

**Julianne Forbes, ND**

P.O. Box 167  
North Bridgton, ME 04057  
207-647-9423 (O)  
207-647-3669 (F)

Date: \_\_\_\_\_

To: \_\_\_\_\_

I am looking forward to meeting you soon.

Enclosed is a Client History form. Although it appears lengthy it can be filled out in a short amount of time. It is very helpful to have this form completed prior to coming in for your appointment, as it will save time. Your appointment is scheduled as follows:

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I have reserved 1.5 hrs. for the initial appointment that will be billed at my rate of \$150.00/hour, based on the actual time spent. (I.e. \$150 for 1 hour, \$75.00 for 1/2 hour, etc.). Payment is expected at the time of service. (We accept Visa and Mastercard). If you are unable to keep this appointment, please call me as soon as possible so this time will be available for another new patient. Cancellations made with less than 24 hours notice may be billed for the amount of time set aside for your appointment unless due to inclement weather.

The office is located **on Rt. 37** in North Bridgton, Maine just past Bridgton Academy.

**Heading North:** Take 117 north towards Harrison, then make a left onto Rt. 37 north. Then take the first left past the Church on the Green. This is Kimball St. (not always marked) and you take the first drive on the right.

**Heading South:** Take Rt. 5 south to Rt. 35 south to Rt. 37 south. Office is few miles on the right across the street from North Bridgton Library. There is an office sign at the foot of the driveway. If you get to Rt. 117 you have gone too far.

The office entrance is at the end of the brick pathway leading to the door in the middle. The waiting room is to the left inside the door. There is no need to ring the bell unless the door is locked so please come in and make yourself comfortable in the waiting area.

Thank you.

Sincerely,

Julianne M. Forbes, N.D.

**Julianne Forbes, ND**

Route 37 P.O. Box 167  
North Bridgton, ME 04057  
207-647-9423

**Client History**

**Client Data:**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Sex F M  
Telephone # (home) \_\_\_\_\_ (work) \_\_\_\_\_  
May we leave messages concerning your visit on your answering machine at home phone? \_\_\_\_\_  
Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_  
Who can we call if we are unable to reach you? \_\_\_\_\_ Phone \_\_\_\_\_  
EMAIL: \_\_\_\_\_ (name) (relationship)

**History of condition:**

When and where did you last receive medical or health care? \_\_\_\_\_  
What was the reason? \_\_\_\_\_

When was your last blood test? \_\_\_\_\_ What kind? \_\_\_\_\_

What are your most important health problems? (list in order of importance)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

How long has your main problem been bothering you? \_\_\_\_\_

When was the first time you noticed this condition? \_\_\_\_\_

What do you suspect is causing your problem or contributing to it? \_\_\_\_\_

What treatment approaches have you tried? \_\_\_\_\_

Have you seen a naturopath before? \_\_\_\_\_ What was the therapy and the results? \_\_\_\_\_

Are you currently working with a Doctor of conventional medicine? (M.D. \_\_\_\_\_ or D.O. \_\_\_\_\_ )

List diagnoses \_\_\_\_\_

**Family History:** Please list ages, health problems and if deceased, the cause of death.

	Mother	Father	Brothers	Sisters	Child	Grandparents (mom's)/(dad's)
Age if living	_____	_____	_____	_____	_____	_____
Health (G=good,P=poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma, Hayfever, Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Age at death/ cause	_____	_____	_____	_____	_____	_____

**Family History continued:**

What is your nationality? \_\_\_\_\_

Do you have any blood relatives (aunt, uncle, grandparent) who has had:

\_\_\_\_\_ allergies    \_\_\_\_\_ arthritis    \_\_\_\_\_ skin disease    \_\_\_\_\_ depression    \_\_\_\_\_ heart attack    \_\_\_\_\_ ulcers  
\_\_\_\_\_ genetic problems    \_\_\_\_\_ thyroid problems    \_\_\_\_\_ seizures    \_\_\_\_\_ sickle cells

**Health History:**

The general state of your health is? (excellent \_\_\_\_\_), (good \_\_\_\_\_), (average \_\_\_\_\_), (fair \_\_\_\_\_), (poor \_\_\_\_\_)

Childhood Illnesses: \_\_\_\_\_ Scarlet Fever    \_\_\_\_\_ Diphtheria    \_\_\_\_\_ Rheumatic fever    \_\_\_\_\_ Polio  
(y=yes,n=no)    \_\_\_\_\_ Mumps    \_\_\_\_\_ Measles    \_\_\_\_\_ German Measles    \_\_\_\_\_ Mono  
\_\_\_\_\_ Smallpox    \_\_\_\_\_ Chickenpox    \_\_\_\_\_ Whooping cough

Immunizations: \_\_\_\_\_ Polio    \_\_\_\_\_ Tetanus Shot(not anti-toxin)    \_\_\_\_\_ Pertussis    \_\_\_\_\_  
(y=yes,n=no)    \_\_\_\_\_ Measles/Mumps/Rubella    \_\_\_\_\_ Diphtheria. Negative Reaction to any? \_\_\_\_\_

Hospitalizations and Surgery: \_\_\_\_\_  
\_\_\_\_\_

X-rays and special studies (CAT scan, MRI) you have had: \_\_\_\_\_  
\_\_\_\_\_

Please list any abnormal lab results ( include when and if you re-tested with a normal result) \_\_\_\_\_  
\_\_\_\_\_

Current Medications: \_\_\_\_\_ laxative    \_\_\_\_\_ cortisone    \_\_\_\_\_ pain relievers    \_\_\_\_\_ antacids  
\_\_\_\_\_ sleeping pills    \_\_\_\_\_ thyroid medication    \_\_\_\_\_ tranquilizers  
\_\_\_\_\_ MAO inhibitor    \_\_\_\_\_ appetite suppressants  
\_\_\_\_\_ Calcium Channel Blocker    \_\_\_\_\_ Diuretic    \_\_\_\_\_ Birth Control Pills

Please list prescription medications, over the counter medications, vitamins or other supplements you are taking (give full name, dosage and how long you have been taking it, write on back if you need more space):

Prescription/Over the counter: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Vitamins/Herbs: \_\_\_\_\_  
\_\_\_\_\_

Which of the following do you currently use:

\_\_\_\_\_ tobacco, packs per day = \_\_\_\_\_    \_\_\_\_\_ alcohol, X per week = \_\_\_\_\_  
\_\_\_\_\_ coffee, cups per day = \_\_\_\_\_    \_\_\_\_\_ soda, X per day = \_\_\_\_\_  
\_\_\_\_\_ artificial sweetner, X per day \_\_\_\_\_

Describe any exercise you currently do and frequency:

\_\_\_\_\_  
\_\_\_\_\_

Do you eat three meals a day? \_\_\_\_\_

Do you sleep well? \_\_\_\_\_ Number of hours per night \_\_\_\_\_ Wake rested? \_\_\_\_\_

Do you enjoy your work? \_\_\_\_\_ Does anything you do at work make your condition worse? \_\_\_\_\_

What are your main interests and hobbies? \_\_\_\_\_  
\_\_\_\_\_

**Review of Systems:**

General: Weight \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_ Maximum weight \_\_\_\_\_ Height \_\_\_\_\_  
Describe your energy level (poor, ok, great) \_\_\_\_\_, is this a change in the last 6 months?

Circle Y (yes) a condition you have now , P (past) a condition you have had before, and N (never) had.

Skin:

Warts Y P N  
Rashes: Y P N  
Eczema: Y P N  
Acne, boils: Y P N  
Itching: Y P N  
Color Change: Y P N  
Lumps: Y P N  
Night sweats: Y P N

Head:

Headache: Y P N  
Head injury Y P N

Eyes:

Impaired vision: Y P N  
Glasses/contacts: Y P N  
Eye pain: Y P N  
Tearing/dryness: Y P N  
Double vision: Y P N  
Glaucoma: Y P N  
Cataracts: Y P N

Ears:

Impaired hearing: Y P N  
Ringing: Y P N  
Earaches: Y P N  
Dizziness: Y P N

Nose/Sinuses:

Frequent colds: Y P N  
Nose bleeds Y P N  
Stuffiness: Y P N  
Hay fever: Y P N  
Sinus problems: Y P N

Mouth/Throat:

Frequent sore throat: Y P N  
Sore tongue: Y P N  
Gum problems: Y P N  
Hoarseness: Y P N  
Dental cavities Y P N

Neck:

Lumps: Y P N  
Swollen glands Y P N  
Goiter: Y P N  
Pain or stiffness: Y P N  
Trouble Swallowing: Y P N

Respiratory:

Constriction Y P N  
Cough: Y P N  
Sputum: Y P N  
Spit up blood: Y P N  
Wheezing: Y P N  
Asthma: Y P N  
Bronchitis: Y P N  
Pneumonia: Y P N  
Pleurisy: Y P N  
Emphysema: Y P N  
Difficulty breathing: Y P N  
Pain on breathing: Y P N  
Shortness of breath: Y P N  
at night? Y P N  
lying down? Y P N  
Tuberculosis: Y P N

Cardiovascular:

Heart Disease: Y P N  
Angina: Y P N  
High Blood Pressure: Y P N  
Murmurs: Y P N  
Chest Pain: Y P N  
Swelling in ankles: Y P N  
Palpitations: Y P N

Gastrointestinal:

Liver disease Y P N  
Ulcer? Y P N  
Heartburn: Y P N  
Change in thirst: Y P N  
Change in appetite: Y P N  
Nausea: Y P N  
Vomiting: Y P N  
Vomit blood: Y P N  
Hemorrhoids: Y P N  
Belching/gas: Y P N  
Blood in stool: Y P N  
Gall bladder Disease: Y P N

Bowel movement, how often: \_\_\_\_\_

Is this a change: \_\_\_\_\_

**Review of Systems: continued**

Urinary:

Pain on urination: Y P N  
Increased frequency: Y P N  
Frequency at night: Y P N  
Inability to hold urine: Y P N  
Frequent infections: Y P N  
Kidney stones: Y P N

Female reproductive:

Age menses began: \_\_\_\_\_  
Average # of days long: \_\_\_\_\_  
Total days in cycle: \_\_\_\_\_  
Bleeding between: Y P N  
Are cycles regular: Y P N  
Pain during intercourse: Y P N  
Painful menses: Y P N  
Excessive flow: Y P N  
Birth control: Y P N

Type: \_\_\_\_\_

# of pregnancies: \_\_\_\_\_  
# of live births: \_\_\_\_\_  
# of miscarriages: \_\_\_\_\_  
# of abortions: \_\_\_\_\_  
Difficulty conceiving: Y P N  
Menopausal symptoms: Y P N  
Sexually active: Y P N  
Venereal disease: Y P N  
Age Menses Ceased \_\_\_\_\_

Breasts:

Do you do self exam: Y P N  
Lumps: Y P N  
Pain or tenderness: Y P N  
Nipple discharge: Y P N

Male reproductive:

Hernias: Y P N  
Venereal disease: Y P N  
Testicular masses: Y P N  
Sexually active: Y P N

Musculoskeletal:

Joint pain or stiffness: Y P N  
Arthritis: Y P N  
Broken bones: Y P N  
Muscle spasms or cramps: Y P N  
Weakness: Y P N

Peripheral vascular:

Deep leg pain: Y P N  
Cold hands/feet: Y P N  
Varicose veins: Y P N  
Thrombophlebitis: Y P N

Neurologic:

Fainting: Y P N  
Seizures: Y P N  
Paralysis: Y P N  
Muscle weakness: Y P N  
Numbness or tingling: Y P N  
Loss of memory: Y P N

Emotional:

Depression: Y P N  
Mood swings: Y P N  
Anxiety or nervousness: Y P N  
Tension: Y P N

Endocrine:

Hypothyroid: Y P N  
Heat or cold intolerance: Y P N

Excessive thirst: Y P N  
Excessive hunger: Y P N  
Blood: Y P N  
Anemia: Y P N

**Health Choices:**

Which of the following would you like included in your health plan if appropriate?

Vitamins \_\_\_\_\_ Minerals \_\_\_\_\_ Dietary supplementation \_\_\_\_\_  
Homeopathy \_\_\_\_\_ Botanicals \_\_\_\_\_ Exercise \_\_\_\_\_  
Hydrotherapy \_\_\_\_\_ Chinese Medicine theory \_\_\_\_\_  
Dietary recommendations \_\_\_\_\_ Stress management \_\_\_\_\_  
Other \_\_\_\_\_

What do you think is the most important part of your healing process? \_\_\_\_\_

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*In an effort to keep costs down we do not offer billing services or payment plans to patients or insurance companies. Payment for services and lab work is due in full upon completion of your visit. There are some insurance companies that cover naturopathic medicine. If you plan to submit your paid invoices to your insurance company I will be happy to provide you with insurance codes. Telephone calls to the doctor over five minutes will be charged at the office visit rate. A fee of \$25.00 will be charged for a missed appointment or an appointment canceled without 24 hours notice. Should you need to cancel an appointment, please call the office and leave a message on the answering machine which records the date and time of your call.*

I have read and understand the above policies: (signature) \_\_\_\_\_