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 # _____ Home Phone _____ Work Phone _____

Email address _____

◯ Married ◯ Partnered ◯ Separated ◯ Divorced ◯ Widowed ◯ Single | Children? ◯ Yes ◯ No

How did you hear about us? _____

Where, when, from whom, and for what reason did you last receive any health care?

_____

_____

Please list, in order of importance, your health concerns and/or goals.

1. _____

2. _____

3. _____

4. _____

Family Health History: Y = Yes N = No D = Caused Death (age of death) P = In the past
Please indicate if a family member has had any of the following. If yes, specify who.

Anemia	◯ Y	◯ N	◯ D	◯ P	_____
Arthritis	◯ Y	◯ N	◯ D	◯ P	_____
Asthma / Hay fever	◯ Y	◯ N	◯ D	◯ P	_____
Cancer (type?)	◯ Y	◯ N	◯ D	◯ P	_____
Cystic Fibrosis	◯ Y	◯ N	◯ D	◯ P	_____

Diabetes	◯Y	◯N	◯D	◯P	_____
Eating Disorder	◯Y	◯N	◯D	◯P	_____
Epilepsy	◯Y	◯N	◯D	◯P	_____
Fibromyalgia	◯Y	◯N	◯D	◯P	_____
Glaucoma	◯Y	◯N	◯D	◯P	_____
Heart Disease (incl heart attacks)	◯Y	◯N	◯D	◯P	_____
Hypertension (high blood pressure)	◯Y	◯N	◯D	◯P	_____
Kidney Disease	◯Y	◯N	◯D	◯P	_____
Mental Illness	◯Y	◯N	◯D	◯P	_____
Lung Disease	◯Y	◯N	◯D	◯P	_____
Stroke	◯Y	◯N	◯D	◯P	_____
Substance Abuse (drugs, alcohol)	◯Y	◯N	◯D	◯P	_____
Venereal Disease	◯Y	◯N	◯D	◯P	_____

Blood Type (please check one) ◯ **A** ◯ **B** ◯ **AB** ◯ **0**

Childhood Illnesses Please check if you have had any of the following:

☐ Scarlet fever ☐ Measles ☐ Diphtheria ☐ Rubella (German measles) ☐ Chicken pox

☐ Rheumatic fever ☐ Mumps ☐ Others _____

Date of last Tetanus shot _____

Allergies:

Drugs? _____

Foods? _____

Environmental? _____

Have you ever been hospitalized? Please list when and why.

Illnesses: _____

Surgeries: _____

Other: _____

Medications: Please indicate if you have used any of the following.

Appetite suppressants	○Y ○N ○P	Sleeping pills	○Y ○N ○P
Antacids	○Y ○N ○P	Pain relievers	○Y ○N ○P
Birth Control Pill or Implant	○Y ○N ○P	Other Hormones	○Y ○N ○P
Thyroid Medicine	○Y ○N ○P	Tranquilizers	○Y ○N ○P
Laxatives	○Y ○N ○P	Cortisone	○Y ○N ○P

Please list current prescription drugs, over-the-counter drugs, vitamins, herbs, or other supplements and the reason for taking them.

_____

_____

_____

_____

Health Conditions Y = Yes N = No P = A condition you've had in the past

Skin

Acne	○Y	○N	○P	Boils	○Y	○N	○P
Color Changes	○Y	○N	○P	Eczema	○Y	○N	○P
Hives	○Y	○N	○P	Itching	○Y	○N	○P
Lumps	○Y	○N	○P	Moles	○Y	○N	○P
Rashes	○Y	○N	○P	Psoriasis	○Y	○N	○P

Head

Hair loss	○Y	○N	○P	Headaches	○Y	○N	○P
Head injury	○Y	○N	○P	Skull fracture	○Y	○N	○P

Eyes

Eye pain	○Y	○N	○P	Cataracts	○Y	○N	○P
Double vision	○Y	○N	○P	Dryness	○Y	○N	○P
Glasses/Contacts	○Y	○N	○P	Glaucoma	○Y	○N	○P
Impaired vision	○Y	○N	○P	Tearing	○Y	○N	○P
Injuries	○Y	○N	○P	Date of last eye exam _____			

Ears

Discharge	○Y	○N	○P	Earaches	○Y	○N	○P
Dizziness	○Y	○N	○P	Impaired hearing	○Y	○N	○P
Ringing	○Y	○N	○P	Injuries	○Y	○N	○P

Nose and Sinuses

Frequent colds	○Y	○N	○P	Hay fever	○Y	○N	○P
Nose bleeds	○Y	○N	○P	Sinus pain	○Y	○N	○P

Stuffiness	Y	N	P	Persistent runny nose	Y	N	P

Mouth and Throat

Bleeding gums	Y	N	P	Difficulty swallowing	Y	N	P
Dental cavities	Y	N	P	Sore throats	Y	N	P
Hoarseness	Y	N	P	Sore tongue	Y	N	P
Dentures	Y	N	P	Ulcerations	Y	N	P
Difficulty speaking	Y	N	P	Chewing tobacco	Y	N	P

Neck

Goiter	Y	N	P	Pain/Stiffness	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
Chest pain	Y	N	P	High blood pressure	Y	N	P
Heart disease	Y	N	P	Swollen ankles	Y	N	P
Murmurs	Y	N	P	Rheumatic fever	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

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
Hesitancy	Y	N	P	Dribbling	Y	N	P

Female Reproductive

Date and results of last pap smear _____

History of abnormal pap smears: Y / N _____

Age menses began _____ Birth Control Y N P

Age menopause began _____ Type _____

Average # of days of flow _____ Days between periods _____

Irregular cycles Y N P Painful menses Y N P

Number of pregnancies _____ Number of live births _____

Number of miscarriages _____ Number of abortions _____

Difficulty conceiving	Y	N	P	PMS	Y	N	P	
Pain during intercourse	Y	N	P	Excess flow	Y	N	P	
Menopausal symptoms	Y	N	P	Sexual difficulties	Y	N	P	
Are you sexually active	Y	N		History of venereal disease	Y	N	P	

Breasts

Do you do self exams	Y	N		Lumps	Y	N	P	
Pain	Y	N	P	Nipple discharge	Y	N	P	

Last mammogram and findings: _____

Male Reproductive

Do you do testicular self exams?	Y	N		Hernias	Y	N	P	
Testicular pain	Y	N	P	Sexual difficulties	Y	N	P	
Testicular masses	Y	N	P	Penile discharge	Y	N	P	
Venereal disease	Y	N	P	Difficult urination	Y	N	P	
Prostate pain	Y	N	P	Prostate disease	Y	N	P	
Sexually active	Y	N						

Birth control type _____

Last digital prostate exam and findings: _____

Last Prostate Specific Antigen (PSA) measurement and value: _____

Musculoskeletal

Joint pain/stiffness	Y	N	P	Broken bones	Y	N	P	
Joint swelling	Y	N	P	Muscle weakness	Y	N	P	
Muscle cramps/spasms	Y	N	P	Arthritis	Y	N	P	

Peripheral vascular

Deep leg pains	Y	N	P	Cold hands & feet	Y	N	P	
Varicose veins	Y	N	P	Numb hands & feet	Y	N	P	
Thrombophlebitis	Y	N	P	Pain in legs while walking	Y	N	P	

Neurological

Dizziness	◯Y	◯N	◯P	Numbness/tingling	◯Y	◯N	◯P
Fainting	◯Y	◯N	◯P	Memory loss	◯Y	◯N	◯P
Seizures	◯Y	◯N	◯P	Paralysis	◯Y	◯N	◯P
Stroke	◯Y	◯N	◯P	Tremors	◯Y	◯N	◯P

Endocrine and Blood

Anemia	◯Y	◯N	◯P	Excessive thirst	◯Y	◯N	◯P
Hypothyroid	◯Y	◯N	◯P	Easy bleeding/bruising	◯Y	◯N	◯P
Excessive hunger	◯Y	◯N	◯P	Heat/cold intolerance	◯Y	◯N	◯P
Excessive fatigue	◯Y	◯N	◯P	Insomnia	◯Y	◯N	◯P
Low/altered libido	◯Y	◯N	◯P				

Mental and Emotional

Excessive fears	◯Y	◯N	◯P	Anxiety/nervousness	◯Y	◯N	◯P
Mood swings	◯Y	◯N	◯P	Depression	◯Y	◯N	◯P
Tension	◯Y	◯N	◯P	Excessive anger	◯Y	◯N	◯P

Habits

Do you awaken rested ◯Y ◯N

Sleep well ◯Y ◯N

Ave. hours sleep _____

Enjoy your job? ◯Y ◯N

Watch TV? ◯Y ◯N

Hours per day _____

Read? ◯Y ◯N

Hours per day _____

What are your main hobbies/interests?

_____

_____

_____

What forms of exercise do you get and how often? _____

_____

Take vacations? ◯Y ◯N

Have you ever been treated for alcohol dependency? ◯Y ◯N Drug dependency? ◯Y ◯N

If yes, when and where? _____

Do you use recreational drugs? ◯Y ◯N

Do you consume alcohol? ◯Y ◯N

How much? _____ How often? _____

Do you smoke cigarettes? ◯Y ◯N

Age started? _____ How much per day? _____

Have you ever smoked? ◯Y ◯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? ◯ Y ◯ 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
			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	Age		Dental Intervention – root canal, extraction	Age
India, China, Mexico, Africa, etc.				
Treated for Parasites, Infections? Yes No				
Pregnancies, Births, Abortions, IUDs, Birth Control Pill use, etc	Age		Medications & Allergies, past or present	Age

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.

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.

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

_____ Date: _____

Patient Signature