Naturopathic Medicine Intake Forms

Patient Information

All information is kept completely confidential and will assist Dr. Weronika Lewkowicz, ND with treatment direction and plan of care development.

First Name: _____ **Last Name** :_____

Preferred Name (if different): _____

Date of Birth: _____ **Sex:** _____

Mobile Phone: ( ) _____ - _____

Home Phone: ( ) _____ - _____ **Work Phone:** ( ) _____ - _____

Street Address: _____

City: _____ **State**: _____ **Zip** :_____

Occupation: _____ **Guardian (if applicable):** _____

Emergency Contact: _____ **Emergency Contact Phone:** _____

Emergency Contact Relationship:_____

Primary Care Physician: _____ **PCP Phone Number:** _____

Name of referring professional _____

How did you hear about us? _____

Are you currently a Connect Physical Therapy LLC physical therapy patient?: Y / N

Medical Intake and Health History

Current Health Concerns (list most important concerns you would like to address)

1. _____

2. _____

3. _____

Current Medications + Supplements

- _____ - _____
- _____ - _____
- _____ - _____

Past Medical History

Childhood Illness (if any out of the ordinary) _____

Previously Diagnosed Illnesses / Conditions _____

Surgeries (please include year) _____

Hospitalizations (please include year) _____

Physical / Emotional / Mental Trauma _____

Other _____

Allergies (Drug, Environmental, or Food) _____

Family History (list parent, grandparent, sibling, or child next to options)

- ☐ Depression_____
- ☐ Anxiety _____
- ☐ ADHD / ADD _____
- ☐ Autism _____
- ☐ Other Mood Disorders_____
- ☐ Hypertension _____

- ☐ High Cholesterol _____
- ☐ Diabetes _____
- ☐ Cancer _____
- ☐ Heart Problems_____
- ☐ Alzheimer's or other dementia _____
- ☐ Other _____

Lifestyle

Exercise? Y / N Kind _____ ____Days/week ____Minutes/day

Occupation: _____

diet (list general diet): _____

water intake (oz) _____

caffeine intake (cups) _____

soda intake (cans / bottles) _____

smoking (list in packs per day) _____

alcohol/number of drinks - please circle: 0-2 per week 2-4 per week 4+ per week

recreational drugs _____

sexual activity (active or not) _____

Energy (please circle below)

0 1 2 3 4 5 6 7 8 9 10 (best)

Hours of Sleep (please circle below)

0 1 2 3 4 5 6 7 8 9 10

Sleep Issues _____

Stress (please circle below)

0 1 2 3 4 5 6 7 8 9 10 (most stressed)

Source(s) of Stress _____

Male Health (fill out only if it applies to you)

Prostate Concerns _____

Urinary Concerns (dribbling, incontinence, split stream) _____

Erectile Dysfunction Y / N

Viagra (or equivalent) Use Y / N

Reproductive Female Health (fill out only if it applies to you)

menses flow /# pads, #tampons _____

clots Y / N

PMS (list symptoms) _____

cycle length _____ days

# of pregnancies _____

# of births _____

history of miscarriages Y / N

currently in menopause (list symptoms) _____

contraceptive use Y / N

last pelvic exam (month and year) _____

history of abnormal PAP Y / N any complications? _____

Review of Systems

Constitutional (circle which apply)

changes in appetite	chills, fatigue	fever
headache	night sweats	sleep disturbance
weight loss	weight gain	

Eyes (circle which apply)

vision changes	vision impairment	blurred vision
use of contact lenses	use of glasses	dry eyes
red eyes	eye discharge	eye strain
itchy eyes	floaters in visual field	flashes of light in visual field

Ears/Nose/Throat (circle which apply)

seasonal allergies	rhinitis	sinus congestion
sinus pain	snoring	sore throat
postnasal drip	painful swallowing	swollen glands/tonsils

Endocrine (circle which apply)

acne	cold intolerance	heat intolerance
difficulty sleeping	dizziness	excessive sweating
excessive thirst	frequent urination	hair loss
hot flashes	irregular menses	thyroid

Cardiovascular (circle which apply)

Palpitations	irregular heart beat	chest pain at rest
chest pain with exertion	blue lips	difficulty lying flat
dizziness	heart murmur	heart problems
high blood pressure	high cholesterol	shortness of breath
swelling in extremities	absent pulses	blood clots
pain / cramping in legs	ulcerations / varicosities	

Respiratory (circle which apply)

Asthma	cough	wheezing
shortness of breath	difficulty breathing	difficulty breathing at rest
difficulty breathing with exertion		sputum production

Breast/Chest (circle which apply)

breast tenderness	breast changes	nipple discharge
breast pain	breast swelling	rashes
red skin	gland swelling	breast asymmetry

GI (circle which apply)

abdominal pain	changes in bowel habits	daily bowel movement
difficulty passing stool	changes in stool consistency	heartburn
reflux	nausea	vomiting
diarrhea	constipation	undigested food in stool
mucous in stool	blood in stool	decreased appetite
rectal bleeding	hemorrhoids	

GU (circle which apply)

increased urinary frequency	decreased urinary frequency	difficulty urinating
urinary incontinence	pelvic pain	pain with sex
lower back pain	kidney problems	kidney stones
blood in urine	foul smelling urine	changes in vaginal discharge
foul smelling vaginal or penile discharge		swollen gland

MSK (circle which apply)

decreased range of motion	joint pain	joint redness
joint swelling	muscle pain	muscle soreness
leg cramps	recent injury	trauma
sciatica	weakness	

Neuro (circle which apply)

Numbness	tingling	muscle weakness
balance difficulties	lack of coordination	difficulty speaking
facial changes	dizziness	fainting
headache	loss of strength	loss of use of extremity
memory impairment	memory loss	paralysis
seizures stroke	tics	tremor

Psych (circle which apply)

anxious mood depressed mood frequent mood changes
irritability difficulty concentrating

loss of interest in things that were previously enjoyable

history of mental illness auditory hallucinations visual hallucinations

difficulty sleeping current disordered eating previous disordered eating
loss of appetite current / past substance abuse

current / previous suicidal ideation history of self-harm

decreased body image or self-esteem

Skin (circle which apply)

new moles / freckles change in moles / freckles acne itching dryness rash

easy bruising/bleeding

Patient Consents

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments. Email _____

☐ I would like email notifications of new, cancelled, and rescheduled appointments

News and Special Promotions

☐ Yes, I would like to receive news and special promotions by email

Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge.

Privacy and Sharing of Information

☐ I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Payment Policy

Connect Physical Therapy LLC collects *payment in FULL at the time of service*. Services are not rendered without payment.

☐ Initial here _____

Dr. Weronika Lewkowicz is considered an Out-Of-Network provider and therefore does not bill insurance in-office. You are welcome to check with your insurance company to verify your Out-Of-Network benefits for naturopathic visits as some carriers allocate coverage and may be able to reimburse part or all of the visit costs. If you would like to try and receive reimbursement from your insurance company, a superbill may be provided for you upon request, which you are welcome to submit to your insurance carrier independently.

☐ I am aware of and will abide by Connect Physical Therapy LLC's payment policy

Cancellation Policy

Connect Physical Therapy LLC reserves the right to utilize your future scheduled sessions as needed for other patients if you cancel or no-show for your appointments 2 or more times with-in 24 hours of the scheduled appointment time.

☐ I agree, and I am aware of the cancellation policy

Signature: _____

Print Name:_____

Date: _____

777 Echo Lake Road, Suite I
Watertown, CT 06795

100 Main Street N
Southbury, CT 06488
(@ Catalyst Training Gyms)

Phone: 959-209-4318
Fax: 959-209-4336

www.connectphysicaltherapyllc.com