RIPPLE
WELLNESS FOR ALL

Naturopathic Intake

Welcome! Thank you for choosing Ripple for your health care needs.
We are here to help and are excited to share our passion for healing.

Thank you for taking the time to fill out these forms. This information gives us a comprehensive picture of your health status and improves our ability to address your health concerns.

Client Information

Name: _____

Date of Birth: _____ Gender: _____

Reason for visit: _____

_____

Name of previous or current primary care provider:_____

Date of last physical exam: _____

In general, would you say that your health is excellent, very good, good, fair, or poor?

Allergies: please list any allergies you have to

1. Medications:

2. Foods:

3. Environmental:

RIPPLE
WELLNESS FOR ALL

Medications & Supplements: please list any that you are currently taking

Name	Strength	Frequency

Social History

Relationship/Marital Status:
Number of children: Ages:
Occupation: Highest level of education:
Tobacco use: □ Current everyday - amount per day: _____ □ Occasional □ Former - quit date/year: _____ □ Never Alcohol use: Number of alcoholic beverages per week? □ 0 □ 1-7 □ 8-14 □ 15+ Drug use: do you use any recreational drugs?
Have you ever been in a sexual relationship: □ Yes □ No
Number of new sexual partners in the past 12 months:
In the past have you had sex with: □ Men □ Women □ Both
Do you have any history of sexually transmitted infections: □ Yes □ No If yes, specify:

RIPPLE
WELLNESS FOR ALL

Past Medical History (check all conditions that you have been diagnosed with in the past)

Eye/Ear/Nose/Throat		**Musculoskeletal**		**Endocrine**	
Eye conditions:		Rheumatoid arthritis		Diabetes	
Hearing loss		Osteoarthritis		Thyroid problems	
Achalasia/dysphagia		Gout			
		Osteoporosis/osteopenia		**Gastrointestinal**	
Neurological				GERD/acid reflux	
Seizures		**Infectious Disease**		Peptic Ulcer Disease	
Multiple Sclerosis		HIV/AIDS		IBD (Crohn's or Ulcerative Colitis)	
Stroke		Hepatitis		Celiac Disease	
Headaches		Tuberculosis		IBS (Irritable Bowel Syndrome)	
Dementia		Malaria		Liver disease or fatty liver	
Respiratory		**Cardiac**		**Dermatology**	
Asthma		High blood pressure		Skin cancer	
COPD		High cholesterol		Herpes/cold sores	
Emphysema		Heart attack		Psoriasis	
Pneumonia		Heart failure		Eczema	
		Arrhythmia			
Genitourinary				**Mental Health**	
Kidney disease		**Other**		Anxiety	
Enlarged prostate		Cancer:		Depression	
Incontinence				Bipolar	
Kidney stones				Suicide attempt	

RIPPLE
WELLNESS FOR ALL

Past Surgical History

List all past surgeries	Doctor/Location	Date or year

Gynecological History (Females Only)

Are you pregnant or is it likely that you could be pregnant at this time: □ **Yes** □ **No** **If yes, due date:**
Do you have periods: □ **Yes** □ **No** **Are they regular:** □ **Yes** □ **No** **Last Menstrual Period:**
Have you ever had a PAP: □ **Yes** □ **No**
Have you had a history of an abnormal PAP: □ **Yes** □ **No**
Date of last PAP:
Would you like to discuss birth control options: □ **Yes** □ **No**
Current birth control method:

Family History: List any chronic medical conditions. Include high blood pressure, high cholesterol, heart attack, stroke, cancer, mental health, and any known or suspected genetic diseases.

Mother:	**Siblings:**
Father:	
Maternal grandmother:	
Maternal grandfather:	**Children:**
Paternal grandmother:	
Paternal grandfather:	

RIPPLE
WELLNESS FOR ALL

Review of Systems: Please check all symptoms that you ****CURRENTLY**** have.

General:
- ❑ Fever
- ❑ Chills
- ❑ Unintentional weight loss
- ❑ Abnormal weight gain
- ❑ Fatigue

Eyes:
- ❑ Double vision
- ❑ Blurred vision
- ❑ Eye pain

Ears:
- ❑ Tinnitus/ringing in ears
- ❑ Ear pain
- ❑ Difficulty or changes to hearing

Nose:
- ❑ Runny nose
- ❑ Congestion
- ❑ Nose bleeds

Head:
- ❑ Headaches
- ❑ Migraines
- ❑ Sinus pressure

Skin:
- ❑ Itching
- ❑ Rashes
- ❑ Changes in moles

Respiratory:
- ❑ Cough
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Sputum
- ❑ Coughing up blood

Cardiovascular:
- ❑ Chest pain
- ❑ Palpitations
- ❑ Difficulty catching breath
- ❑ Shortness of breath when lying flat
- ❑ Leg swelling

Musculoskeletal:
- ❑ Arthritis
- ❑ Back pain
- ❑ Joint pain
- ❑ Muscle pain

Neurological:
- ❑ Dizziness
- ❑ Numbness
- ❑ Tingling
- ❑ Weakness

Mental Health:
- ❑ Depression
- ❑ Nervousness
- ❑ Change in mood
- ❑ Poor memory

Gastrointestinal:
- ❑ Abdominal pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn/acid reflux
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in stool
- ❑ Black, tarry stool
- ❑ Change in bowel habits
- ❑ Excessive hunger
- ❑ Excessive thirst

Genitourinary:
- ❑ Pain with urination
- ❑ Frequency of urination
- ❑ Urgency
- ❑ Incontinence
- ❑ Awakening frequently to urinate
- ❑ Discharge
- ❑ Itching
- ❑ Odor

Other:

RIPPLE
WELLNESS FOR ALL

Informed Consent Form for Naturopathic Medicine

I, _____, come to Dr. Maria Russell, ND for naturopathic treatment.

I hereby request and consent to the performance of naturopathic treatments and other procedures within the scope of the practice of naturopathic medicine on me by Dr. Russell and/or other licensed naturopathic doctors who or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Russell, including those working at the clinic or office listed below or any other office or clinic.

I understand that the herbs, nutritional supplements, and homeopathic remedies discussed in this office are neither a medical treatment for my condition nor replacement for medication. I agree to inform Dr. Russell immediately if any adverse reactions develop while I am taking these substances. I understand that in all circumstances I should continue to consult with my regular physician in regard to all medical concerns that I may have.

Accordingly, I sign this Informed Consent, to express that it is my own decision without undue persuasion to see Dr. Russell for naturopathic treatment. I hold no party responsible for my own actions. I hereby release Dr. Maria Russell from liability for any results that may occur to me thereafter.

Patient Signature _____

Parent or guardian signature _____

Date _____

Thank you for taking the time to fill out these forms.

I am looking forward to working with you!