

Hello,

Welcome and Thank You, for scheduling an appointment with me at Vermont Naturopathic Clinic.

I am dedicated to providing excellent health care that is tailored to your specific needs. In order to do so, I ask that you please fill out the accompanying paperwork. Please take the time to fill the information out thoroughly. You may even benefit from having someone help you who knows your health history. Sometimes you may not consider an aspect of your health significant although it may be so from another's perspective.

Please bring to your appointment:

- ☞ All of the enclosed paperwork. I require a completed Informed Consent prior to treatment.
- ☞ A complete list of medications and supplements including dosages. There is a form in the enclosed paperwork for this. Also, bring the actual bottles of supplements, herbs, nutrients, etc. so that the ingredients can be viewed.
- ☞ Copies of any lab work, x-ray reports, MRI reports, CT scan reports, EMG reports, etc. reports pertinent to your complaint(s) regardless of time completed or generally completed in the last year for other complaints or prevention screening.
- ☞ Insurance card: If you are covered by Worker's Compensation or Personal Injury (auto insurance), bring your claim information including claim number, adjustor contact and referral/approval letter. Note that Medicare and Medicaid do not cover my services, but many insurance companies do. Check your policy for details.
- ☞ Dress Appropriately. Please bring or wear clothing that is comfortable, such as shorts and a tank top or sports bra that allows access to your arms and legs for physical examination. If you are coming for acupuncture and/ or manual therapy you will need to bring these each visit.

If you have further questions, please contact our office at the number listed on the side. I look forward to meeting with you and helping you reach your goals in health and wellness.

In health,



**PATIENT INFORMATION**

Patient Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ Email: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: M / F

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

May we contact your primary and referring doctors? \_\_\_\_\_

If you were not referred how did you hear about our clinic?

ad: \_\_\_\_\_  friend  web site  brochure  other: \_\_\_\_\_

**Financial Policy:**

- **Payment for services, laboratory tests and dispensary items are due at time of service (insurance information, cash, check, Visa, MasterCard). You are responsible for knowing the extent of your insurance coverage, cost of co-pays and all payments. Co-pays are due at time of service.**
- **Dispensary Policies are published on the website.**
- **You will be billed for missed appointments without 24 hours notice.**

**Privacy Practice:** I acknowledge that Sam Russo N.D., LAc. has provided me with a copy of its Notice of Privacy Practices (in the office or on the web site) that describes how medical information about me may be used and disclosed, and how I can access this information. **I understand that if I have questions or complaints I may contact Dr. Russo at 802-859-0000.** I also understand that I am entitled to receive updates upon request if Dr. Russo amends or changes its Notice of Privacy Practices in a material way.

**I authorize the release of any information necessary to process my claims.**

Signature _____	Date _____	Relationship, if signed by someone other than patient. _____
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**THIS SECTION IS TO BE COMPLETED BY THE OFFICE  
IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT**

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (specify): \_\_\_\_\_

\_\_\_\_\_  
Name and signature and employee

\_\_\_\_\_  
Date

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## Mandatory Disclosure of Information and Informed Consent for Treatment by Sam Russo ND, LAc

*You are the most important person on your health care team. You are entitled to receive clear and understandable information about the options for and methods of therapy, techniques used, and duration of therapy. If you have questions about your treatment, please contact Dr. Russo. You may seek a second opinion from another health care professional, or terminate therapy at any time.*

I understand that methods of treatment may include, but are not limited to: diet and lifestyle therapies, nutritional counseling, therapeutic use of nutrients (including oral, injection or intravenous therapy), herbal medicine, acupuncture, moxibustion, cupping, electrical stimulation, infrared, ultrasound, soft tissue manipulation and/or joint manipulation.

### **Naturopathic Pharmacy:**

- I understand that pharmacy items need to be prepared and consumed according to the instructions provided orally and in writing.
- Herbal Medicine: I understand that some herbs may need to be prepared. I understand that herbal tinctures are usually prepared with alcohol and will inform the physician if I cannot use them.
- I understand that some pharmacy items may have an unpleasant smell, taste or texture, which is not a reason for returning an item. However, I will immediately notify Dr. Russo of any unanticipated or unpleasant effects associated with a pharmacy item.

**Acupuncture:** I understand that there is some minor risk attendant to acupuncture treatment including, but not limited to, light headedness, slight bruising of the skin (hematoma) or slight bleeding. I understand that the risk of infection is negligible as Dr. Russo uses needles that are sterile and disposable. I understand that while this document describes the common risks of treatment, other side effect and risks may occur.

**Manual Therapy:** I understand that a minority of patients may notice stiffness or soreness after the first few days of treatment. I understand that the risk of more severe complications due to joint manipulation have been described as "rare", having been estimated at one in one million to one in twenty million, and is even further reduced by the use of screening procedures as used by Dr. Russo. With this consideration, I understand and am informed that, as in the practice of medicine, in the practice of manual therapy there are some risks to treatment, including but not limited to dislocations, strains and sprains, fractures, disc injuries or strokes.

**Injection and Intravenous Therapy:** I understand that injection or intravenous therapy may not be covered by my insurance provider even if other services are covered. I understand that, because injection and intravenous therapies are invasive procedures that they carry increased risk, depending on the treatment, that I can discuss with Dr. Russo. I understand that a minority of patients have allergic reactions to some of the injection or intravenous treatments and I will notify Dr. Russo if I have any allergies or sensitivities of any kind.

**Photography,** either conventional or digital may be utilized to record my condition. Photography of my condition may also be used to illustrate a patient's condition or an aspect of treatment for educational purposes. I understand that photographs form a part of my medical records and are protected in the same way as any other medical record and if used for medical illustration my privacy will be protected.

I do not expect Dr. Russo to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on them to exercise judgment during the course of treatment, which the doctor thinks at the time is in my best interest based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and to discuss with Dr. Russo the nature, purpose, risks and benefits of treatments provided. I understand that not all of the above-named procedures may be utilized for my treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I understand that results are not guaranteed. I hereby request and consent to the treatment and use of the procedures listed above on me (or on the patient named below, for whom I am legally responsible).

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Patient signature (or guardian, if minor)

date

Printed name (guardian and  
minor if applicable)

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## ADULT PATIENT HEALTH HISTORY

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Date: \_\_\_\_\_

**MAIN HEALTH PROBLEMS/ REASONS FOR THIS APPOINTMENT:** (rank in terms of importance to you)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Note: we may not be able to address every problem during the course of one visit.

**REVIEW OF SYSTEMS:** Check symptoms that currently apply.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Maximum weight \_\_\_\_\_ When? \_\_\_\_\_ Easy weight change? \_\_\_\_\_

Constitutional	Heart & Circulation	Digestion & Abdomen	Women: Reproductive
<input type="checkbox"/> Fatigue	<input type="checkbox"/> chest pain	<input type="checkbox"/> poor appetite	Age period started _____
<input type="checkbox"/> Feel hot <input type="checkbox"/> Feel cold	<input type="checkbox"/> Lightheadedness <input type="checkbox"/> fainting	<input type="checkbox"/> excessive thirst	Length of complete cycle _____
<input type="checkbox"/> Fevers <input type="checkbox"/> Chills	<input type="checkbox"/> Palpitations	<input type="checkbox"/> difficulty swallowing	Last menstrual period: _____
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Swelling: _____	<input type="checkbox"/> belching	<input type="checkbox"/> bleed between periods
<input type="checkbox"/> Hot flashes	<input type="checkbox"/> blood clots	<input type="checkbox"/> bad breath	<input type="checkbox"/> excessive menstrual flow
<b>Eyes</b>	<input type="checkbox"/> heart murmur	<input type="checkbox"/> heartburn	<input type="checkbox"/> irregular menstrual cycle
<input type="checkbox"/> eye pain	<input type="checkbox"/> varicose veins	<input type="checkbox"/> nausea	<input type="checkbox"/> abnormal pap smears
<input type="checkbox"/> poor night vision	<input type="checkbox"/> cold hands / feet	<input type="checkbox"/> vomiting	<input type="checkbox"/> # of pregnancies
<input type="checkbox"/> macular degeneration	<input type="checkbox"/> anemia	# _____ bowel movements / day	<input type="checkbox"/> # live births
<b>Ears, Nose, Mouth, Throat</b>	<input type="checkbox"/> easy bruising	<input type="checkbox"/> constipation	<input type="checkbox"/> infertility
<input type="checkbox"/> jaw pain	<b>Immune System</b>	<input type="checkbox"/> loose stools <input type="checkbox"/> diarrhea	<input type="checkbox"/> premenstrual syndrome
<input type="checkbox"/> facial pain	<input type="checkbox"/> lymph gland swelling	<input type="checkbox"/> abdominal cramping / pain	<input type="checkbox"/> pelvic pain
<input type="checkbox"/> gum problems	<input type="checkbox"/> frequent infections	<input type="checkbox"/> gassy gut	<input type="checkbox"/> vaginal discharge
<input type="checkbox"/> grinding teeth	<input type="checkbox"/> allergies to food	<input type="checkbox"/> rectal pain/itching	<input type="checkbox"/> vaginal itching or soreness
<input type="checkbox"/> trouble chewing	<input type="checkbox"/> allergies to environment	<input type="checkbox"/> blood in stool	<input type="checkbox"/> sexual difficulties
<input type="checkbox"/> dentures	<b>Skin, Hair, Breast</b>	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> pain with intercourse
<input type="checkbox"/> sore throat	<input type="checkbox"/> rashes	<input type="checkbox"/> liver or gall bladder disease	
<input type="checkbox"/> mouth sores	<input type="checkbox"/> itching, hives	<b>Muscles, Bones &amp; Joints</b>	<b>Men: Reproductive</b>
<input type="checkbox"/> dry mouth	<input type="checkbox"/> hair loss	<input type="checkbox"/> muscle pain	<input type="checkbox"/> testicle lump/swelling/pain
<input type="checkbox"/> nosebleed	<input type="checkbox"/> eczema	<input type="checkbox"/> neck pain	<input type="checkbox"/> prostate disorder
<input type="checkbox"/> postnasal drip	<input type="checkbox"/> fibrocystic breasts	<input type="checkbox"/> mid back pain	<input type="checkbox"/> sexual difficulties
<input type="checkbox"/> sinus problems	<input type="checkbox"/> breast leaks fluid	<input type="checkbox"/> low back	<input type="checkbox"/> infertility
<input type="checkbox"/> trouble with taste/smell	<input type="checkbox"/> breast lumps or pain	<input type="checkbox"/> painful joints: <i>note R or L</i>	<input type="checkbox"/> urethral discharge
<input type="checkbox"/> poor hearing or hearing aid	<b>Nerves, Movement, Brain</b>	<input type="checkbox"/>	<b>Urine, Kidney, Bladder</b>
<input type="checkbox"/> earaches	<input type="checkbox"/> nerve pain	<input type="checkbox"/> shoulder <input type="checkbox"/> hip	<input type="checkbox"/> wake up to urinate
<input type="checkbox"/> itchy ears	<input type="checkbox"/> poor balance	<input type="checkbox"/> elbow <input type="checkbox"/> knee	<input type="checkbox"/> loss of control
<input type="checkbox"/> ringing ears	<input type="checkbox"/> poor coordination	<input type="checkbox"/> wrist <input type="checkbox"/> ankle	<input type="checkbox"/> frequent / urgent urination
<b>Breathing &amp; Lungs</b>	<input type="checkbox"/> tremors	<input type="checkbox"/> hand <input type="checkbox"/> foot	<input type="checkbox"/> recurrent infections
<input type="checkbox"/> cough	<input type="checkbox"/> headaches	<input type="checkbox"/> joint swelling	<input type="checkbox"/> painful urination
<input type="checkbox"/> wheezing	<input type="checkbox"/> seizures	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> blood/pus urine
<input type="checkbox"/> asthma	<input type="checkbox"/> numbness or tingling	<input type="checkbox"/> morning stiffness: _____ hours	<input type="checkbox"/> kidney stones
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> poor memory	<input type="checkbox"/> hernia	<input type="checkbox"/>

**Any other symptoms not listed above:**

For Dr. Russo :  IF NOT NOTED ABOVE IT IS EITHER NEGATIVE, NON-CONTRIBUTORY, AND/OR NON-PERTINENT.

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Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date: \_\_\_\_\_

**LIFESTYLE / SELF-CARE ISSUES**

Do you exercise regularly? <input type="checkbox"/> YES <input type="checkbox"/> NO what exercise and frequency?	
Do you sleep soundly and wake rested? <input type="checkbox"/> YES <input type="checkbox"/> NO	Are you satisfied with your social life? <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you satisfied with your sex life? <input type="checkbox"/> YES <input type="checkbox"/> NO	Are you satisfied with your spiritual life? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you enjoy your job? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you manage stress well? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you allow time to unwind and relax? <input type="checkbox"/> YES <input type="checkbox"/> NO	How many hours of TV per day?
How many alcoholic drinks per week?	How many caffeinated drinks per day?
How many packs of cigarettes per day? for _____yrs.	Do you use recreational drugs?

Over the past two weeks, how often have you been bothered by any of the following problems?  
Circle the number that corresponds to your answer.

Little interest or pleasure in doing things. 0 = not at all 1 = several days 2 = more than half the days 3 = nearly every day	felling down, depressed, or hopeless 0 = not at all 1 = several days 2 = more than half the days 3 = nearly every day
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Diet: Restrictions? \_\_\_\_\_ Cravings? \_\_\_\_\_

Fluids: \_\_\_\_\_ oz. per day Are you happy with your diet?  YES  NO

	Food on a good weekday	Food on a bad weekday	Typical Weekend
<b>Breakfast Time:</b>			
<b>Lunch Time:</b>			
<b>Dinner Time:</b>			
<b>Snack</b>			
<b>Snack</b>			

\_\_\_\_\_  
Date Patient / Guardian signature Date

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

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Name: \_\_\_\_\_

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

<b>Marital status:</b> <input type="checkbox"/> Single	<b>Living arrangement</b> <input type="checkbox"/> Alone <input type="checkbox"/> significant other	<b>Education level completed:</b> <input type="checkbox"/> high school
<input type="checkbox"/> Married/ Partnered	<input type="checkbox"/> roommate	<input type="checkbox"/> college
<b>Occupation:</b>		<input type="checkbox"/> professional school

Past Medical History: prior illness, injury, hospitalization, surgery	Date

Are your vaccinations up to date?  yes  no

**Do You Use/Have Any of these Devices?**

\_\_\_\_\_ Brace/ splint(s) for: \_\_\_\_\_ Pacemaker \_\_\_\_\_ Artificial Limb: \_\_\_\_\_

\_\_\_\_\_ Metal implants where? \_\_\_\_\_ Artificial joints? where: \_\_\_\_\_

**FAMILY HISTORY: For grandparents, use P for paternal, M for maternal i.e. PGM = paternal grandmother , MGF= maternal grand father. Use a star ( \* ) by the cause of death if applicable.**

	Mother	Father	Grand parents	Sister/ Brother
Alcoholism				
Asthma				
Auto immune disease				
Bleeding Disorder				
Cancer (what type?)				
COPD / Emphysema				
Dementia				
Diabetes				
Glaucoma				
Heart Disease				
Hepatitis				
High Blood Pressure				
High Cholesterol				
IBS				
Kidney Disease				
Liver Disease				
Mental Illness				
Osteoarthritis				
Rheumatoid arthritis				
Stroke				
Thyroid disorder				
Ulcers				
Other:				

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