

## Natural Health and Wellness Center New Patient Information

Telephone: (203) 874-4333

Fax: (203) 878-1725

88 Noble Avenue, Suite 104

Milford, CT 06460

### Professional Staff

Lisa M Singley, ND, MS

Christine Kontomerkos, ND, MS

Anthony Tortorella, DC

### Office Staff

William White (Office Manager)

Shannon McCabe

Annette McCabe

### Office Hours:

Mondays: 10AM- 3PM

Tuesdays: 10AM- 6PM

Wednesdays: 10AM- 6PM

Thursdays: 10AM – 7PM

Fridays: 10AM – 7PM

Saturdays: 10AM – 4PM

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## ***Specialties and Services:***

### **Acupuncture**

*A safe, effective, holistic medical treatment that has been used to for thousands of years to treat a wide variety of conditions. Sterile, disposable needles are inserted painlessly to relieve pain, reduce inflammation, improve function and restore hormonal balance.*

### **Chiropractic Care**

*A health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. Chiropractors use spinal manipulation, physical therapy and sports rehabilitation to improve function and restore balance to the musculoskeletal and nervous system.*

### **Massage Therapy**

*Therapeutic massage is an age-old remedy and health practice found in all major civilizations past and present. In addition to the commonly known benefits of relaxation, improved circulation, and relief for muscle tension, new applications for therapeutic massage are surfacing in areas related to mental and emotional well-being, infant care, and anti-aging.*

### **Naturopathic Medicine**

*A comprehensive, holistic healthcare system that integrates the most advanced modern scientific testing and diagnostic procedures with safe, all natural therapies. According to the Princeton Review "In addition to a repertoire of conventional medical practices, stellar people skills, and capacity for out-of-the-box thinking really come in handy for a naturopathic physician, to better grasp the big picture of holistic health and helping patients understand the benefits of an integrated, healthy lifestyle. "*

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## **Special Programs:**

### **Detoxification Program:**

*Each program is individually designed based on your symptoms, medical history, and lifestyle. This program is often used to support Weight Loss, smoking cessation and to improve the outcomes of many other treatment protocols. In general, it is recommended that we all do some type of detoxification program once a year – like spring cleaning for your body!*

### **Facial Rejuvenation Acupuncture:**

*A painless, non-surgical method of reducing the signs of aging; although this treatment does focus on improving your appearance it also improves your overall health and well being too.*

### **Smoking Cessation Program:**

*This program uses clinical proven forms of treatment that give you the tools you need to manage your cravings and stop smoking. It will also be an excellent way to start building a health foundation for you to use for the rest of your life.*

### **Weight Loss Resistance:**

*An individualized approach that identifies and overcomes factors that have prevented successful weight loss/weight management in the past.*

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## **General information about office visits:**

### Naturopathic Office visit

First Appointment (90 minutes)

Follow up visits (30-60 minutes depending on the nature of the chief complaint)

### Acupuncture Office visit

First office visit (60 minutes)

Follow up visits (45-60 minutes)

### Chiropractic Office visit

First office visit (30-45 minutes)

Follow up visits (15-30 minutes)

### Facial Acupuncture (90 minutes)

### Massage Therapy (length of appointment depends upon treatment and type of therapy)

Swedish and Deep Tissue

Hot Stone

Reiki

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Date \_\_\_\_\_

**PATIENT INTAKE FORM**

Date of Birth \_\_\_\_\_

Name \_\_\_\_\_ Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

Physician \_\_\_\_\_ Last physical exam \_\_\_\_\_ Last blood tests \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Referred by \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

What are your chief health concerns? \_\_\_\_\_

**Past Medical History (include date – year)**

*Significant Illnesses:*  Cancer \_\_\_\_\_;  Diabetes \_\_\_\_\_;  High Blood Pressure \_\_\_\_\_;  Musculoskeletal Disease \_\_\_\_\_;

HIV/AIDS \_\_\_\_\_;  Hepatitis \_\_\_\_\_;  Lung Disease \_\_\_\_\_;  Rheumatic Fever \_\_\_\_\_;  Thyroid Disease \_\_\_\_\_;

Ulcers \_\_\_\_\_;  Seizures;  Other \_\_\_\_\_

*Significant Trauma:* (auto accident, falls, etc) \_\_\_\_\_

*Your Birth History:* (prolonged labor, forceps delivery, etc.) \_\_\_\_\_

*Allergies:* (drugs, chemicals, foods) \_\_\_\_\_

*Past Surgeries:* \_\_\_\_\_

*Medicines (taken within the past 2 months include, over-the-counter drugs, herbs, etc.)* \_\_\_\_\_

*Occupation Stresses:* (chemical, physical, psychological, etc) \_\_\_\_\_

*Exercise:* \_\_\_\_\_

*Type of Diet:* \_\_\_\_\_

Habits:  Cigarettes;  Coffee;  Tea;  Soda;  Alcohol;  Recreational Drugs;  Sweets;  Salt.

Family Medical History:  Diabetes;  Cancer;  High Blood Pressure;  Heart Disease;  Stroke;

Asthma;  Allergies;  Alcoholism;  Mental Illness;  Arthritis;  Other \_\_\_\_\_

**GENERAL**

Now Past	Now Past	Now Past	Now Past
<input type="checkbox"/> <input type="checkbox"/> Poor Appetite	<input type="checkbox"/> <input type="checkbox"/> Poor Sleep	<input type="checkbox"/> <input type="checkbox"/> Night Sweats	<input type="checkbox"/> <input type="checkbox"/> Tremors
<input type="checkbox"/> <input type="checkbox"/> Change in Appetite	<input type="checkbox"/> <input type="checkbox"/> Cold Hands/Feet	<input type="checkbox"/> <input type="checkbox"/> Excessive Sweating	<input type="checkbox"/> <input type="checkbox"/> Poor Balance
<input type="checkbox"/> <input type="checkbox"/> Food Cravings	<input type="checkbox"/> <input type="checkbox"/> Frequent Colds	<input type="checkbox"/> <input type="checkbox"/> Sudden Energy Drops	<input type="checkbox"/> <input type="checkbox"/> Poor Coordination
<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/> Chills	<input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> Easy Bleeding
<input type="checkbox"/> <input type="checkbox"/> Poor Appetite	<input type="checkbox"/> <input type="checkbox"/> Fevers	<input type="checkbox"/> <input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> <input type="checkbox"/> Vertigo /Dizziness

**SKIN & HAIR**

Now Past	Now Past	Now Past	Now Past
<input type="checkbox"/> <input type="checkbox"/> Rashes	<input type="checkbox"/> <input type="checkbox"/> Hair Loss	<input type="checkbox"/> <input type="checkbox"/> Broken Blood Vessels	<input type="checkbox"/> <input type="checkbox"/> Ulcerations
<input type="checkbox"/> <input type="checkbox"/> Eczema	<input type="checkbox"/> <input type="checkbox"/> Acne	<input type="checkbox"/> <input type="checkbox"/> Hives	<input type="checkbox"/> <input type="checkbox"/> Itching
<input type="checkbox"/> <input type="checkbox"/> Dandruff	<input type="checkbox"/> <input type="checkbox"/> Changes in Hair or Skin Texture		<input type="checkbox"/> <input type="checkbox"/> Low Blood Sugar

**HEAD, EYES, EARS, NOSE & THROAT**

Now Past	Now Past	Now Past	Now Past
<input type="checkbox"/> <input type="checkbox"/> Eyes Strain	<input type="checkbox"/> <input type="checkbox"/> Poor Hearing	<input type="checkbox"/> <input type="checkbox"/> Teeth Problems	<input type="checkbox"/> <input type="checkbox"/> Headaches
<input type="checkbox"/> <input type="checkbox"/> Cataracts	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Gum Problems	<input type="checkbox"/> <input type="checkbox"/> Facial Problem
<input type="checkbox"/> <input type="checkbox"/> Eye Pain	<input type="checkbox"/> <input type="checkbox"/> Ear Pain	<input type="checkbox"/> <input type="checkbox"/> Mouth Sores	<input type="checkbox"/> <input type="checkbox"/> Sinus Problems
<input type="checkbox"/> <input type="checkbox"/> Blurry Vision	<input type="checkbox"/> <input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> <input type="checkbox"/> Sore Throat	<input type="checkbox"/> <input type="checkbox"/> Post Nasal Drip
<input type="checkbox"/> <input type="checkbox"/> Glasses	<input type="checkbox"/> <input type="checkbox"/> Jaw Pain/Clicking	<input type="checkbox"/> <input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> <input type="checkbox"/> Other

**CARDIOVASCULAR**

Now Past

- High Blood Pressure  
  Low Blood Pressure  
  Other

Now Past

- Fainting  
  Irregular Heart Beats

Now Past

- Chest Pain  
  Swelling Hands/Feet

Now Past

- Blood Clots  
  Phlebitis
- 

**RESPIRATORY**

Now Past

- Cough  
  Pneumonia

Now Past

- Asthma  
  Emphysema

Now Past

- Chest Pain  
  Tight Chest

Now Past

- Sputum Prod.  
  Other
- 

**GASTROINTESTINAL**

Now Past

- Nausea  
  Vomiting  
  Unable to hold urine  
  Other

Now Past

- Belching  
  Gas  
  Stomach Pain  
  Rectal Pain

Now Past

- Hemorrhoids  
  Bloody Stool  
  Diarrhea  
  Change in Bowel Patterns \_\_\_\_\_

Now Past

- Constipation  
  Irritable Bowel
- 

**GENITAL – URINARY**

Now Past

- Painful Urination  
  Frequent Urination  
  Unable to hold urine  
  Other

Now Past

- Waking to Urinate  
  Blood in Urine  
  Impotency

Now Past

- Trichomonas  
  Herpes  
  Warts

Now Past

- Gonorrhea  
  Syphilis  
  Chlamydia
- 

- \_\_\_\_\_ Number of Pregnancies  
 \_\_\_\_\_ Number of Births  
 \_\_\_\_\_ Number of Premature Births  
 \_\_\_\_\_ Miscarriages  
 \_\_\_\_\_ Age of First Menses  
 Birth Control Type and Duration \_\_\_\_\_

Now Past

- Irregular Flow  
  Heavy Flow  
  Flow with Clotting  
  PMS  
  Menstrual Pain

Now Past

- Menopause  
  Pelvic Pain  
  Vaginal Discharge  
  Vaginal Sores  
  Irregular Flow

Now Past

- Breast Discharge  
  Breast Pain  
  Breast Lumps  
 Last PAP \_\_\_\_\_  
 Last Mammogram \_\_\_\_\_
- 

**NEUROPSYCHOLOGY**

Now Past

- Depression  
  Poor Memory  
  Psychological Counseling

Now Past

- Anxiety  
  Seizures  
  Loss of Skin Sensation

Now Past

- Unsteady Gait  
  Hyperactivity

Now Past

- Sleep Disturbance  
  Other \_\_\_\_\_
- 

**MUSCULOSKELETAL**

Now Past

- Joint Pain  
  Joint Swelling  
  Adverse Reaction to Spinal Manipulation  
  Previous X-Rays done

Now Past

- Muscle Pain  
  Muscle Weakness

Now Past

- Back Pain  
  Previous Spinal Manipulation

Now Past

- Back or Neck Injury
- 

I authorize Natural Health and Wellness Center to contact me via phone/email \_\_\_\_\_ to leave a message regarding healthcare issues such as office visits, diagnostic testing and supplements. SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## **Notice of Privacy Practices**

*This notice describes how medical information about you may be used and discloses how you can get access to this information.*

### **Please review if carefully:**

**USE AND DISCLOSURES: Treatment :** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment.

**PAYMENT:** Your health information may be used to seek payment from your health plans, from other sources of coverage such as an automobile insurer, or from credit card companies that may use to pay for services.

**HEALTH CARE OPERATIONS:** Your health information may be used as necessary to support the day-to-day activities of Natural Health and Wellness Center.

**LAW ENFORCEMENT:** Your health information may be disclosed to the public health agencies as required to report certain communicable disease to the state's public health department.

### **OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:**

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorization a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

### **ADDITIONAL USES OF INFORMATION:**

**Appointment Reminders:** Your health information may be used by our staff to send you appointment reminders.  
**Information About Treatment:** Your health information may be used to send you information that you may find interesting on the treatment or management of your medical condition. We may also send you information describing other health-related products and services we believe may interest you.

### **INDIVIDUAL RIGHTS:**

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the and disclosure of your protected health information;
- The right to receive confidential communication concerning your medical condition and treatment.
- The right to inspect and copy your protected health information;
- The right to amend or submit corrections to your protected health information;
- The right to receive an accounting of how and whom your protected health information has been disclosed; and
- The right to receive a printed copy of this notice.

**Natural Health and Wellness Center duties**

We are required by law to maintain the privacy of your protected health information to provide you with this privacy practices.

**REQUEST TO INSPECT PROTECTED HEALTH INFORMATION**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the OFFICE MANAGER. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

**COMPLAINTS**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. The name and address of the person you may contact for further information concerning our privacy practices is:

OFFICE MANAGER  
Natural Health and Wellness Center  
88 Noble Avenue, Suite 104  
Milford, CT 06460  
Telephone: (203) 874-4333  
Fax: (203) 878-1725

This notice is effective on or after \_\_\_/\_\_\_/\_\_\_

SIGNATURE\_\_\_\_\_

PAYMENT POLICY

Natural Health and Wellness Center will bill your insurance company as a courtesy to you. We will inform you (to the best of our knowledge) of all charges that are covered by your insurance and of any charges you will be responsible for out of your own pocket. I agree that I am responsible for all charges that are not covered by my health insurance.

Signature\_\_\_\_\_ Date \_\_\_\_\_