `	Yes No
How did you hear about us?						
Where, when, from whom,	and for what r	eason d	id you	last receiv	ve any health care?	
Please list, in order of impor 1 2						
3		 				
4						
Family Health History: Please indicate if a family m						P = In the past
Anemia	Υ	N	D	Р		
Arthritis	Y	N	D	Р		
Asthma / Hay fever	Y	N	D	Р		
Cancer (type?)	Υ	N	D	Р		
Cystic Fibrosis	Υ	N	D	Р		

Diabetes		Υ	N	D	Р				
Eating Disorder		Υ	N	D	Р				
Epilepsy		Υ	N	D	Р				
Fibromyalgia		Υ	N	D	Р				
Glaucoma		Υ	N	D	Р				
Heart Disease (incl hear	t attacks)	Υ	N	D	Р				
Hypertension (high bloo	d pressure)	Υ	N	D	Р				
Kidney Disease		Υ	N	D	Р				
Mental Illness		Υ	N	D	Р				
Lung Disease		Υ	N	D	Р				
Stroke		Υ	N	D	Р				
Substance Abuse (drugs, alcohol)		Υ	N	D	Р				
Venereal Disease		Υ	N	D	Р				
Blood Type (please che	eck one)		A B	3	AB	0			
Childhood Illnesses	Please	che	ck if you	have	had any	of t	the following:		
Scarlet fever	_ Measles		Diphtheri	ia	Rube	ella ((German measles)	Chicken pox	
Rheumatic fever	_ Mumps		Others _						
Date of last Tetanus sho	ot								
Allergies:									
Drugs?		-							
Foods?									
Environmental?									
Have you ever been h	<u>nospitalize</u>	<u>d?</u>	Please list	t wher	n and w	hy.			
Illnesses:									

Medications: Please indicate i	f you ha	ve u	sed any of th	ne following.			
Appetite suppressants	Υ	N	Р	Sleeping pills	Υ	N	Р
Antacids	Υ	Ν	Р	Pain relievers	Υ	Ν	Ρ
Birth Control Pill or Implant	Υ	Ν	Р	Other Hormones	Υ	Ν	Ρ
Гhyroid Medicine	Υ	Ν	Р	Tranquilizers	Υ	Ν	Ρ
_axatives	Υ	Ν	Р	Cortisone	Υ	Ν	Ρ

Health Conditions		Y = \	Yes	N = No	P = A condit	ion you	ı've had	in the pa	st
Skin Acne Color Changes Hives Lumps Rashes	Y Y Y Y	N N N N	P P P P	Boils Ecze Itch Mole Psor	ema ing	Y Y Y Y	N N N N	P P P P	
Head Hair loss Head injury	Y Y	N N	P P		daches Il fracture	Y Y	N N	P P	
Eyes Eye pain Double vision Glasses/Contacts Impaired vision Injuries	Y Y Y Y	N N N N	P P P P	Dryr Glau Teai	aracts ness ucoma ring e of last eye exa	Y Y Y Y	N N N	P P P	
Ears Discharge Dizziness Ringing	Y Y Y	N N N	P P P		aches aired hearing ries	Y Y Y	N N N	P P P	
Nose and Sinuses Frequent colds Nose bleeds	Y Y	N N	P P		fever ıs pain	Y Y	N N	P P	

Mouth and Throat Bleeding gums	Stuffiness	Υ	N	Р	Persistent runny nose	Υ	N	Р
Dental cavities Y N P Sore throats Y N P Ploarseness Y N P Sore tongue Y N P Dentures Y N P Difficulty speaking Y N P Ulcerations Y N P Difficulty speaking Y N P Chewing tobacco Y N P P Difficulty speaking Y N P Chewing tobacco Y N P P Swollen glands Y N P P Injuries Y N P P Swollen glands Y N P Injuries Y N P P P P P P P P P P P P P P P P P P				_	Disc: II II i			_
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Dentures Y N P Chewing tobacco Y N P Neck Goiter Y N P P Pain/Stiffness Y N P Swollen glands Y N P P Injuries Y N P Swollen glands Y N P P Injuries Y N P Respiratory Asthma/Wheezing Y N P P Pneumonia Y N P Emphysema Y N P P Pneumonia Y N P Spitting up blood Y N P Short of breath Y N P Spitting up blood Y N P With exertion Y N P Difficult/Painful breathing Y N P Dizziness after standing Y N P Cardiovascular Angina Y N P Dizziness after standing Y N P Chest pain Y N P High blood pressure Y N P Heart disease Y N P Swollen ankles Y N P Palpitations Y N P Rheumatic fever Y N P Palpitations Y N P Fluttering Y N P Change in thirst Y N P Fluttering Y N P Heartburn Y N P Dizzinessing gas Y N P Change in thirst Y N P Swollen ankles Y N P Heartburn Y N P Swollen ankles Y N P Change in thirst Y N P Change in appetite Y N P Heartburn Y N P Jaundice/Yellow skin Y N P Hemorrhoids Y N P Jaundice/Yellow skin Y N P Ulcers Y N P Liver disease Y N P Bowel movements: How often? Consistency & Color List this a change? Y N P Bowel movements: How often? List this a change? Y N P Kidney stones Y N P Increased frequency Y N P Nighttime frequency Y N P Increased frequency Y N P Pain with urination Y N P Urethral discharge Y N P Pain with urination Y N P Urethral discharge Y N P Pain with urination Y N P Urethral discharge Y N P Pain with urination Y N P Urethral discharge Y N P Pain with urination Y N P	Dental cavities							
Difficulty speaking Y N P Chewing tobacco Y N P	Hoarseness	Υ	N	Р	Sore tongue	Υ	N	
Neck Goiter Y N P Pain/Stiffness Y N P Swollen glands Y N P Injuries Y N P Swollen glands Y N P Injuries Y N P Respiratory Asthma/Wheezing Y N P Bronchitis Y N P Emphysema Y N P Pneumonia Y N P Tuberculosis Y N P Short of breath Y N P Spitting up blood Y N P with exertion Y N P Difficult/Painful breathing Y N P While lying down Y N P Cardiovascular Angina Y N P Dizziness after standing Y N P Heart disease Y N P High blood pressure Y N P Heart disease Y N P Rheumatic fever Y N P Palpitations Y N P Rheumatic fever Y N P Heartburn Y N P Fluttering Y N P Heartburn Y N P Swollen ankles Y N P Heartburn Y N P Short of breath Y N P Heartburn Y N P Swollen ankles Y N P Heartburn Y N P Swollen ankles Y N P Heartburn Y N P Change in appetite Y N P Hemorrhoids Y N P Jaundice/Yellow skin Y N P Hemorrhoids Y N P Liver disease Y N P Hemorrhoids Y N P Liver disease Y N P Hemorrhoids Y N P Liver disease Y N P Hemorrhoids Y N P Liver disease Y N P Hemorrhoids Y N P Constipation Y N P Bowel movements: How often? Stiflney Stones Y N P Frequent infections Y N P Kidney Stones Y N P Increased frequency Y N P Nighttime frequency Y N P Pain with urination Y N P Urethral discharge Y N P Pain with urination Y N P Urethral discharge Y N P Pain with urination Y N P Urethral discharge Y N P Pain with urination Y N P	Dentures	Υ	N	Р	Ulcerations	Υ	N	Ρ
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Murmurs Y N P Rheumatic fever Y N P Palpitations Y N P Fluttering Y N P Palpitations Y N P Fluttering Y N P Gastrointestinal Blood in stool Y N P Belching/Passing gas Y N P Change in thirst Y N P Change in appetite Y N P Heartburn Y N P Vomiting Y N P Hemorrhoids Y N P Jaundice/Yellow skin Y N P Ulcers Y N P Liver disease Y N P Hernia Y N P Constipation Y N P Diarrhea Y N P Abdominal pain Y N P Bowel movements: How often? Consistency & Color Is this a change? Y N Foul odor? Y N P Kidney stones Y N P Frequent infections Y N P Kidney pain Y N P Increased frequency Y N P Nighttime frequency Y N P Pain with urination Y N P	Chest pain	Υ	N	Р	High blood pressure	Υ	N	Ρ
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Gastrointestinal Blood in stool Y N P Belching/Passing gas Y N P Change in stool Y N P Belching/Passing gas Y N P Change in thirst Y N P Change in appetite Y N P Hearntburn Y N P Vomiting Y N P Hemorrhoids Y N P Jaundice/Yellow skin Y N P Ulcers Y N P Liver disease Y N P Hernia Y N P Constipation Y N P Diarrhea Y N P Abdominal pain Y N P Bowel movements: How often?	Murmurs	Υ	N	Р	Rheumatic fever	Υ	N	Р
Blood in stool Y N P Belching/Passing gas Y N P Change in thirst Y N P Change in appetite Y N P Heartburn Y N P Vomiting Y N P Hemorrhoids Y N P Jaundice/Yellow skin Y N P Ulcers Y N P Liver disease Y N P Hernia Y N P Constipation Y N P Diarrhea Y N P Abdominal pain Y N P Bowel movements: How often? Is this a change? Y N Foul odor? Y N P N P Increased frequency Y N P N Increased frequency Y N P Incontinence Y N P N P Incontinence Y N P Incontinence Y N P N P N Incontinence Y N P P P P Incontinence Y N P P P P P P P Incontinence Y N P P P P P P P P P P P P P P P P P P	Palpitations	Y	N	Р	Fluttering	Υ	N	Р
Blood in stool Y N P Belching/Passing gas Y N P Change in thirst Y N P Change in appetite Y N P Heartburn Y N P Vomiting Y N P Hemorrhoids Y N P Jaundice/Yellow skin Y N P Ulcers Y N P Liver disease Y N P Hernia Y N P Constipation Y N P Diarrhea Y N P Abdominal pain Y N P Bowel movements: How often? Is this a change? Y N Foul odor? Y N P Firequent infections Y N P N Foul odor? Y N P Increased frequency Y N P N N P Increased frequency Y N P N N P Incontinence Y N P N N P Nighttime frequency Y N P Incontinence Y N P Pain with urination Y N P Urethral discharge Y N P	Gastrointostinal							
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Is this a change? Y N Foul odor? Y N Foul odor? Y N Urinary Kidney stones Y N P Frequent infections Y N P Kidney pain Y N P Increased frequency Y N P Nighttime frequency Y N P Incontinence Y N P Pain with urination Y N P Urethral discharge Y N P	Bowel movements: H	low ofte	en?					
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Kidney painYNPIncreased frequencyYNPNighttime frequencyYNPIncontinenceYNPPain with urinationYNPUrethral dischargeYNP				_				
Nighttime frequency Y N P Incontinence Y N P Pain with urination Y N P Urethral discharge Y N P	•				•			
Pain with urination Y N P Urethral discharge Y N P		Υ	N	Р		Υ	N	Р
	Nighttime frequency	Υ	N	Р	Incontinence	Υ	N	Р
Hesitancy Y N P Dribbling Y N P	Pain with urination	Υ	N	Р	Urethral discharge	Υ	N	Р
	Hesitancy	Υ	N	P	Dribbling	Υ	N	Р

Female Reproductive

Date and results of	last pa	p smear	·							
History of abnormal	pap sı	mears: \	′ / N							
Age menses began					Birth Control Y	1	N	Р		
Age menopause beg	gan				Туре					
Average # of days of	of flow				Days between periods _					
Irregular cycles		Υ	N	Р	Painful menses Y	1	N	Р		
Number of pregnan	cies				Number of live births	,				
Number of miscarria	ages _				Number of abortions					
Difficulty conceiving				P	PMS Y	1	N	P		
Pain during intercou			N		Excess flow Y			P		
Menopausal sympto			N	Р	Sexual difficulties Y			Р		
Are you sexually act	ive	Y	N		History of venereal disea	ase \	Y	N	Р	
Breasts Do you do self exan	20	Υ	N		Lumps Y	1	N	Р		
Pain	15	Y	N	Р	Nipple discharge Y			P		
		-						Г		
Last mammogram a	nd find	dings: _								
Male Reproductiv	<u>e</u>									
Do you do testicular	self e	xams?	Υ	N	Hernias Y	ſ	N	Р		
Testicular pain	Υ	N	Р		Sexual difficulties Y	1	N	Р		
Testicular pain Testicular masses	Υ	Ν	Р		Penile discharge Y	1	N	Р		
Venereal disease	Υ	Ν	Р		Difficult urination Y		N	Р		
Prostate pain	Υ	Ν	Р		Prostate disease Y	1	N	Р		
Sexually active	Υ	N								
Birth control type _										
Last digital prostate	exam	and find	lings: _							· · · · · · ·
Last Prostate Specif	ic Anti	gen (PSA	A) meas	surement	and value:					
Musculoskeletal										
Joint pain/stiffness		Υ	Ν	Р	Broken bones Y	1	N	Р		
Joint swelling		Υ	Ν	Р	Muscle weakness Y	1	N	Р		
Muscle cramps/spas	sms	Υ	N	Р	Arthritis Y	1	N	Р		
Peripheral vascul	<u>ar</u>									
Deep leg pains	Υ	N	P		Cold hands & feet Y		N	P		
Varicose veins	Y	N	P		Numb hands & feet Y		N	P		
Thrombophlebitis	Υ	N	Р		Pain in legs while walkin	ıg Y 🏻 1	N	Р		

<u>Neurological</u>			_				_	
Dizziness	Y	N	P		Numbness/tingling Y		P	
Fainting	Y	N	P		Memory loss Y		P	
Seizures	Y	N	P		Paralysis Y		P	
Stroke	Υ	N	Р		Tremors Y	N	Р	
Endocrine and Blo	<u>ood</u>							
Anemia	Υ	N	Р		Excessive thirst Y	N	Р	
Hypothyroid	Υ	N	Р		Easy bleeding/bruising `	Y N	Р	
Excessive hunger	Υ	N	Р		Heat/cold intolerance Y	N	Р	
Excessive fatigue	Υ	N	Р		Insomnia Y	N	Р	
Low/altered libido	Υ	N	Р					
Mental and Emoti	<u>onal</u>							
Excessive fears	Υ	N	Р		Anxiety/nervousness Y	N	Р	
Mood swings	Υ	N	Р		Depression Y	N	Р	
Tension	Υ	N	Р		Excessive anger Y	N	Р	
<u>Habits</u>								
Do you awaken rest	ed	Υ	N		What are your main hol	obies/inte	erests?	
Sleep well		Υ	N					
Ave. hours s	leep							
Enjoy your job?		Υ	N					
Watch TV?		Y	N		What forms of exercise	do you c	get and	
Hours per day					how often?			
			N.					
Read?		Y	N					
Hours per day					Take vacations? Y	N		
Have you ever been	treate	d for al	cohol d	ependency?	Y N Drug dep	pendency	/? Y	N
If yes, when	and w	here? _						
Do you use recreation	onal dr	ugs?	Υ	N				
Do you consume ald	cohol?		Υ	N				
How much?					How often?			
Do you smoke cigar			Y	N				
Age started?	·				How much per day?			
Have you ev	er smo	ked?	Υ	N	When did you quit?			

Do you use chewing (smokeless) tobacco	? Y	N	
Age started?		_	How much per day?
Have you ever used chewing tobacco?	Υ	N	When did you quit?

Thank you for taking the time to fill out this form completely. Don't worry if you were not able to answer some of the questions. During your office visit, we will discuss some of your responses in detail. Please feel free to attach any additional sheets describing your medical history or symptoms in detail.

Neural Therapy History: Please be as accurate as possible and include age of occurrence.

Surgery	Age	Toxic Profession past or present	Age
Injuries, Accidents without Stitches	Age	Major Psychological Trauma	Age
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		Serious Infections & Diseases	Age
Typical childhood vaccinations?			
Yes No			
Long Periods of Prescription, Street Drugs,	Age	Injuries or Accidents with Stitches	Age
Alcohol or Cigarettes			
Long Visits or Lived in Foreign Country like India, China, Mexico, Africa, etc.	Age	Dental Intervention — root canal, extraction	Age
India, China, Mexico, Africa, etc.			
Treated for Parasites, Infections? Yes No			
Pregnancies, Births, Abortions, IUDs, Birth	Age	Medications & Allergies, past or present	Age
Control Pill use, etc			

Consent to Naturopathic Treatment Provided by Paloma Defuentes, N.D.

- 1. This is to acknowledge that I have been informed and understand that:
 - a) Any treatment or advice provided to me as a patient of Paloma Defuentes, N.D. is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider.
 - b) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider.
 - c) I understand that Paloma Defuentes, N.D. is not preventing me from seeking or following the advice of another licensed health care provider.
 - d) The treatment and therapies provided to me by Paloma Defuentes, N.D. may be different from those offered by another licensed health care provider.
- 2. I agree to pay for any fees for services, costs of supplements and homeopathic remedies, cost of laboratory tests, or other fees at the time of the visit.
- 3. I hereby authorize and consent to treatment.

9. I have read and agree to all terms and policies.

- 4. I understand that what we talk about will remain confidential exception of the a case where I feel you or someone else will get hurt. This includes such things as: suicide, homicide, and reportable crimes such as physical or sexual abuse. If you have questions, please ask me.
- 5. I understand that the information I provide will be handled in accordance with patient confidentiality and HIPPA laws.
- 6. I understand that this office uses an outside billing agency for billing.
- 7. Authorization/Assignment: I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to be paid to Montana Naturopathic Clinic and I'm fully financially responsible for non-covered services. I understand and agree to pay any collection fees, interest, court fees, and attorney fees if my account is placed in collections or court for non-payment.
- 8. Please refer to the HIPPA policy on my website under the "Clinic Forms" tab.

	Date:
Patient Signature	