

James Prego, ND
Long Island Naturopathic, Inc
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(888) 339-8683 / Fax 631-930-3963

New Patient Intake Form

*Welcome! Please complete this questionnaire as thoroughly as possible. Print all information clearly and mark anything you don't understand with a question mark. **Please then e-mail or fax a copy to the office (see above).** All information contained in these pages is completely confidential. If you enjoy your experience here, please tell others. If you don't, please tell us. Thank you.*

Personal Information

Name _____ Today's Date _____

Age _____ Date of birth _____

Home Phone _____ Work _____ Mobile _____

Address _____

City _____ State _____ Zip _____

Email address _____

Gender _____ Marital status _____

Children/other family members _____

Occupation _____ Hours per week _____

Emergency Contact

Name _____

Relationship _____

Phone Number _____

Address _____

Why did you choose to come to this clinic? _____

What do you know about our approach? _____

What three expectations do you have from this visit to our clinic? _____

What long-term expectations do you have from working with our clinic? _____

What expectations do you have of me personally as your physician? _____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

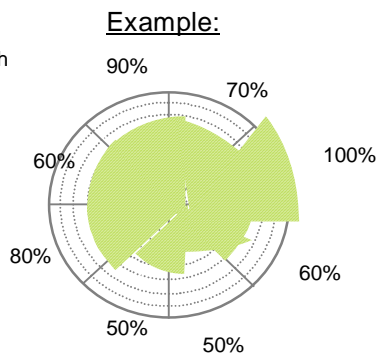
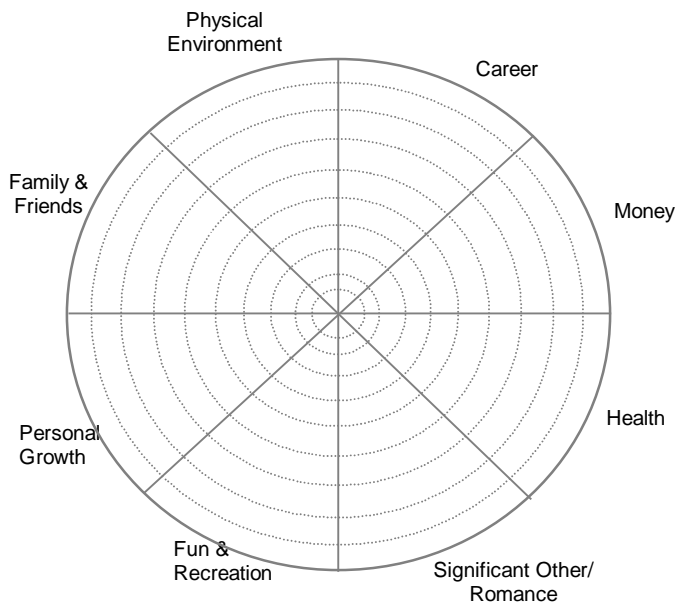
What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do? _____

100
or
80%



Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.

Do you have any known contagious diseases at this time? Y N

If yes, what? _____

Do you have any surgical implants? (dental, cosmetic, reconstructive) Y N

Interests and hobbies _____

Exercise _____ How often _____

Do you have a religious or spiritual practice, and what is it _____

Any other habits you feel are important to mention _____

Health History Questionnaire

Who referred you to our office? _____

Are you currently receiving healthcare? Y N

If yes, where and from whom? _____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Weight _____ Weight 1 yr ago _____

Maximum Weight _____ When? _____

Height _____

Time of day energy is best _____ Worst _____

Family History						
	MOTHER	FATHER	BROTHERS	SISTERS	SPOUSE	CHILDREN
Age (if living)	_____	_____	_____	_____	_____	_____
Health (good/poor)	_____	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____	_____
Check Applicable						
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Allergies	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

Y = condition you currently have, N = never had, P = a condition you had in the past

Childhood Illnesses

Scarlet fever	Y P N	Mumps	Y P N	Chicken Pox	Y P N
Diphtheria	Y P N	Measles	Y P N	German measles	Y P N
Rheumatic Fever	Y P N				

Immunizations

Polio	Y N	Pertussis	Y N	Diphtheria	Y N
Chicken Pox	Y N	Flu	Y N	Pneumonia	Y N
Tetanus shot	Y N	Measles/Mumps/Rubella			Y N
Other _____					

What Hospitalizations have you had and when?

_____	_____
_____	_____

What X-rays, CAT scans, or other studies you have had and when:

_____	_____
_____	_____

Allergies

Drugs_____

Foods_____

Environmental_____

Current Medications

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking

1)_____ 5)_____

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

Typical Food Intake

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Liquids/Drinks_____

Is there *any* information about your health you would like to add_____

DISCLOSURE STATEMENT AND INFORMED CONSENT

1. I, _____ (client name) request, authorize and consent to a program of naturopathic services to be performed by Long Island Naturopathic, and/or James Prego, ND. .

2. I understand that the naturopathic services to be performed is not medical care and/or medical treatment, which may only be provided in the State of New York by a licensed medical provider(s). It is expressly understood that Long Island Naturopathic and/or James Prego, ND does not diagnose and/or treat any disease and/or condition of the client, but rather the services to be provided by Long Island Naturopathic and/or James Prego, ND offers an alternative approach to the client for the condition(s) presented.

3. It is understood that the services to be provided by Long Island Naturopathic and/or James Prego, ND are not to act as a replacement or substitute for proper medical care by licensed, medical providers and that it is the responsibility of the client to obtain such treatment by primary care physicians and/or specialists and to obtain all appropriate tests and evaluations. It is also understood that it is the client's responsibility to inform their primary care physicians and/or other medical providers (and to keep them regularly informed) of the program provided by Long Island Naturopathic and/or James Prego, ND.

4. Client has been advised and understands that James Prego, ND is not a licensed medical doctor in the State of New York, as the State of New York does not presently recognize qualified, naturopathic physicians. It is therefore understood that James Prego, ND does not practice medicine nor does he diagnose and treat any disease and/or condition.

5. It is further understood that the ultimate responsibility for my health is my own and that it is the responsibility of the client to inform Long Island Naturopathic and/or James Prego, ND of their complete medical and family history and of all other relevant factors concerning their condition(s) and to keep them advised of any prescription or over the counter medications that are utilized.

6. It is also understood that a naturopathic program is not an exact science and that the client has received no guarantees about the benefits or results of the services provided.

7. It is also understood that there may be alternative programs, including alternative forms of medical treatment, and that such medical alternatives are to be explained to the client by the appropriate licensed medical provider(s). It is also understood that there are risks attendant to the services provided by Long Island Naturopathic and/or James Prego, ND, including but not limited to unforeseen or allergic reactions or otherwise.

8. Client acknowledges that he/she has read this entire document and understands it and that client has been given the opportunity to ask questions and those questions have been answered to client's satisfaction.

Client/guardian signature

Date

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Expectations

Expect your appointments to be on-time. We only have your scheduled appointment times to achieve our goals.

Bring New Patient Intake forms filled out to the appointment. This is necessary for you to be seen at your first appointment.

Expect to pay for your visit at time of services, and to schedule your next appointment at this time. (check, cash, visa, or mastercard accepted)

Expect your visit time to be devoted to achieving your health goals. Honesty is important, as is avoiding distractions such as cell phone calls, distractions from others, or other interruptions.

There will be a \$50 cancellation fee charged, unless 48hrs notice is given (emergency situations will be considered).

\$20 fee for returned checks. After one returned check, only cash or mastercard/visa will be accepted.

Supplements can only be returned if they are unopened and seal is not broken, and it is within 30 days of purchase.