Patient Intake Forms

Welcome

To make your first visit with us about your health, not paperwork, please complete the health history packet and sign all releases.

We require all completed forms be delivered to us **no later than 2 business days before your appointment**. This policy allows the doctor to review your history and current concerns.

IF WE DO NOT RECEIVE YOUR PAPERWORK, WE WILL WORK WITH YOU TO RESCHEDULE YOUR APPOINTMENT.

HOW TO GET THEM TO US

Please deliver completed forms and any additional information you would like to share **at least two business days prior** to your appointment:

MAIL
1136 N. Lincoln Ave
Loveland, CO 80537

FAX
970-667-4755

DROP OFF AT OUR OFFICE
DURING BUSINESS HOURS • Tuesday - Friday 10-4
AFTER HOURS • use back door mail slot

EMAIL
info@sageholistichealth.com

PATIENT CONTACT INFORMATION

Printed Legal Name _____

Preferred Name _____

Date of Birth _____

Address _____

_____

State _____ **Zip** _____

Phone number(s) _____

May we leave a message at this number? Yes◯ No◯

Email address _____

(used solely for our monthly newsletter & is never shared)

Alternate phone _____

Is there an emergency contact or alternative way to reach you?

Name _____

Phone _____

How did you hear about us?

Yellow pages☐ Sign☐ Business card☐ Website☐

Other _____

Referral (From whom?) _____

COMPREHENSIVE PATIENT HISTORY FORM

Name: _____ Date: _____

Occupation: _____ Full or Part time Employer: _____

Marital Status: _____ Name of partner/spouse: _____

Have you seen a naturopathic doctor before? Y N When? _____
What is your **primary health concern** or main reason for coming today?

When did your symptoms start? _____
Describe your symptoms:

What seems to make it better? _____

What seems to make it worse? _____

Are there related symptons? _____
List in order of importance other **health problems/concerns** that are troubling you:

1. _____ since: _____ causes*: _____

2. _____ since: _____ causes*: _____

3. _____ since: _____ causes*: _____

4. _____ since: _____ caus _____
es*: _____

*

*What do you feel/think is **causing** your health concern(s)?*
How would you describe your general state of health? Excellent Good Fair Poor

When do you last remember feeling great? _____

How long do you think it'll take to improve your health concerns? _____
When you're thinking of how soon you want results, consider how long you've had the condition.

Are you currently under the care of any **health practitioners**? Reason: _____
What type?

Chiropractor ☐ Acupuncturist ☐ Massage therapist ☐
Physiotherapist ☐ Counselor ☐ Psychotherapist ☐
Homeopath ☐ Medical doctor ☐ Dentist ☐

Other: _____

DRUG/MEDICAL HISTORY
Date of last physical: _____

Name of **medical doctor**: _____ Tel: _____

Sage Holistic Health

COMPREHENSIVE PATIENT HISTORY FORM

Have you had any accidents, conditions, illnesses, injuries, surgeries or hospitalizations which affected your health in such a manner that you've never been totally well since? Y/N If so, please list the type of condition and the approximate date it occurred.

Have you used or are you currently using any of the following? Indicate Y/N, name, and frequency:

- Laxatives: _____
- Antacids: _____
- Antibiotics: _____
- Corticosteroids: _____
- Pain killers (aspirin, Tylenol, ibuprofen, Advil, Motrin etc.): _____
_____

- Thyroid medication: _____
- Hormone Replacement: _____
- Birth Control Pill (BCP): _____
- Sleeping pills: _____
- Recreational drugs: _____
- Nasal sprays/allergy pills: _____

Please list any other medication(s) not mentioned above, the amount you're taking and the condition(s) it's for:

List vitamins/minerals/supplements/herbs/remedies you're taking, amount(s), and reason:

Do you know your Blood Type? _____

PERSONAL HABITS & HISTORY

Any weight concerns? _____ (now☐past☐) (gained☐lost☐) Since/how long: _____ How many meals do you have/day? _____ Do you skip meals? _____

Do you have any complaints with your digestion? _____ How often do you have a bowel movement? _____

How is your sleep? _____ Difficulty falling asleep? _____Waking in the night? _____
Bed time: _____ Rising time: _____ How many hours of sleep do you get each night? _____

Are your sleep habits regular? _____ How often do you wake in the night to urinate? _____

Any dreams (recurrent/not) or nightmares? _____
_____

COMPREHENSIVE PATIENT HISTORY FORM

What's your **energy** level (1-10; 10=high)? _____
Do you **meditate** or use **relaxation** exercise? _____ How often? _____
Do you enjoy your **work**? _____ Do you take vacations? _____
Do you follow any **religious** or **spiritual practice**? Please specify:

_____
What do you enjoy most in your life? _____
What do you **worry** most about in life? _____
What are the things that you find **stressful** in your life?

_____
Where/When do you experience them? _____
Who lives with you? (any pets?) _____
What **relationships** in your life are satisfying? _____
Do you have any relationships that are challenging/difficult? _____

_____
How would you describe your relationship(s) with your partner/ children/ parent(s) /employer?

Has there been any **traumatic** experience or major loss in your life?

Age at time of trauma: ____
Where have you last **traveled** outside of Canada/US? _____
_____When? _____
Have you been exposed to **toxic chemicals** (from home/where you live/work: paints, industrial cleaners, pesticides, orchards, golf courses)?

Have you ever lived in a home with smokers? If so, when? _____
Have you ever had silver fillings put in your teeth? If so, when? _____
Have you ever had silver fillings replaced? If so, when? _____
Have you ever had reactions to any vaccinations, medications, or supplements? If so, what and when?

Do you use a method of **birth control or protection**? If so, what type do you use?

_____
Are there any incidents of physical or sexual abuse in your past?

Is there anything else you would like to share?

PLEASE PROVIDE COPIES OF BLOOD TESTS OR IMAGING REPORTS PERFORMED IN THE LAST YEAR

CONFIDENTIAL

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

– Symptoms –

Check (✓) conditions you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

– Conditions –

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

– Medications –

List medications you are currently taking.

Pharmacy Name _____ Phone _____

– Allergies –

– Health History –

– Family History –

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

– Hospitalizations –

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ◯ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

– Pregnancies –

Year of Birth	Sex of Birth	Complications if any

– Health Habits –

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

– Occupational –

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

Education and Fee Schedule

Sage Holistic Health, LLC offers holistic health care in the form of naturopathic medicine and classical Chinese medicine. The primary treatment modalities used are nutrition, herbal medicine, bodywork, acupuncture, nature cure, homeopathy and hydrotherapy.

The doctors at Sage Holistic Health were both trained in naturopathic medicine at the National College of Natural Medicine, now called the National University of Natural Medicine (NUNM) in Portland Oregon, a school accredited by the US Department of Education. They both received their Doctor of Naturopathic Medicine after four years of post-graduate clinical and academic training.

Kathryn Plummer, ND earned her BA (biology) at Colorado College in 1993. She received over 1,000 hours of training at the Massage Therapy Institute of Colorado and ran a massage therapy practice prior to attending naturopathic medical school. She earned her ND in 2002. She utilizes advanced restorative bodywork to complement her naturopathic medical practice.

Dr. Plummer is a registered naturopathic doctor (ND) in the State of Colorado (#22) under the registration law for naturopathic doctors passed in 2013. She also holds an active ND license (#9623351-7100) in the state of Utah and has a Colorado massage therapy license (#6926).

Deirdre G. Koloski, ND, LAc earned her BA (biology) at Mount Holyoke College in 1992. She earned her ND and Master of Science of Oriental Medicine in 2001 at NUNM with three years of specialized post-graduate training in Chinese herbology, acupuncture and oriental massage techniques. Dr. Koloski is recognized by the National Certification Commission for Acupuncture and Oriental Medicine, (NCCAOM), as a Diplomate of Oriental Medicine.

Dr. Koloski is a registered naturopathic doctor (ND) in the State of Colorado (#15). Her Colorado Acupuncture license number is #882. Dr. Koloski also holds an active ND license (#1164) in the state of Oregon.

Both doctors are members of the Colorado Association of Naturopathic Doctors. Dr. Koloski is also a member of the Acupuncture Association of Colorado. No license or certification issued to Dr. Koloski or Dr. Plummer has ever been revoked or suspended.

The practices of acupuncture and naturopathic medicine are regulated by the Colorado Department of Regulatory Agencies. The address and phone number for the complaints and investigation section is: 1560 Broadway, Suite 1545, Denver, CO 80202. Director of the Division of Registrations can be reached at (303) 894-2464.

Initial two-part consultations at Sage Holistic Health cost $360, payable at the time of the first visit. An initial acupuncture visit is $225. Follow up naturopathic fees are based on the length of time for the visit, based on a rate of $180 per hour. A menu of services and a complete fee schedule is available upon request. Any additional services, treatments, laboratory tests, or medicinary products are individually priced.

All clients are asked to pay in full at the time of each visit; cash, check, credit cards, HSA/FSA accepted. Upon request we will provide you ICD-10 coded receipts for you to submit to your insurance carrier for possible reimbursement. 24 hours' notice is required for all cancellations. Missed appointments without 24 hour notice will be billed half of your appointment fee the first time. Future cancellations in less than 24 hours will be billed in full.

Sage Holistic Health is in full compliance with all rules and regulations of the Department of Health, using disposable, one time use stainless steel needles in the practice of acupuncture and proper sanitation of the offices. As a patient, you are entitled to receive information about the methods of therapy, techniques used, and duration of therapy if it can be determined. You may seek a second opinion from another health care professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Division of Registrations in the Department of Regulatory Agencies.

I have read the above information and my signature endorses my understanding of the conditions.

_____ _____

Patient or guardian Signature Date

DISCLOSURES AND INFORMED CONSENT

Welcome
We are honored to be a part of your journey to better health. In order to comply with state regulations issued by Colorado Department of Regulatory Agencies regarding the practice of naturopathic medicine, we must ask all patients to read and sign the following:

Services
Naturopathic medicine and acupuncture are branches of the healing arts distinct from other branches. Our services include the prevention, evaluation, diagnosis, and treatment of injuries, diseases, and conditions through education, nutrition, naturopathic preparations, natural medicines, physical medicine, physical agents, homeopathy, and other therapies and modalities designed to support the body's natural healing ability. Naturopathic Doctors (ND) are registered under the Colorado Naturopathic Doctor Act. They are not Medical Doctors (MD), Doctors of Osteopathy (DO), Doctors of Chiropractic (DC), or Doctors of Nursing (DNP) who are licensed under separate practice acts. As Naturopathic Doctors in Colorado, we do not prescribe, dispense, administer, or inject controlled substances (including general or spinal anesthetics) or practice medicine (including performing surgery, obstetrics, or administering ionizing radiation therapy). The only adjustments, manipulations, and mobilizations naturopathic doctors perform are referred to as naturopathic manual therapies. We cannot recommend against a course of care recommended or prescribed by a licensed provider in another branch of the healing arts.

We recommend that our pediatric patients follow the CDC immunization schedule and have a relationship with a licensed pediatric health care provider. In order for us to treat a child, this form must be fully read and signed. You must be provided with a current vaccination schedule; we need a release from the parent to share information with the child's licensed pediatric health care provider, if the child has one.

Alternatives and Collaboration:
Alternatives to naturopathic medicine and acupuncture include declining such care and consulting with others such as an MD, DO, DC, or DNP. Naturopathic medicine and acupuncture are not a substitute for other types of health care and we encourage you to seek second opinions, have a relationship with an MD or DO, to communicate with all your providers about the care recommended in our office, and to authorize us to attempt to collaborate with your other providers. If applicable and desired, please identify the provider(s) with whom you give your permission and directive to attempt collaboration:
Providers names and phone numbers:

_____
_____
_____

Emergencies:
If you are having a medical emergency, do not wait to seek care. Call 911.

No Guarantee:
Every individual responds to care differently and no guarantee or assurance is made as to the results of care in any specific case, as care may not improve your condition.

Payment, Insurance, Refunds:
The fee schedule is attached. Sage Holistic Health does not offer insurance billing. Payment is due at the time the service is rendered and is not conditional on response to care.

Rights:
You are entitled to receive information about your provider's credentials (attached), the methods of therapy, the techniques used, and the duration of therapy, if known. Complaints regarding Dr. Koloski or Dr. Plummer must be submitted in writing to the Office of Naturopathic Doctor Registration. To obtain a complaint form, contact the Division by phone at (303) 894-7414 or find more information on how to file a complaint at: https://dpo.colorado.gov/FileComplaint

DISCLOSURES AND INFORMED CONSENT

Notice of Privacy Practices and Acknowledgment
This notice describes how your health information may be used and disclosed. Please Review it carefully.
You have certain rights with respect to your health information, subject to legal limitations, including:

- Obtaining an electronic or paper copy of your record. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Asking us to correct incorrect or incomplete information. We may say "no," but if we do, we will tell you why in writing within 60 days.
- Requesting confidential communications or asking us to contact you in a specific way (e.g., home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Asking us to limit what we use or share for treatment, payment, or our operation. We are not required to agree to your request, and we may say "no." If, however, you pay for a service or item out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Obtaining a list (accounting) of those with whom we've shared your information for six years prior to the date you ask, who we shared it with, and why. The list will not include disclosures for treatment, payment, and health care operations, and certain other disclosures (e.g. made at your request). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for additional accountings.
- Obtaining a paper copy of this notice at any time, even if you agreed to receive the notice electronically.
- Designating someone to act for you. If you have a medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act on your behalf before we take any action.
- You have the right and choice to have us share your information with family, friends, or other providers involved with your care, **which we will do only with written consent from you**.

ADDITIONAL DISCLOSURES:

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

Do not sign until you have read and fully understand:
I have read and fully understand this consent form, and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words.

Patient or Person with Authority to Consent and acknowledge receipt of privacy practices

I have read the above information and my signature endorses my understanding of the conditions.

_____ _____
Signature Date