

**Dr. Abigail Seaver, N.D.**

**Naturopathic Physician**

123 South Laura St. Ridgway, CO 81432

P.O. Box 500

Phone (970) 626-3188

Fax (970) 626-3187

[www.drabigailseaver.com](http://www.drabigailseaver.com)

Dear New Client,

It is very helpful if you prepare some information before your first appointment to ensure that the visit is as thorough and useful as possible. Enclosed is a questionnaire to be completed before your first visit.

If another physician has ordered laboratory work for you in the previous twelve months, please call their office and ask that a copy of the results be sent either to you or me, preferably before the first visit.

Thank you for putting your time into this preparation. Please remember to bring it to your appointment on \_\_\_\_\_ at \_\_\_\_\_.

I look forward to meeting you,

Sincerely,

Abigail Seaver, N.D.

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Abigail Seaver, N.D. received her degree of Doctor of Naturopathic Medicine from Bastyr University, a four-year, fully accredited doctorate program. The State of Colorado does not offer licensing for naturopathic physicians, therefore she holds a license to practice naturopathic medicine in Washington state.

Fee Schedule:

First visit (one hour): \$100

Follow up visits (30-45 minutes): \$70

10% discount for students and seniors

All expenses for supplements and herbs are in addition to the cost of the visit.

All clients are asked to pay in full at the time of the visit. Cash and checks are accepted. We will provide you with receipts to send to your insurance carrier for your reimbursement.

24 Hour notice is required for all cancellations.

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 care at any time.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## **Notice of Privacy Practices Summary**

This summary discloses how health information about you may be used.

Dr. Abigail Seaver, ND uses health information about you for treatment, to help you obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care that you receive.

Dr. Abigail Seaver, ND will not disclose your information to others unless you tell us to do so, or unless the law authorizes us to do so.

Dr. Abigail Seaver, ND may use your information to provide appointment reminders, information about treatment alternatives or other health related issues.

Dr. Abigail Seaver, ND may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function and in order to comply with workers compensation laws and regulations. You have a right to request restriction, report and retain a copy of your health records, request a communication of your information by alternative means at alternative locations, or revoke your authorization and request an accounting of your health records.

You may complain to the Department of Health and Human Services if you believe that your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Dr. Abigail Seaver, ND must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for any reasons other than those listed above and permitted under law.

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Signature

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Date

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Name \_\_\_\_\_ Date of First Visit \_\_\_\_\_

Address \_\_\_\_\_

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

Telephone # (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

E-mail \_\_\_\_\_ Fax # \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth (M/D/Y) \_\_\_\_\_ Gender: F M

Occupation \_\_\_\_\_

If child, parents' names \_\_\_\_\_

Emergency contact \_\_\_\_\_

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**Health Overview**

Name of current general practitioner \_\_\_\_\_

GP's contact information \_\_\_\_\_

What is the main reason for your visit today? \_\_\_\_\_

What are your most important health problems? List in order of importance.

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

How did you hear about us? \_\_\_\_\_

**Health History Questionnaire**

**Family History**

Do you have a family history of any of the following?

Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_

Kidney Disease \_\_\_\_\_ Epilepsy \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

Tuberculosis \_\_\_\_\_ Stroke \_\_\_\_\_ High Cholesterol \_\_\_\_\_

Asthma/Hayfever/Hives \_\_\_\_\_ Arthritis \_\_\_\_\_

Anemia \_\_\_\_\_

Any other relevant family history? \_\_\_\_\_  
What is your ethnic heritage? \_\_\_\_\_

**Childhood Illnesses**

Chicken Pox \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_  
German Measles \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_ Scarlet Fever \_\_\_\_\_  
Diphtheria \_\_\_\_\_

**Immunizations**

Polio \_\_\_\_\_ Pertussis \_\_\_\_\_ Tetanus (when?) \_\_\_\_\_  
Diphtheria \_\_\_\_\_ Measles/Mumps/Rubella \_\_\_\_\_

**Hospitalizations, Surgeries, Imaging**

What hospitalizations or surgeries, X-rays, CAT scans, MRI, EEG, EKG's have you had?  
\_\_\_\_\_ year \_\_\_\_\_ year \_\_\_\_\_  
\_\_\_\_\_ year \_\_\_\_\_ year \_\_\_\_\_  
\_\_\_\_\_ year \_\_\_\_\_ year \_\_\_\_\_

**Allergies/Sensitivities**

Are you hypersensitive or allergic to:  
Any drugs? \_\_\_\_\_ Any foods? \_\_\_\_\_  
Any environmental or chemical agents? \_\_\_\_\_

**Current Medications**

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

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

**General**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_  
Max Weight \_\_\_\_\_ When? \_\_\_\_\_ Min. Adult Weight \_\_\_\_\_ When? \_\_\_\_\_  
When during the day is your energy the best? \_\_\_\_\_ worst? \_\_\_\_\_  
Do you exercise and if so, how often and what type? \_\_\_\_\_  
\_\_\_\_\_

**Review of Systems**

Put a "C" next to any of the following conditions that you currently have, a "P" next to those you have had in the past, and an "H" next to any that you feel are a significant part of your medical history.

**Lifestyle**

\_\_\_\_ Alcohol, How much? How often? \_\_\_\_\_ History of Smoking  
\_\_\_\_ Marijuana \_\_\_\_\_ How many packs per day?  
\_\_\_\_ Recreational Drugs \_\_\_\_\_ How many years?

Treated for drug dependence  
 Stress

Occupational Hazards \_\_\_\_\_  
 Any major traumas (please explain)

### **Mental/Emotional**

Treated for emotional problems  
 Mood swings  
 Considered/attempted suicide  
 Poor concentration

Depression  
 Anxiety or nervousness  
 Tension/stress  
 Memory problems

### **Sleep**

Hours of sleep per night  
 Waking rested?  
 Wake up in the middle of the night?  
 If so, can you fall back to sleep easily?

Trouble falling asleep?  
 Do you remember your dreams?  
 Do you have nightmares?  
 What position do you sleep in?

### **Endocrine**

Thyroid problems  
 Hypoglycemia  
 Excessive thirst  
 Fatigue  
 Hair loss

Heat or cold intolerance  
 Diabetes  
 Excessive hunger  
 Easy weight gain

### **Immune**

Chronic fatigue  
 Chronically swollen glands  
 Reaction to vaccines

Chronic infections  
 Slow wound healing  
 Night sweats

### **Skin**

Rashes  
 Acne, boils  
 Color change  
 Lumps/growths

Eczema, Hives  
 Itching  
 Changes in Hair/Nails  
 Skin cancer? What type \_\_\_\_\_

### **Head**

Headaches? Where? \_\_\_\_\_  
 Migraines

Head injury  
 Jaw/TMJ problems

### **Eyes**

Spots in eyes/Floaters  
 Impaired vision  
 Blurriness  
 Color Blindness  
 Double vision  
 Glasses or contacts

Tearing or dryness  
 Itchy eyes  
 Red eyes  
 Eye strain or pain  
 Cataracts  
 Glaucoma

### **Ears**

Impaired hearing  
 Earaches

Ringing in the ears/Tinnitus  
 Dizziness or vertigo

### **Nose and Sinuses**

Frequent colds  
 Stuffiness  
 Sinus problems  
 Congestion

Nose bleeds  
 Hayfever  
 Loss of smell  
 Post-nasal drip

### **Mouth and Throat**

Frequent sore throat  
 Teeth grinding  
 Gum problems  
 Dental cavities

Copious saliva  
 Sore tongue/lips  
 Hoarseness  
 Jaw clicks

### **Neck**

Lumps  
 Goiter

Swollen glands  
 Pain or stiffness

### **Respiratory**

Cough  
 Spitting up blood  
 Asthma  
 Pneumonia  
 Emphysema  
 Pain on breathing  
 Positive TB test ever?  
 Shortness of breath at night

Sputum  
 Wheezing  
 Bronchitis  
 Pleurisy  
 Difficulty breathing  
 Shortness of breath  
 Shortness of breath lying down

### **Cardiovascular**

Heart disease  
 High/low blood pressure  
 Rheumatic fever  
 Blood clots  
 Phlebitis  
 Angina

Swelling in ankles  
 Palpitations/Fluttering  
 Murmurs  
 Fainting  
 High cholesterol  
 Chest pain

### **Gastrointestinal/Digestion**

Trouble swallowing  
 Reflux  
 Heart burn  
 Nausea  
 Vomiting/Vomiting blood  
 Change in appetite  
 Hemorrhoids  
 Colon Polyps

Constipation  
 Diarrhea  
 Blood or mucous in stool  
 Bowels move how often?  
 Is this a change?  
 Black stools  
 Belching  
 Gas and/or bloating

- \_\_\_ Gallbladder disease
- \_\_\_ Jaundice
- \_\_\_ Liver disease

- \_\_\_ Ulcer
- \_\_\_ Abdominal pain or cramps

**Urinary**

- \_\_\_ Pain on urination
- \_\_\_ Increased frequency
- \_\_\_ Urgency/inability to hold urine

- \_\_\_ Frequent infections
- \_\_\_ Frequency at night
- \_\_\_ Kidney stones

**Neurologic**

- \_\_\_ Seizures
- \_\_\_ Muscle weakness
- \_\_\_ Tremors
- \_\_\_ Paralysis

- \_\_\_ Fainting
- \_\_\_ Numbness or tingling
- \_\_\_ Loss of memory
- \_\_\_ Difficulty concentrating

**Musculoskeletal**

- \_\_\_ Joint pain or stiffness
- \_\_\_ Broken bones
- \_\_\_ Muscle spasms

- \_\_\_ Arthritis
- \_\_\_ Weakness
- \_\_\_ Cold hands/feet

**Blood/Peripheral Vascular**

- \_\_\_ Easy bruising or bleeding
- \_\_\_ Deep leg pain
- \_\_\_ Varicose veins

- \_\_\_ Anemia
- \_\_\_ Cold hands/feet
- \_\_\_ Thrombophlebitis

**Male Reproduction**

- \_\_\_ Hernias
- \_\_\_ Testicular masses
- \_\_\_ Testicular pain
- \_\_\_ Prostate problems or disease
- \_\_\_ Sexually transmitted disease: Which one(s)? \_\_\_\_\_
- \_\_\_ Do you do self testicular exams? How often? \_\_\_\_\_
- \_\_\_ Birth control: What type? \_\_\_\_\_

- \_\_\_ Discharge or sores
- \_\_\_ Difficulty starting urination
- \_\_\_ Impotence

**Female Reproduction**

- Age menses began \_\_\_\_\_ Length of complete cycle \_\_\_\_\_
- # of days of menstrual flow \_\_\_\_\_ Age of last menses if menopausal \_\_\_\_\_
- Date of last menses \_\_\_\_\_
- Date of last annual exam/PAP \_\_\_\_\_

- \_\_\_ Irregular cycles
- \_\_\_ Bleeding between cycles
- \_\_\_ Cramps
- \_\_\_ Color of menstrual blood \_\_\_\_\_
- \_\_\_ Clotting

- \_\_\_ Abnormal PAP? When? \_\_\_\_\_
- \_\_\_ Cervical dysplasia
- \_\_\_ Endometriosis
- \_\_\_ Ovarian cysts
- \_\_\_ Uterine fibroids

\_\_\_ Flow: scant/normal/excessive                      \_\_\_ Sexually active  
\_\_\_ Vaginal discharge                                      \_\_\_ Painful intercourse  
\_\_\_ Menopausal symptoms                                \_\_\_ Sexual difficulties  
\_\_\_ Breast lumps    \_\_\_ Birth Control: type \_\_\_\_\_  
\_\_\_ Breast pain/tenderness(other than PMS) \_\_\_ Difficulty conceiving  
\_\_\_ Nipple discharge  
\_\_\_ PMS: breast tenderness, cravings, bloating, irritability  
\_\_\_ Sexually Transmitted Diseases: Which one(s)? \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_  
Number of miscarriages \_\_\_\_\_ Number of abortions \_\_\_\_\_  
Have you had a hysterectomy? \_\_\_\_\_ If yes, at what age? \_\_\_\_\_

### **Dietary Habits**

Do you follow a particular dietary regimen (vegetarian, low-carb, low-fat, etc.)? \_\_\_\_\_

How often do you consume the following items:

Pop, soft drinks \_\_\_\_\_

Pastries, Doughnuts, Cookies, Cake \_\_\_\_\_

Coffee \_\_\_\_\_

Tea (caffeinated) \_\_\_\_\_

Nutrisweet (including diet soda) \_\_\_\_\_

Preserved meats (bacon, hot dogs, lunch meats, etc.) \_\_\_\_\_

How many 8 ounce glasses of water do you drink per day? \_\_\_\_\_