Dr. Jonathan E. Goodman, ND
New Patient Intake and History Form

Welcome to my practice! Please take the time to complete this form so I can more effectively address your concerns at your first visit. If your visit is for health issues other than weight loss, you may skip the sections from the bottom of page 3 on, but please sign the last page along with the Consent and Privacy Practices forms. Once you have filled them out, you can email them as an attachment to drgoodmannd@gmail.com or fax to 860-584-5748.

Thank you!

What is/are your reason(s) for wanting to see Dr. Goodman?

Your Name: _____A**ddress:**_____

_____**Primary Phone #:** _____ **h/w/c Backup Phone #:** _____**h/w/c**

Birthdate: _____**Age:** _____ **Email:** _____**Ok to add to list? y/n**

Sex: M F T

Circle one: Married Separated Divorced Widowed Single Partnership

Live with: Spouse Partner Parents Children Friends Alone

Student Status: Non-Student Part-time Full-time

School Name: _____

Occupation: _____ **Hrs/wk:** _____ **Retired:** _____

Employer: _____ **Work Address:** _____

How Did You Hear About Dr. Goodman? _____

Have any family members been patients here? _____

Emergency Contact: _____

Relationship: _____ **Phone #:** _____

Address: _____

INSURANCE INFORMATION – If you prefer you can fax a copy of the card(s) with the insured's info if not you.

PRIMARY

Insurance Company: _____

Primary Insurance Holder's Name: _____

Primary Insurance Holder's Date of Birth: _____

Member ID Number: _____

Telephone number on back of insurance card

Member/Provider services [Either 1-800 or 1-866 number] : _____

SECONDARY

Insurance Company: _____

Secondary Insurance Holder's Name: _____

Secondary Insurance Holder's Date of Birth: _____

Member ID Number: _____

Telephone number on back of insurance card

Member/Provider services [Either 1-800 or 1-866 number]: _____

Responsible Party (Complete if someone other than patient is responsible for account)

Name: _____ Relationship to patient: _____
Address: _____Home Phone: _____
Cell Phone: _____ Email: _____Currently a patient here? ○ *Y*○ *N*

I hereby authorize payment of insurance benefits directly to Dr. Goodman. I am responsible for any deductibles, copayments and retroactive fees not covered by my insurance policy.

X _____ _____

DR. JONATHAN GOODMAN
5 MAPLE ST BRISTOL, CT 06010 • 173 OAKWOOD AVE WEST HARTFORD CT 06119
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Signature of patient or parent/guardian if minor **Date**

HEALTH HISTORY

Family History:

Father: Health _____ Age _____ Deceased _____ at age _____ Cause _____
Mother: Health _____ Age _____ Deceased _____ at age _____ Cause _____
# of siblings:_____ # living_____ #deceased: _____ Cause _____

Family Diseases: Check diseases known in your blood relatives (not yourself)

☐ High blood pressure ☐ Allergy ☐ Heart trouble ☐ Anemia
☐ Migraine ☐ Bleeding (abnormal) ☐ Edema ☐ Epilepsy
☐ Strokes ☐ Cancer ☐ Diabetes ☐ Obesity
☐ Kidney disease ☐ Fever
☐ Arthritis

Examinations:

Date of last physical examination _____ Reason:_____
Hospitalizations _____ Dates _____ Reason:_____
X-Rays: Chest _____Stomach _____ Gallbladder _____ Kidney _____Colon _____
Other _____Date of last laboratory tests:_____

Do you now have or have had any of the following?

☐ Itching ☐ Eczema ☐ Hives ☐ Joint pains ☐ Muscle aches
☐ Arthritis ☐ Limitation of motion ☐ Backache ☐ Leg pains ☐ Heel Pains
☐ Pain or stiffness (neck) ☐ Goiter ☐ Swelling, enlarged glands
☐ Asthma ☐ Lung disease ☐ Emphysema Bronchitis ☐ Dizziness
☐ Heart trouble ☐ High blood pressure ☐ Shortness of breath ☐ Palpitation or fluttering
☐ Chest pain ☐ Lips or nails turn blue ☐ Tire easily ☐ Swelling of ankles
☐ Indigestion ☐ Nausea or vomiting ☐ Abdominal pain ☐ Gas or bloating ☐ Diarrhea
☐ Hard bowel movements No. of bowel movements - daily _____ ☐ Colitis
☐ Jaundice ☐ Hemorrhoids ☐ Bleeding or black stools ☐ Hernia
☐ Urinary System ☐ Kidney disease ☐ Bladder disease ☐ Kidney stones
☐ Painful urination ☐ Pus or blood in urine ☐ Albumin or sugar in urine
☐ Dribbling of urine ☐ Varicose veins ☐ Nervousness or anxiety
☐ Trouble sleeping ☐ Headaches ☐ Bored or depressed ☐ Nervous breakdown
☐ Fainting ☐ Edema ☐ Seizures ☐ Numbness ☐ Loss of consciousness
☐ Neuritis or Neuralgia ☐ Paralysis ☐ Celiac Disease/Gluten Intolerance
☐ Diabetes ☐ High Cholesterol ☐ Food Allergies/Sensitivities (list)

Menstrual History:

Menstruation began at age:_____28 day cycle? _____ If no, how many days? _____
Duration of bleeding:_____Pain with periods?_____
Amount of flow : Light _____ Med. _____Heavy _____
Date of 1st day of last menstrual period:_____
Bleeding between periods:_____Bleeding after intercourse:_____
Irritation or discharge:_____Itching or burning _____

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Medication and Supplement Use

Please list the medications and supplements you are currently taking

Name	Dose	Times per day	Condition taken for
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

Add more on separate sheet of paper

Weight History:

When did you first become overweight? (your age then)_____(year) _____

How did your weight gain start? Describe any circumstances: _____

_____

What do you think is the cause of your weight problem:_____

_____

Your present weight: _____ your weight goal: _____height: _____

What was your highest weight? (excluding pregnancy) _____your age then _____# of years ago:_____

What was your lowest weight? _____your age then _____# of years ago:_____

Have you ever stayed the same weight for 10 years or more? Yes/ No

Have you attempted to lose weight before? _____ most lbs lost:_____how long it took:_____

Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results:

_____

_____

Where and when do you do most of your overeating?_____

_____

How many meals do you eat a day? _____ How many times do you snack a day? _____How many times a week do you eat out? _____

What foods do you eat when snacking?

_____

_____

HOW MOTIVATED ARE YOU TO LOSE WEIGHT NOW? (1- NONE, 10 – VERY MOTIVATED)

_____

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ARE YOU ADDICTED TO FOOD? TAKE THE QUIZ

Food Addiction Questionnaire:

Based on Yale University's research and adapted from a scale for substance dependence.

Please answer questions 1-7 using the following scale: 0=never, 1=once per month, 2=2-4 times per month, 3=2-3 times per week, 4=4+ times per week.

1) I find myself consuming certain foods even though I am no longer hungry ___
2) I worry about cutting down on certain foods ___
3) I feel sluggish or fatigued from overeating ___
4) I have spent time dealing with negative feelings from overeating certain foods, instead of spending time in important activities such as time with family, friends, work or recreation ___
5) I have had physical withdrawal symptoms such as agitation and anxiety when I cut down on certain foods. (Caffeinated drinks not included here). ___
6) My behavior with respect to food and eating causes me significant distress ___
7) Issues related to food and eating decrease my ability to function effectively (daily routine, job/school, social or family activities, health difficulties) ___\

IN THE PAST 12 MONTHS – ANSWER YES OR NO TO QUESTIONS 8 AND 9

8) I kept consuming the same types or amounts of food despite significant emotional and/or physical problems related to my eating Y/N
9) Eating the same amount of food does not reduce negative emotions or increase pleasurable feelings the way it used to. Y/N

We will go over your answers and discuss ways of overcoming food addiction as part of your program. Fear not! You don't have to go through this alone.

Please go to next page

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DO YOU HAVE SLEEP APNEA?

Sleep apnea is a common condition that can lead to serious health problems. The following is the Epworth Sleepiness Scale, a common screening test for sleep apnea.

Use the following scale to choose the most appropriate number for each situation:
0 = would never doze or sleep.
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

_____ Sitting and reading
_____ Watching TV
_____ Sitting inactive in a public place
_____ Being a passenger in a motor vehicle for an hour or more
_____ Lying down in the afternoon
_____ Sitting and talking to someone
_____ Sitting quietly after lunch (no alcohol)
_____ Stopped for a few minutes in traffic
_____ While driving

_____ Total score (add the scores up) (This is your Epworth score)

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7 or less = You have a normal amount of sleepiness
8 to 9 = You have a average amount of sleepiness
10 to 15 = You may be excessively sleepy depending on the situation and you may want to seek medic al attention
16 + up = You are excessively sleepy and should seek medical attention

All statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from Dr. Goodman, I accept full liability from any consequences arising there from.

_____ _____
Patient's Signature Date

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CONSENT FOR TREATMENT

General Information: Due to the diversity of modalities offered at this office, your treatment may include any or all of the following general modalities: Acupuncture, Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling and Nutritional Counseling.

Methods, Procedures and Therapeutic Approaches: Your clinician may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns:

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments).
Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
Acupuncture: (insertion of special sterilized needles at specific points on the body)
Topical Treatments and Prepping (includes cupping --a technique using glass cups on the surface of the skin with usually a heat-created vacuum; and Gua Sha--rubbing on an area of the body with a blunt, round instrument)
Herbs/Natural Medicines (prescribing of various therapeutic substances including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters , washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)
Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment.
Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)
Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies.)

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant , since some of the therapies used could present a risk to the pregnancy. We do not use labor-stimulating acupuncture points or any labor-inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Jonathan Goodman regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

_____ _____
Guardian/Personal Representative's Name (PRINT) Patient's Name (PRINT)

_____ _____
Guardian/Personal Representative's Signature Patient's Signature

_____ _____
Relationship/Representative's Authority Date

_____
Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
This office may disclose your health care information to other health care professionals for the purpose of treatment.

Payment
This office may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Emergencies
This office may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or your death,

Public Health
As required by law, this office may disclose your health information to public health authorities for purposes related to: preventing or controlling disease. Injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
This office may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
This office may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
This office may disclose your health information to coroners or medical examiners.

Organ Donation
This office may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research
This office may disclose your health information to researchers conducting research that has been approved by an institutional review board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person to the general public.

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Specialized Government Agencies
This office may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
This office may from time to time distribute post cards reminding patients of the need to update their diagnostic test information or schedule an appointment. Also, newsletters may be sent to patients providing up-to-the-minute information about matters relating to natural medicine. It is not the practice of this office to disclose patient health information in these correspondences.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have the right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of the denial reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by this practice.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about your privacy rights, please contact this office.

Complaints
Complaints about your privacy rights or how this practice has handled your health information should be directed to this office. If you are not satisfied with the manner in which this office handles your request, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of July 19, 2005.

I have read the Privacy Notice and understand my rights contained in the notice.

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By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as prescribed in the Privacy Notice.

_____

Patient's Name (print)

_____ _____

Patient's Signature Date

_____ _____

Authorized Facility Signature Date

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MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your health care provider. In order to give you and all our patients, the best possible care, we request that you review our policy regarding missed appointments.

A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24-hours.

Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients.

If you are unable to keep your scheduled appointment time, please call our office at least 24-hours in advance in order to avoid a missed appointment fee. This charge is not covered by insurance. Your phone call is critical in helping us provide continuous care to all of our valued patients. If you fail to give us notice of your missed appointment, you will be charged a $60 missed appointment fee.

I have read and understand the policy stated above

Signature: _____Date: _____

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