



remède
NATUROPATHICS

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Welcome to Remède Naturopathics. Our philosophy and approach to care is holistic and seeks to understand all the factors that may be affecting your health. This intake form will help us uncover the root cause of your health concerns. Please fill out as much of it as possible before your appointment. We look forward to meeting you.

Our fax # is: 212.254.2216

INTAKE FORM

Name: _____
(Last name) *(First)* *(Initial)*

Date of birth: _____ Sex: Male Female
(Month/Day/Year)

Occupation: _____

Level of formal education: _____

Names of family members who are patients at our clinic:

- 1) _____
- 2) _____
- 3) _____

Contact Information:

Please inform the clinic if your contact information changes

Address: _____
(Street and number) *(City)* *(State)* *(Zip code)*

Phone: _____
(Daytime) *(Evening)* *(Fax)*

Email: _____

Emergency contact: _____
(Name) *(Relationship)*

_____ *(Daytime phone number)* *(Evening phone number)*

How did you hear about our clinic? _____

We are deeply appreciative when family, friends and healthcare providers refer people to our clinic. In order to send them a token of our appreciation, please provide us with their name and address:

Referred by: _____
(Name) *(Address)*

Your Healthcare Providers:

Who is your primary care physician or nurse practitioner?

(Name) (Address)

When was your last physical exam?

(Month) (Year)

Who is your dentist?

(Name) (Address)

When did you last visit a dentist?

(Month) (Year)

Who is your optometrist/ ophthalmologist?

(Name) (Address)

When did you last have your eyesight checked?

(Month) (Year)

Are you currently under the care of a specialist?

1) _____
(Name) (Address)

2) _____
(Name) (Address)

3) _____
(Name) (Address)

Are you currently under the care of an alternative healthcare provider (e.g., acupuncturist, chiropractor, massage therapist)?

1) _____
(Name) (Type) (Address)

2) _____
(Name) (Type) (Address)

3) _____
(Name) (Type) (Address)

HEALTH CONCERNS:

Please list any health concerns in order of importance:

1)
(Describe your condition)
When did it start? _____
Has this condition been diagnosed? Yes No _____
(Diagnosis)
Are you receiving treatment of any kind for this condition? Please describe:

2)
(Describe your condition)
When did it start? _____
Has this condition been diagnosed? Yes No _____
(Diagnosis)
Are you receiving treatment of any kind for this condition? Please describe:

3)
(Describe your condition)
When did it start? _____
Has this condition been diagnosed? Yes No _____
(Diagnosis)
Are you receiving treatment of any kind for this condition? Please describe:

4)
(Describe your condition)
When did it start? _____
Has this condition been diagnosed? Yes No _____
(Diagnosis)
Are you receiving treatment of any kind for this condition? Please describe:

5)
(Describe your condition)
When did it start? _____
Has this condition been diagnosed? Yes No _____
(Diagnosis)
Are you receiving treatment of any kind for this condition? Please describe:

Please list any **allergies** or sensitivities (food, pollen, mold, animals, chemicals) you suffer from or have previously experienced.

Allergy	Age of onset

List all **surgeries** you have had.

Procedure	Year	Complications?

List all **hospitalizations**.

Reason	Year	Outcome

List any **major injuries** you have sustained.

Injury	Year	Outcome

If you are currently experiencing or have experienced any of the following, place a checkmark in the corresponding box.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Measles | <input type="checkbox"/> Polycystic Ovaries |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> German Measles | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Angina/ Heart attack | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cervical Dysplasia | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Nerve damage | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid imbalance |
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other sexually transmitted diseases | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parasites | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> HIV | <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Hives | <input type="checkbox"/> Peritonitis | |
| <input type="checkbox"/> Ectopic Pregnancy | <input type="checkbox"/> HPV | <input type="checkbox"/> Pleurisy | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Intestinal Polyps | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | | |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Kidney Stones | | |
| <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Lupus | | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lyme disease | | |

REVIEW OF SYSTEMS

Please place a checkmark in the corresponding box if you have experienced or are currently experiencing any of the following:

Mental Emotional:

- Abuse
- Anxiety or nervousness
- Depression
- Easily anger
- Indecision
- Irritability
- Memory problems
- Mental illness
- Mood swings
- Panic attacks
- Phobias
- Prolonged sadness or grief

What were the four most stressful events in your life? Are any of these still affecting you?

1. _____
2. _____
3. _____
4. _____

Has there been an event or sickness that you have never fully recovered from?

Endocrine

- 20 lbs change in weight
- Sluggish after eating
- Poor concentration
- Sluggish after coffee
- Generally feel hot
- Generally feel cold
- Hypoglycemia (low blood sugar)
- Mental dullness

Rate your energy level between 1 and 10

1(extreme fatigue) 2 3 4 5 6 7 8 9 10 (vital)

Rate your stress level

1 (relaxed) 2 3 4 5 6 7 8 9 10 (extremely stressed)

At what time of day is your energy the best?

At what time of day is your energy the worst?

Have you recently lost or gained weight?

Yes No

How many hours of sleep do you get a night?

Do you wake feeling rested?

Immune

- Chronic infections
- Frequent antibiotics
- Frequent colds and flus
- Cold sores
- Swollen glands or lymph nodes
- Shingles
- Slow wound healing
- Frequent sore throat

Neurologic

- Paralysis
- Numbness
- Muscle weakness
- Tingling
- Loss of memory
- Loss of balance
- Vertigo or dizziness

Skin Hair and Nails

- Rashes
- Lumps or abscesses
- Excessive perspiration
- Itching
- Change in color
- Strong body odor
- Dry skin
- Hair loss
- Change in the size, shape or color of a mole or freckle
- Night sweats
- Brittle nails
- Warts

How many times have you had a sunburn?

Head, Ears, Eyes, Nose, Throat

- Headaches
- Cataracts
- Color blindness
- Nose bleeds
- Gum Problems
- Poor Night Vision
- Migraine headaches
- Visual disturbances
- Ringing in ears
- Poor sense of smell
- Hoarseness
- Far Sighted
- Jaw pain or clicking
- Excessive tearing
- Earaches
- Post nasal drip
- Teeth Grinding
- Runny nose
- Nearsighted
- Dry eyes
- Impaired hearing
- Loss of smell
- Itchy ear canal
- Breathe through your mouth

Respiratory System

- Chronic cough
- Shortness of breath lying down
- Chronic phlegm
- Pain while breathing
- Cough up blood
- Shortness of breath during the day
- Wheezing

Cardiovascular System

- Chest pain
- Hemorrhoids
- You feel dizzy when you stand up quickly
- Fainting
- Heart palpitations
- Easy bleeding or bruising
- Cold hands and feet
- Your socks leave imprints on your ankles
- Heaviness or pain in legs
- Varicose veins
- Heart murmurs

Gastrointestinal System

- Trouble swallowing
- Nausea
- Blood in stool or on tissue
- Mucous in stool
- Stool floats in bowl
- Heartburn
- Bloating
- Stomach cramps or pain
- Itching around rectum
- Change in thirst
- Gas
- Constipation
- Black stool
- Undigested food in stool
- Change in appetite
- Burping
- Diarrhea or loose stool
- Hard stool
- Grey Stool

How often do you have a bowel movement? _____

Have you ever traveled to a third-world country? If so, for how long?

Have you ever had parasites that you are aware of?

Urinary

- Pain on urination
- Frequent bladder infections
- Strong urine odor
- Inability to hold urine
- Kidney infections
- Increased frequency
- Awaken to urinate
- Must strain to urinate
- Pain on urination

Male Reproductive

- Hernia
- Discharge or sores
- Testicular mass
- Sexual difficulties
- Testicular pain
- Impotence
- Low sex drive
- Prostate condition

What is your sexual orientation? _____

Are you sexually active? _____

When was your last prostate exam? _____

Female Reproduction

Age of first menses _____

Age of last menses _____

How long is your cycle (in days)? _____

How many days is your menses? _____

Number of pregnancies? _____

Are you pregnant? _____

Are you trying to conceive? _____

What type of birth control do you use (if any)? _____

Are you sexually active? _____

What is your sexual orientation? _____

DIET

What type of water do you drink? _____

How much water do you drink per day? _____

How many times a week do you eat dairy products? _____

How many times per week do you eat red meat? _____

How many times per week do you eat fish? _____

How many times per week do you eat fruit? _____

How many times per week do you eat vegetables? _____

Do you eat organic food? _____

How often do you eat out? _____

What foods do you crave? _____

How many sodas, coffees and teas do you drink per week? _____

Do you eat smoked foods? _____

Do you have any dietary restrictions? (vegetarian, religious, allergies) _____

FAMILY HEALTH HISTORY

Please indicate which of the below have affected any of your relatives

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Neurological disorder |
| <input type="checkbox"/> Eczema or other skin condition | <input type="checkbox"/> High blood pressure or cholesterol | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Syphilis |
| | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Asthma |

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Sisters			
Brothers			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunt/ Uncle			

Thank you for taking the time to fill out these forms. All information contained herein is strictly confidential.

So that our clinicians can prepare for your visit, please email or fax this form to us before your arrival.

email: info@remedenaturopathics.com

fax: 212.254.2216

CLINIC SERVICES

Naturopathic Medicine – Nicole Egenberger, ND

Initial Comprehensive Consultation	\$275
Follow-up Visit (50 min)	\$175
Follow-Up Visit (30 min)	\$110
Acute Visit (10-15 min, phone optional)	\$45
Pediatric Initial Visit	\$250
Pediatric Follow-up Visit	\$150

Naturopathic Medicine – Caroline Westin-Garcia, ND

Initial Comprehensive Consultation	\$225
Follow-up Visit	\$175
Acute Visit (10-15 min, phone optional)	\$45
Pediatric Initial Visit	\$175
Pediatric Follow-up Visit	\$100

Infrared Sauna Therapy

Single Session	\$50
Package of 6 sessions	\$270

Hydrotherapy

Single Session	\$95
Package of 6 sessions	\$510

Detoxification Programs

The Boost (1-day program)	\$250
Revitalize (1-week program)	\$575
Rejuvenate (3-week program)	\$1,275
Just for you (customized)	varies

Massage Therapy - Carrie Dirks MA, LMT and Michael Dent LMT

Swedish, Deep tissue, Pre-Natal, Hot Stone, Shiatsu, Reflexology

1 Hour Therapeutic Massage	\$95
1 ½ hour Therapeutic Massage	\$135
1 hour Hot Stone Massage	\$125
Series of Six 60-min Therapeutic Massage Sessions	\$513

Acupuncture and Chinese Medicine - M. Allison Keltner L.Ac

Initial consultation and acupuncture treatment	\$130
Series of six acupuncture sessions	\$ 690

Natural Medicines – Vitamins, Minerals and Botanical Remedies

Remède Naturopathics offers a wide range of natural health products that have been carefully selected by Nicole Egenberger, ND. For more details or to place an order, please inquire.

OFFICE POLICIES

PAYMENT FOR SERVICE: You are expected to pay for services at the time they are provided unless other arrangements have been made. Payment may be made by cash, check or credit card.

CANCELLATIONS: When you have a scheduled appointment, time is reserved for you. A minimum of 24 hours notice is required for rescheduling or cancellation of an appointment. With the exception of true emergencies, **you will be charged the full visit fee for any appointment that is not rescheduled with 24hrs notice.**

LATE ARRIVALS: Treatments require a minimum amount of time to be performed safely. If you arrive with less than the minimum amount of time required, we will not be able to provide treatment and you will be charged the full appointment fee.

For Massage therapy, Sauna and Hydrotherapy:

Patients must arrive with at least **15 min remaining** in their session in order to receive treatment.

For Acupuncture:

Patients must arrive with at least **30 min remaining** in their session in order to receive treatment

INSURANCE: Although we will gladly help you with your insurance requests, we do not accept, participate in or file insurance. Please check with your provider to find out which of our services are covered. Flex plans are generally one avenue to seek coverage for alternative care, supplements and psychotherapeutic services.

CONFIDENTIALITY: The privacy and confidentiality of your sessions are extremely important to Dr. Egenberger and Remède Naturopathics. To the degree allowed by law, information about your contact with our office will not be disclosed to any person or organization without your permission.