THE ROTHFELD CENTER
FOR INTEGRATIVE MEDICINE™

_____/_____/_____
Today's Date

New Patient Registration

Personal Information

Last Name | First Name | Middle Initial

Home Address | City | State | ZIP

Home Telephone | Email Address

Occupation

☐ Male ☐ Female ☐ _____

Employer Name

/ /
Date Of Birth (Month/Date/Year)

Employer Address

— —
Social Security #

Work Telephone

☐ Single ☐ Married ☐ Live-In Partner ☐ Separated ☐ Divorced ☐ Widowed

Insurance Information

Primary Care Physician | Physician's Address | Physician's Telephone

Insurance Company

Relationship to Insured
☐ Self ☐ Spouse ☐ Dependant

Address/Telephone

/ /
Insured's Date Of Birth

Group # | ID/Plan #

Insured's Name | Insured's Address | Insured's Telephone

Is Patient's Condition Related to Work? ☐ Yes ☐ No If Yes, Date of Injury / /

Is Patient's Condition Related to an Auto Accident? ☐ Yes ☐ No If Yes, Date of Accident / /

Emergency Contact

Name | Relationship | Telephone

I hearby certify that the above information is true and correct to the best of my knowledge.

Printed Name (Patient/Parent/Guardian) | Signature | Date

The Rothfeld Center - INTAKE FORM

MAIN PROBLEMS / REASON FOR THIS VISIT	Additional problems you would like addressed:
1	1
2	2
3	3
4	4

CURRENT MEDICATIONS	DOSE	TIMES/DAY

HERBS, VITAMINS, AND SUPPLEMENTS	DOSE	TIMES/DAY

ALLERGIES

LIFESTYLE / SELF-CARE ISSUES

Have you ever smoked cigarettes?	___YES	___NO	If YES, _________packs per day. Have smoked for _______years.
Are you still a smoker?	___YES	___NO	If NO, when did you last quit? _______________________________
Do you drink caffeinated beverages?	___YES	___NO	If YES, which? ____________cups, cans, etc/day.
Do you drink alcohol?	___YES	___NO	If YES, which? ____________. Number of drinks/week______.
Do you use recreational drugs?	___YES	___NO	If YES, which? ______________________________
Previous alcohol/drug problems?	___YES	___NO	If YES, which? ______________________________
Do you manage stress well?	___YES	___NO	___NOT SURE ___NEED HELP
Do you exercise regularly?	___YES	___NO	If NO, why? ________________________________
Do you enjoy your job?	___YES	___NO	If NO, why? ________________________________
Do you allow time to unwind and relax?	___YES	___NO	If NO, why? ________________________________
Do you sleep soundly?	___YES	___NO	If NO, why? ________________________________
Are you satisfied with your sex life?	___YES	___NO	If NO, why? ________________________________
Are you satisfied with your social life?	___YES	___NO	If NO, why? ________________________________
Are you satisfied with your spiritual life?	___YES	___NO	If NO, why? ________________________________

The Rothfeld Center - PATIENT HISTORY

NAME OF PATIENT ______________________________
DATE ______/______/______

Past Medical and Dental History

(Prior illness, hospitalization, surgery, injury-include vehicle

Item and Reason **Date**

____
____
____
____
____

Family History

Number of Brothers and Sisters ______________________
Your Birth Order (1st, last, etc.) ______________________

Check all that apply	Mother	Father	Grandparent	Sister/Brother	Spouse	Children
AIDS						
Alcoholism						
Allergies						
Alzheimer's						
Arthritis						
Asthma						
Cancer						
Depression						
Diabetes						
Drug abuse						
Heart disease						
High blood pressure						
Stroke						
Thyroid problems						
Tuberculosis						

Social History

Check all that apply

Relationship Status	Education	Memories of your childhood
___ Single	___ High sch	___ Mostly happy
___ Married	___ College	___ Mostly painful
___ Divorced	___ Prof. sch	___ Normal
___ Other:	___ Other:	___ Don't recall

Occupation ____
Living arrangement ___Alone ___Family ___Roommate ___Other: ______________________
Children (list ages) ___________________________________
Major stresses in last 6 months ____

The Rothfeld Center - INTAKE FORM

DIET

Is your diet healthy enough? ___YES ___NO ___NOT SURE ___NEED HELP

Typical breakfast ________________________________

Typical lunch ________________________________

Typical dinner ________________________________

Typical snacks ________________________________

HEALTH SCREENING HISTORY List the date of your most recent testing or exam below.

Mammogram ___/___/___ Pap smear, Female exam ___/___/___

Breast exam by self ___/___/___ By healthcare professional ___/___/___

Blood test for anemia ___/___/___ Blood test for cholesterol ___/___/___

Other blood test ________________________ Reason, if you know ________________________

Immunizations: Polio ___/___/___ Tetanus ___/___/___ Hepatitis ___/___/___ Pneumonia ___/___/___ Flu shot ___/___/___

Test for blood in stool ___/___/___ Rectal exams: Feeling prostate ___/___/___ Scope of the lower bowel ___/___/___

Testicle exam by self ____/____/____ By healthcare professional ____/____/____

X-Rays or imaging studies: Chest ___/___/___ Neck ___/___/___ Low back ___/___/___ Other ________________________

REVIEW OF SYSTEMS

DIGESTION

- ___indigestion
- ___belching
- ___difficulty swallowing
- ___heartburn
- ___nausea
- ___liver trouble
- ___vomiting
- ___diarrhea
- ___cramping bowels
- ___gassy gut
- ___constipation
- ___abdominal pain
- ___rectal pain or itching
- ___hemorrhoids, piles
- ___blood in stools
- ___foods that upset your system:
  ____

BREATHING AND LUNGS

- ___shortness of breath
- ___wheezing or asthma
- ___repeated colds and flus
- ___cough, dry or irritating
- ___cough up mucous or blood

URINE, KIDNEYS, BLADDER

- ___painful urination
- ___wake up to urinate
- ___kidney stones
- ___loss control of urine
- ___frequent urination
- ___sudden urges to urinate
- ___blood or pus in urine
- ___decreased urine flow

WOMEN'S REPRODUCTIVE

- age period started ___
- number of pregnancies ___
- pregnancies lost ___
- past fertility problems ___
- number of live births ___
- children currently living ___
- age period stopped, menopause ___

EYES

- ___eye pain
- ___blurred vision
- ___poor vision ___day ___night
- ___wear corrective lenses
- ___near ___far sighted
- ___other: _________________

SEXUAL ORGANS

- ___sores on genitals
- ___lumps or swellings
- ___erection problems
- ___poor sexual response
- ___pain with sex
- ___infertility
- ___repeated infections

WOMEN

- ___pelvic pain
- ___vaginal discharge
- ___painful periods
- ___PMS
- ___hot flashes
- ___itching or soreness

IMMUNE SYSTEM

- ___too many infections
- ___allergies to food/envir.
- ___other concerns

BLOOD SYSTEM

- ___lymph gland swelling
- ___anemia
- ___easy bruising

The Rothfeld Center - INTAKE FORM

CONSTITUTIONAL

___poor appetite
___fevers
___chills
___food cravings
___weight loss
___weight gain
___fatigue

HEART AND CIRCULATION

___chest pain
___lightheadedness
___palpitations
___cold hands/feet
___fainting
___swelling feet
___blood clots
___varicose veins

NERVES, MOVEMENT, BRAIN

___seizures
___nerve pains
___poor balance
___poor coordination
___tremors or shaking
___numbness
___dizziness
___poor memory
___trouble sleeping

EARS, NOSE, MOUTH, THROAT

___ringing ears
___nose bleeds
___postnasal drip
___sinus problems
___trouble with taste or smell
___poor hearing
___earaches
___headaches
___facial pain
___jaw clicks
___teeth problems
___grinding teeth
___trouble chewing
___sore throats
___mouth sores
___bad breath

MOVES, THOUGHTS, EMOTIONS

___depression
___loneliness
___apathy, don't care anymore
___panic or fear attacks
___anxiety, overstressed
___hopelessness
___anger problems
___isolated from family, friends, or coworkers
___spiritual needs
___sex energy problems
___manic episodes

MUSCLES, BONES, JOINTS

___neck pain
___back pain
___muscle pain
___painful joints ___R ___L
___shoulder ___elbow
___hip ___knee ___ankle
___foot ___toe ___hand
___wrist ___fingers
___joint swelling
___muscle weakness
___muscle cramps

SKIN, HAIR, BREASTS

___breast lumps or pain
___breast leaks fluid
___rashes
___itching, hives
___hair loss
___mole changes
___dry skin, eczema

HORMONE AND METABOLISM

___thyroid trouble
___fluid retention
___weight and diet trouble

The undersigned acknowledges that he/she has requested healthcare services from The Rothfeld Center for Integrative Medicine. Many of the therapies offered at TRC are considered unconventional by the mainstream medical establishment. Although some treatments have been in continuous use for a long period of time, they have been deemed "unproven" by such organizations as the American Medical Association, the Food and Drug Administration and certain insurance companies. Any therapy suggested to you can, of course, be refused and/or terminated at any time and you can receive only conventional therapies without the use of alternative or complementary modalities. Under no circumstances are you obligated to accept any treatment offered to you.

Financial Terms
You are expected to pay for your care in full at the time services are rendered. As a new patient, if TRC does not have an agreement with your insurance company, you are expected to pay for your initial visit, and as a courtesy, we will bill your insurance company with a zero balance. In the event TRC maintains a contract with your PPO or HMO, you will only be responsible for your co-payment and/or deductible. Your insurer ultimately determines coverage at the time a claim is filed. We cannot guarantee coverage and/or payment. If your carrier denies payment for any reason, you will be 100% responsible for the amount owed to TRC. Patients covered by insurance are expected to pay applicable co-payments and/or deductibles at the time services are rendered. If the amount owed by a patient is not received on a timely basis, the patient may be responsible for reasonable attorney fees and the cost of collection.

Canceled/Missed Appointments and Late Arrivals
When you make an appointment, time is reserved on a practitioner's schedule and is no longer available to other patients. We require notice at least 24 hours in advance if you are canceling your appointment. You may call (781)-641-1901 24 hours a day and leave a message to cancel on our voice mail. **For cancelled appointments with less than 24 hours notice we will charge $35.00. New Patients who cancel without 48 hours notice (not including weekends or holidays) will be charged $125.**
Please help us serve you and other patients better by keeping scheduled appointments.
Late arrivals create scheduling problems. If possible, please call if you will be late. If you arrive more than thirty minutes late to an appointment with a practitioner, your appointment may not be honored unless the practitioner has an open appointment directly following your scheduled time and can accommodate your appointment.

Other Requests
Because we treat environmentally sensitive patients, on the day of your appointment, please refrain from wearing perfume or cologne or bringing your pets with the exception of guide dogs. We appreciate your cooperation.

Acknowledgement and Agreement
I have read the above information and thoroughly acknowledge, understand and agree to all of the above information, including the financial terms as stated above.

____

Patient (or parent/guardian) PRINTED | Signature | Date