NATURAL FAMILY HEALTH & INTEGRATIVE MEDICINE, LLC

DR. JODY E. NOÉ MS, ND

PATIENT PROFILE

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____ Gender at birth: _____ Gender: _____

Address Line 1: _____
Address Line 2: _____ Home phone: _____ Cell phone: _____
City: _____ State: _____ Zip: _____ Work phone: _____ Best time to call: _____
Email: _____ Preferred Number (circle one): Home Work Cell
May we email you with medical information? (circle one) YES NO May we leave a message? (circle one): YES NO
May we send you mobile notifications? (circle one) YES NO

S.S.#: _____
Employer: _____ Occupation: _____ Full or Part Time: _____
Address: _____ Education: _____
City: _____ Referred by:_____

Are you (circle all that apply): Married Separated Divorced Single Cohabitating

Live with (circle all that apply): Spouse Partner Parents Relatives Friends Pets Alone

Emergency Contact: _____ Relationship: _____
Address Line 1: _____ Home phone: _____
Address Line 2: _____ Cell phone: _____
City: _____ State: _____ Zip: _____ Work phone: _____

A NOTE TO OUR PATIENTS:

Naturopathic, Holistic and Preventive Healthcare require the physician to have a complete picture of the patient physically, mentally and emotionally. Please take the time to complete this health history questionnaire carefully, accurately, and completely. Your doctor and your health thank you ☺

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____
Any foods? _____
Any chemicals or environmental toxins? _____
What happens to you when you have an "allergy attack?" _____
_____
How severe is the reaction? _____
What prior types of allergy testing have you had? _____

_____ Intradermal _____ Scratch _____ Blood IgG food _____ Blood IgE inhalant/food
_____ Electroacupuncture _____ Kinesiology _____ Cytotoxic _____ Food Intolerance
_____ None

CURRENT HEALTH CONDITION

When, where and from whom did you last receive medical or health care?

_____

What are your most important health concerns?

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Which of the above problems are of most immediate concern? _____

Do you have any contagious diseases at this time: Y __ N __ If yes, what? _____

CURRENT MEDICATIONS

Do you take or use (check all that apply):

___ Laxatives ___ Pain relievers ___ Antacids ___ Cortisone

___ Tranquilizers ___ Thyroid medication ___ Sleeping pills ___ Antibiotics

___ Appetite suppressants ___ Nasal decongestants ___ Birth control pills ___ Hormones

Please list any prescription or over-the-counter medications, vitamins or other supplements you are taking and include dosages:

1._____ 8._____

2._____ 9._____

3._____ 10._____

4._____ 11._____

5._____ 12._____

6._____ 13._____

7._____ 14._____

FAMILY HISTORY

	Father	Mother	Paternal Grandfather	Paternal G.Mother	Maternal G.Father	Maternal G.Mother	Sibling	Sibling	Sibling	Child	Child	Child	Other (specify)	Other (specify)
Ages	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Health	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Check those applicable:														
Anemia	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Asthma/Hayfvr/Hives	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Gout	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Seizure/Epilepsy	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Thyroid Problem	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

PERSONAL HEALTH HISTORY

For the following, please mark:
YES = a condition you now have NEVER = a condition you never had PAST = a condition you have had before

Head	YES	NEVER	PAST		YES	NEVER	PAST
Headaches/migraines	_____	_____	_____	Head injury	_____	_____	_____
Double vision	_____	_____	_____	Jaw/TMJ problems	_____	_____	_____
Dizziness	_____	_____	_____	Fainting spells	_____	_____	_____
Eyes							
Glasses or contacts	_____	_____	_____	Impaired vision	_____	_____	_____
Spots in eyes	_____	_____	_____	Cataracts	_____	_____	_____
Blurriness	_____	_____	_____	Eye pain/strain	_____	_____	_____
Color blindness	_____	_____	_____	Tearing or dryness	_____	_____	_____
Sensitivity to light	_____	_____	_____	Glaucoma	_____	_____	_____
Ears							
Discharge from ears	_____	_____	_____	Pain in ears	_____	_____	_____
Hearing problems	_____	_____	_____	Ringing in ears	_____	_____	_____
Sensitivity to noise	_____	_____	_____	Many ear infections	_____	_____	_____
Nose and Sinuses							
Frequent colds	_____	_____	_____	Nosebleeds	_____	_____	_____
Stuffiness	_____	_____	_____	Hay fever	_____	_____	_____
Sinus problems	_____	_____	_____	Loss of smell	_____	_____	_____
Mouth and Throat							
Frequent sore throat	_____	_____	_____	Copious saliva	_____	_____	_____
Teeth grinding	_____	_____	_____	Mouth ulcers	_____	_____	_____
Bleeding gums	_____	_____	_____	Hoarseness	_____	_____	_____
Speech difficulties	_____	_____	_____	Loss of voice	_____	_____	_____
Neck							
Lumps	_____	_____	_____	Swollen glands	_____	_____	_____
Goiter	_____	_____	_____	Pain or stiffness	_____	_____	_____
Cardiovascular							
Heart disease	_____	_____	_____	Angina	_____	_____	_____
High blood pressure	_____	_____	_____	Low blood pressure	_____	_____	_____
Blood clots	_____	_____	_____	Fainting	_____	_____	_____
Phlebitis	_____	_____	_____	Palpitations	_____	_____	_____
Rheumatic fever	_____	_____	_____	Chest pain	_____	_____	_____
Swelling in ankles	_____	_____	_____	Heart murmurs	_____	_____	_____
Respiratory							
Cough	_____	_____	_____	Sputum production	_____	_____	_____
Spitting up blood	_____	_____	_____	Wheezing	_____	_____	_____
Asthma	_____	_____	_____	Bronchitis	_____	_____	_____
Pneumonia	_____	_____	_____	Pleurisy	_____	_____	_____
Emphysema	_____	_____	_____	Difficulty breathing	_____	_____	_____
Pain on breathing	_____	_____	_____	Shortness of breath	_____	_____	_____
Tuberculosis	_____	_____	_____	" " lying down	_____	_____	_____
Night sweats	_____	_____	_____	" " at night	_____	_____	_____

	YES	NEVER	PAST		YES	NEVER	PAST
Gastrointestinal							
Trouble swallowing	_____	_____	_____	Heartburn	_____	_____	_____
Bad breath	_____	_____	_____	Bad taste in mouth	_____	_____	_____
Change in thirst	_____	_____	_____	Change in appetite	_____	_____	_____
Nausea	_____	_____	_____	Vomiting	_____	_____	_____
Vomiting blood	_____	_____	_____	Constipation	_____	_____	_____
Blood in stool	_____	_____	_____	Diarrhea	_____	_____	_____
Pain or cramps	_____	_____	_____	Gall bladder disease	_____	_____	_____
Belching	_____	_____	_____	Ulcers	_____	_____	_____
Passing gas	_____	_____	_____	Hemorrhoids	_____	_____	_____
Eating disorder	_____	_____	_____	Distress from eating fats	_____	_____	_____
Black stools	_____	_____	_____	Jaundice	_____	_____	_____
Liver disease	_____	_____	_____	Bad body odor	_____	_____	_____
Bowel movements:	How often? _____ per day per week (circle one)			Is this a change?	_____ YES	_____ NO	

Female reproduction/breasts

Age of first menses	_____			Length of cycle	_____		
				Cycles regular	_____	_____	_____
Duration of menses	_____			Pain during intercourse	_____	_____	_____
Bleeding between cycles	_____	_____	_____	Clotting with menses	_____	_____	_____
Painful menses	_____	_____	_____				
PMS	_____	_____	____	If yes, please list your symptoms: _____			
Birth control	_____	_____	_____	Type	_____		
Number of pregnancies	_____			Number of miscarriages	_____		
Number of live births	_____	_____	_____	Number of abortions	_____		
Endometriosis	_____	_____	_____	Ovarian cysts	_____	_____	_____
Difficulty conceiving	_____	_____	_____	Menopausal symptoms	_____	_____	_____
Cervical dysplasia	_____	_____	_____	Abnormal PAP smear	_____	_____	_____
Sexual difficulties	_____	_____	_____	Vaginal discharge	_____	_____	_____
Pelvic pain	_____	_____	_____	Chlamydia	_____	_____	_____
Gonorrhea	_____	_____	_____	Condyloma	_____	_____	_____
Herpes	_____	_____	_____	Syphilis	_____	_____	_____
Do you do breast exams	_____	_____	_____	Breast pain/tenderness	_____	_____	_____
Breast lumps	_____	_____	_____	Nipple discharge	_____	_____	_____
Sexually active	_____	_____	_____				

Male reproduction

Hernias	_____	_____	_____	Testicular Mass	_____	_____	_____
Testicular pain	_____	_____	_____	Prostate disease	_____	_____	_____
Discharge or sores	_____	_____	_____	Herpes	_____	_____	_____
Syphilis	_____	_____	_____	Chlamydia	_____	_____	_____
Gonorrhea	_____	_____	_____	Condyloma	_____	_____	_____
Premature ejaculation	_____	_____	_____	Impotence	_____	_____	_____
Vasectomy	_____	_____	_____	Painful erections	_____	_____	_____
Sexually active	_____	_____	_____				

	YES	NEVER	PAST		YES	NEVER	PAST
Urinary							
Pain on urination	_____	_____	_____	Increased frequency	_____	_____	_____
Frequency at night	_____	_____	_____	Inability to hold urine	_____	_____	_____
Many urinary infections	_____	_____	_____	Problems starting urine	_____	_____	_____
Blood in urine	_____	_____	_____	Kidney stones	_____	_____	_____
Musculoskeletal							
Joint pain or stiffness	_____	_____	_____	Arthritis	_____	_____	_____
Broken bones	_____	_____	_____	Weakness	_____	_____	_____
Muscle spasms or cramps	_____	_____	_____	Back pain	_____	_____	_____
Blood/peripheral vascular							
Easy bleeding/bruising	_____	_____	_____	Anemia	_____	_____	_____
Deep leg pain	_____	_____	_____	Cold hands/feet	_____	_____	_____
Varicose veins	_____	_____	_____	Thrombophlebitis	_____	_____	_____
Fluid retention	_____	_____	_____	Bleeding unusual places	_____	_____	_____
Emotional							
Treated for emotional problems	_____	_____	_____	Anxiety/nervousness	_____	_____	_____
Mood swings	_____	_____	_____	Depression	_____	_____	_____
Considered/attempted suicide	_____	_____	_____	Tension	_____	_____	_____
Excessive worry	_____	_____	_____	Panic attacks	_____	_____	_____
Neurologic							
Seizures/epilepsy	_____	_____	_____	Paralysis	_____	_____	_____
Muscle weakness	_____	_____	_____	Numbness or tingling	_____	_____	_____
Loss of memory	_____	_____	_____	Easily stressed	_____	_____	_____
Vertigo or dizziness	_____	_____	_____	Loss of balance	_____	_____	_____
Endocrine							
Hypothyroid	_____	_____	_____	Heat/cold intolerance	_____	_____	_____
Hypoglycemia	_____	_____	_____	Diabetes	_____	_____	_____
Excessive thirst	_____	_____	_____	Excessive hunger	_____	_____	_____
Fatigue	_____	_____	_____	Seasonal depression	_____	_____	_____
Unexplained weight loss/gain	_____	_____	_____	Change in sexual desire	_____	_____	_____
Immune							
Vaccinations	_____	_____	_____	Reactions to vaccinations	_____	_____	_____
Chronic fatigue syndrome	_____	_____	_____	Chronic infections	_____	_____	_____
Chronically swollen glands	_____	_____	_____	Slow wound healing	_____	_____	_____
Skin							
Rashes	_____	_____	_____	Eczema/hives	_____	_____	_____
Acne/boils	_____	_____	_____	Itching	_____	_____	_____
Color changes	_____	_____	_____	Hair loss	_____	_____	_____
Lumps	_____	_____	_____	Warts	_____	_____	_____

GENERAL INFORMATION

Current Weight: _____ Weight 1 year ago: _____ Maximum weight: _____lbs. When: _____ Height: _____ft. _____ in.

When is your energy the best during the day? _____ Worst? _____

CHILDHOOD ILLNESSES

Check all that apply:

_____ Rubella (German 3-day measles) _____ Measles (2 weeks) _____ Mumps _____ Chickenpox
_____ Whooping cough _____ Rheumatic fever _____ Polio _____ Scarlet fever
_____ Roseola _____ Asthma _____ Others

IMMUNIZATIONS

_____ Pertussis _____ Tetanus _____ Polio _____ Diphtheria
_____ Measles/Mumps/Rubella _____ Hepatitis _____ Others

X-RAYS AND SPECIAL STUDIES

_____ Electrocardiogram (EKG) _____ Electroencephalogram (EEG) _____ Intravenous Pyelogram (IVP)

What x-rays, CAT scans, or other studies have you had?

_____
_____
_____

HOSPITALIZATION AND SURGERY

What hospitalizations or surgeries have you had?

_____
_____
_____

LIFE STYLE

Main interests and hobbies:

_____
_____
_____

Do you exercise? _____ Yes _____ No If yes, what kind? _____
Do you have a religious/spiritual practice? _____ Yes _____ No If yes, what kind? _____
Do you eat 3 meals a day? _____ Yes _____ No If no, how many? _____
Do you average 6-8 hours sleep? _____ Yes _____ No If no, how many? _____
Do you sleep well? _____ Yes _____ No If no, what is the problem? _____
_____
Do you awaken rested? _____ Yes _____ No If no, what is the problem? _____
Do you enjoy your work? _____ Yes _____ No If no, why not? _____
Do you spend time outside? _____ Yes _____ No If yes, how much and in what form?_____
Do you watch television? _____ Yes _____ No If yes, how much? _____
Do you read? _____ Yes _____ No If yes, what and how much?_____
Do you take vacations? _____ Yes _____ No If yes, how long and what kind? _____
Do you have a supportive relationship? _____ Yes _____ No If no, what's wrong with it? _____
Do you have a history of abuse/trauma? _____ Yes _____ No If yes, please describe: _____

AdditionalComments: _____
_____
_____

HABITS

For the following, please mark: YES = a condition you now have NEVER = a condition you never had PAST = a condition you have had before

	NEVER	PAST	YES		NEVER	PAST	YES
Use alcoholic beverages	_____	_____	_____	Ever treated for alcoholism	_____	_____	_____
If yes, list types and amounts:	_____						
Use recreational drugs	_____	_____	_____	Ever treated for drug dependence?	_____	_____	_____
If yes, list types and amounts:	_____						
Smoke tobacco products	_____	_____	_____	Chew tobacco products	_____	_____	_____
If yes, list types and amounts:	_____						
Drink coffee	_____	_____	_____	If yes, amount/frequency: _____			
Drink black tea	_____	_____	_____	Drink cola	_____	_____	_____
Eat out often	_____	_____	_____	Go on diets often	_____	_____	_____
Eat excessive sugar	_____	_____	_____	Eat excessive salt	_____	_____	_____

TYPICAL FOOD INTAKE

Breakfast: When: _____

Food: _____

_____

Lunch: When: _____

Food:_____

_____

Dinner: When: _____

Food:_____

_____

Snacks: When: _____

Food:_____

_____

CURRENT ILLNESS OR CONDITION

How does your condition affect you?

_____

_____

_____

What do you think is happening?

_____

_____

_____

Why?

_____

_____

_____

What do you feel needs to happen for you to get better?

_____

_____

_____

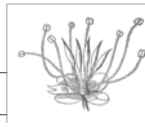
What do you enjoy most in life?

_____

_____

_____

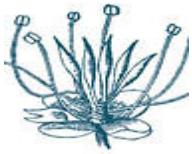
How much change are you willing to make at this time for improving your health?



_____

_____

_____



NATURAL FAMILY HEALTH & INTEGRATIVE MEDICINE, LLC

Dr. **JODY E. NOÉ** MS, ND

48-Hour Cancellation Policy

If you cannot make your appointment, please give us the courtesy of at least 48 hours' notice so that another patient may have the opportunity to see the doctor. Arriving for your appointment 10-15 minutes early will help ensure that you and other patients are seen in a timely manner.

If you are more than 15 minutes late for your scheduled appointment, your appointment may be rescheduled. Of course, exceptions are made for emergencies.

Our physicians are committed to spending enough time with you to listen to your history and perform a thorough physical exam so they can accurately determine the root cause of your symptoms. This limits the number of patients we can see per day. Because of our commitment to quality care for you and our other patients, and the increasing trend of the general public to skip appointments without giving us notice, it has become necessary for us to charge for missed visits (No Shows).

Missed Visits / No Shows

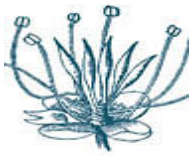
Missed visits (No Shows) is defined as failing to give us 48 hours' notice of your inability to make a scheduled appointment. Patients who no show visits will be charged in the amount of $55.00 for the time reserved. This will *not* be processed through your insurance company.

By signing this notice, I am acknowledging I have received a copy of the 48-hour cancellation policy.

_____ _____ _____ _____

Signature Date Witness Date

82 Norwich Westerly Rd., North Stonington, CT 06359Tel: (860) 495.5688 Fax: (860) 495.5687www.drjodyenoe.com Email: contact@nfhim.com



NATURAL FAMILY HEALTH & INTEGRATIVE MEDICINE, LLC

Dr. **JODY E. NOÉ** MS, ND

Financial Agreement

The undersigned, jointly and severally, in consideration of services to be rendered to patient, agrees to pay the provider of service, in accordance with their regular rates and terms, for the services rendered. The undersigned further agrees to pay reasonable attorney fees and expenses incurred in collecting all sums not paid when due, whether or not litigation is actually commenced, as well as all attorney fees and costs on appeal. The undersigned agrees to pay for all supplements from the apothecary at time of delivery or at time of shipping with the incurring postal fees that may be applicable.

I agree to the above consents, authorizations and financial agreement apply to the Naturopathic medical services provided as long as I am a patient of Dr. Jody E. Noé. I have read, fully understand, and agree to the above statements.

_____ _____

Patient (18 years or older) Date

_____ _____

Patient, Guardian, Responsible Party or Legal Representative Date

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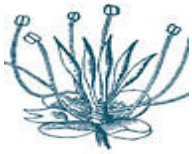

NATURAL FAMILY HEALTH & INTEGRATIVE MEDICINE, LLC

Dr. **JODY E. NOÉ** MS, ND

Assignment of Benefits Form

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/ medical plan, to issue payment check(s) directly to NATURAL FAMILY HEALTHY & INTREGRATIVE MEDCINE, LLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize NATURAL FAMILY HEALTH & INTEGRATIVE MEDICINE, LLC to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from NATURAL FAMILY HEALTH & INTEGRATIVE MEDICINE, LCC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment.
I further understand that fees are due and payable on the date that services are rendered and agreed to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Witness Date

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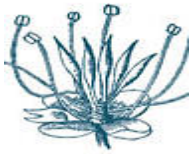

NATURAL FAMILY HEALTH & INTEGRATIVE MEDICINE, LLC

Dr. JODY E. NOÉ MS, ND

Acknowledgment of Receipt of our Privacy Notice
Documentation of Good Faith Efforts to Obtain Written Acknowledgment

As required by the Health Insurance Portability and Accountability Act, we document compliance by retaining copies of our Privacy Notices and any written acknowledgments of receipt of the Privacy Notice or documentation of good faith efforts to obtain such written acknowledgment, in accordance with our obligation to provide the privacy notice at first service after compliance date, or, when and emergency occurs, as soon as possible after emergency treatment situation.

_____ I have received a copy of the Privacy Notice.

_____ _____
Signature Date

If not signed by the patient please indicate your relationship to the patient:

_____

_____ We have made a good faith effort to deliver a copy of our Privacy Notice to:

_____
Patient Name

_____
Signature (Privacy Officer) Date

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DR. JODY E. NOÉ, MS, ND
www.drjodyenoe.com

AUTHORIZATION FOR RELEASE OF PATIENT'S PROTECTED HEATLH INFORMATION

Patient Name _____ Social Security # _____

Date of Birth _____ Medical Record # _____

I hereby authorize Natural Family Health & Integrative Medicine, LLC to use/disclose my individual health information as described below (which may include, but is not limited to information concerning treatment for drug/alcohol abuse, mental health; HIV status; communicable or venereal disease; genetic testing records, if applicable). I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I hereby authorize the use of disclosure of the Protected Health Information (PHI) described below to be provided to or obtained by the following:

Name of Doctor to Receive PHI

Dr. Jody E Noe MS, ND
Natural Family Health & Integrative Medicine
82 Norwich-Westerly Rd. Bldg. G
North Stonington, CT 06359

Name/address of Doctor to Disclose PHI

_____

_____

_____

Information authorized for use of disclosure, or to be obtained:

- Medical Records Summary _____
- History / Physical / Consultation Reports _____
- Hospitalization Summaries _____
- Lab Reports / Ultrasound Films / Other Radiographic Summaries _____
- All of the above _____

Purpose of the use and/or disclosure:

_____

Description of information to be disclosed:

- At the Request of the patient _____
- Insurance _____
- Continued Treatment _____
- Legal _____
- Other (specify) _____

I understand that I may revoke this authorization at any time in writing and the automatic expiration date is one year from the date of authorization. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider; the disclosed information may no longer be protected by federal and state privacy regulations.

_____ _____ _____
Signature of Patient or Legal Representative Date Description of Legal Representative Authority