NEW DIMENSIONS FAMILY CARE, PLLC

Phone: 603-275-9585

Web: drcindicroft.com

Office Manager:
Karol Pennock

Hello Valued Patient,

Welcome to our telehealth practice!

Please review our website at drcindicroft.com for our policies and procedures.*

We are a paperless office and we ask that you complete the attached dynamic entry PDF patient registration forms online. If you have any difficulty, please print to complete and then scan them to newdimensionsfc102@gmail.com.

Once received, we will create an e-chart and contact you to schedule your first appointment.

* Non-Covered Service Fee: There is a modest annual fee of $200/yr per adult; Children are free with 2 enrolled individuals. Or you can opt for the monthly membership program (see our web site for full details).

* We do not bill or take any insurance for patients residing outside of NH.

Thank you and we look forward to working with you,

Dr. Cindi Croft

NEW DIMENSIONS FAMILY CARE, PLLC – *the future of medicine*

Dr. Cindi Croft

Phone: **603-275-9585**
e-mail: NewdimensionsFC102@gmail.com
Website: drcindicroft.com
Office Manager: Karol Pennock

Dear Patient,

Welcome to New Dimensions Family Care. We look forward to meeting you.

We ask you that you keep an active credit card on file with us.

Patient: _____ Date:_____ DOB: _____

Billing Address : _____ Phone : _____

Preferred Method of Payment *(please mark one)*: ☐ Debit Card ☐ Credit Card ☐ HSA of FSA Card
If paying by credit card, we accept debit cards, VISA, MasterCard and Discover.

**Note: If Discover is your primary card, please provide another card (i.e., MasterCard or Visa) for transactions (i.e., supplement orders, etc.) that we may need to process. Some pharmacies do not accept Discover.*

PRIMARY CARD

Name on Card: _____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ HSA of FSA Card

Account Number: _____

Expiration Date (mm/yy): _____CVV#: _____

SECONDARY CARD

Name on Card: _____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ HSA of FSA Card

Account Number: _____

Expiration Date (mm/yy): _____CVV#: _____

Credit Card Authorization

The following conditions apply to the recurring payments programs:

1. If any payment is refused by a bank or credit card issuer you may no longer be eligible for recurring payments and may be discharged from New Dimensions Family Care, PLLC.

   _____(Please initial)

2. All future installment payments will be processed via recurring payments as required by the New Dimensions Family Care Payment Policies. _____(Please initial)

The undersigned authorizes New Dimensions Family Care, PLLC to debit my Visa, MasterCard, Discover, HSA or FSA Card for future payments, the annual non-covered service fee AND for any outstanding balances due. You may **discontinue** the recurring credit card plan anytime by providing New Dimensions Family Care with 30 days written notice. Please be aware that New Dimensions Family Care Payment Policy requires recurring Visa, MasterCard, or Discover for all payments. _____(Please initial)

PLEASE MARK ONE:

Option 1: Annual Individual Discounted Fee $200

Option 2: Annual Family Discounted Fee $400

Option 3: Monthly Membership Program $500

Please charge my card $_____for the selected option noted above.

I agree to make all future payments under this recurring charge authorization according to my credit card statement. I understand that my New Dimensions Family Care partnership will be subject to cancellation if my credit card is declined or if I contest any recurring charge made under this recurring payments authorization.

ALL RECURRING CHARGES WILL SHOW ON YOUR CREDIT CARD STATEMENT AS:

New Dimensions Family Care, PLLC.

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Please email me my receipts to: _____ @_____

Patient's signature: _____ Date: _____

Spouse's or guardian's signature: _____ Date: _____

PRIVACY PRACTICES

Communication Authorization Research Consent

Notice of Privacy Practices

This notice describes how medical information about you
may be used and disclosed and how you can get access to this information.

Please review it carefully

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

- You can ask us to contact you in a specific way (for example: home, office or cell phone) or to send mail to a different address.
  You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to 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.

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make) as described in this Notice of Privacy Practices. We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

- If you have given someone 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 for you before we take any action.

• You can complain if you feel we have violated your rights by contacting us using the information on the back page. You can leave a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting www.hhs.gov/ocr/privacy/hipaa/ complaints/.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.

- Share information in a disaster relief situation
  Include your information in a hospital directory If you are not able to tell us your preference, for example: if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we never share your information unless you give us written permission:

- Marketingpurposes
- Saleofyourinformation
- Mostsharingofpsychotherapynotes

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Please view this short video that summarizes your rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

https://www.youtube.com/watch?v=y1BOc9HN0TA&feature=youtu.be

You have certain privacy rights concerning your protected health information (PHI). Under this law your health care providers generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibilities to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your optimal health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly, but we will never share confidential details of your case with another provider without first asking for and obtaining your consent.

- For healthcare operations of our office. For example, we may call you by name in the waiting room when ready to see you, and we may use or disclose your protected health information, as necessary, to contact you and remind you of your upcoming appointment(s).
  With third party business associates that perform various activities—such as billing, collections, or records management—for the clinic. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your information.

- To provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- For marketing activities. For example, your name and address may be used to send you a newsletter about our clinic and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities. If you do not wish to be contacted for these purposes, please call or write to our office at the address or phone number specified on page one.

- With your family, friends, relatives, or others who are involved in your health care or health care bills unless you indicate otherwise (use the restriction field below).

- To protect the public's health & safety, such as reporting when a communicable disease is in your area, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority, track products, product recalls, defects or problems, to make repairs or replacements, reporting adverse reactions to medications, conduct post marketing surveillance, as required, and prevent or reduce a serious threat to anyone's health or safety.

- To make required reports to the police, such as in instances of abuse, neglect, or domestic violence.

carry out their duties should you die.

For workers' compensation claims, law enforcement, government requests, authorized federal officials for conducting national security and intelligence activities, court or administrative order, and in response to a subpoena.

To a correctional institution or law enforcement official if you are an inmate of a correctional facility or under the custody of a law enforcement official and your physician created or received your protected health information in the course of providing care to you. Such information may be released only for the following purposes:

1. To enable the correctional institution or law enforcement official to provide you with necessary healthcare services

2. To protect your own health and safety or the safety of others; and

3. For the safety and security of the correctional institution.

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and TO obtain payment from third party payers, such as insurance companies.

• For health research.

• For health oversight/compliance monitoring-for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

To respond to organ & tissue donation requests from organ procurement organizations.

• To work with a coroner, medical examiner, or funeral director, if necessary, for them to privacy practices described in this notice and give you a copy of it if requested. Your signed copy will always be available to you for review via your patient portal. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see these helpful documents produced by hhs.gov:

https://www.healthit.gov/sites/default/files/YourHealthInformationYourRights_Infographic-Web.pdf

https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/consumers/sharing-familyfriends.pdf?language=es

https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Changes to the Terms of This Notice:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Communication Authorizations

I authorize Cindi Croft DO, her office and any covering provider to leave messages on my phone's answering machine or voice mail.

Signature: _____Date: _____
I authorize Cindi Croft DO, her office and any covering provider to send me email at the

address I have provided in accordance with her policies.
Signature: _____Date: _____

INFORMED CONSENT REGARDING EMAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

NDFC provides patients the opportunity to communicate with Dr. Croft and administrative staff by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, which should be considered before using e-mail.

1. Risks:

    - General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail; e- mail is easier to falsify than handwritten or signed documents; backup copies of e-mail may exist even a er the sender or the recipient has deleted his/her copy.

    - Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.

2. It is the policy of NDFC that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of that patient's protected personal health information and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. NDFC use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, **we cannot, however, guarantee the security and confidentiality of e-mail or internet**

communication.
Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, such as NDFC physicians, nurses, other health care practitioners, insurance coordinators and upon written authorization other health care providers and insurers will have access to e-mail messages contained in protected personal health information.

- NDFC may forward e-mail messages within the practice as necessary for diagnosis and treatment. NDFC will not, however, forward the email outside the practice without the consent of the patient as required by law.

- NDFC will endeavor to read e-mail promptly but can provide **no assurance** that the recipient of a particular e-mail will read the e-mail message promptly. Therefore, **e-mail must not be used in a medical emergency.**

- It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.

- Because some medical information is so sensitive that unauthorized discloser can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health or developmental disability; or alcohol and drug abuse.

- NDFC cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail or internet communication but NDFC is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.

- If consent is given for the use of e-mail, it is the responsibility of the patient's to inform NDFC of any types of information you do not want to be sent by e-mail.

- It is the responsibility of the patient to protect their password or other means of access to email sent or received from NDFC to protect confidentiality. NDFC is not liable for breaches of confidentiality caused by the patient. Any further use of e-mail initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to NDFC. I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Signature: _____

RESEARCH CONSENT AGREEMENT

THE STUDIES

You are being asked to provide your consent for NDFC to use information from your medical records in research studies; the goal of which is to improve the practices of the comprehensive integrative & functional medicine approach. No personal identifying information will be used in the study. The Principal Investigator of these research studies is Cindi Swift-Croft, DO.

If you consent to the use of your medical records in these research studies, your personal information will be kept confidential to the extent permitted by law and will not be released without your written permission except as described in this paragraph. In all study forms, you will be identified only by a randomly selected patient number. Your name will not be reported in any publication; only the data obtained as a result of the use of your medical records in these studies will be made public.

Your decision as to whether or not to consent to the use of your medical records is completely voluntary (of your free will). If you decide not to consent to the use of your medical records it will not affect the care you receive.

If you decide to consent to the use of your medical records in connection with these studies, you may withdraw consent at any time without affecting the care you receive. You should contact the Principal Investigator and let him know about your decision if you decide to withdraw consent.

AGREEMENT TO PARTICIPATE

I have read the description of the research studies and general conditions. Anything I did not understand was explained to me and any questions I had were answered by Dr. Croft. I hereby give my consent to New Dimensions Family Care to use my medical records as described herein in connection with the research

studies described herein. I have free access to this Consent Form via my secure patient portal.

Acknowledgment of Policies

ACKNOWLEDGMENT OF POLICIES AND PROCEDURES:

_____ (please initial) I have reviewed the office “Practice Policies” of New Dimensions Family Care on the office website, drcindicroft.com including the Communications (email and phone) Authorization and have had all of my questions answered regarding its contents.

_____ (please initial) I have reviewed the Notice of Privacy Practice for Protected Health Information of New Dimensions Family Care and have had all of my questions answered regarding its contents.

Print Patient’s Name **Date of Birth** **Date**

Signature of Patient or Legal Guardian (if minor) **Relationship to Patient**

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION UPON REQUEST.

** Our practitioners and staff may at times communicate health information with you via unsecured email.

*** A complete copy of our HIPAA Notice of Privacy Practices is available. You may request a copy.

This Notice of Privacy Practices applies to New Dimensions Family Care. Effective Jan. 1, 2021

NEW DIMENSIONS FAMILY CARE, PLLC – *the future of medicine*

Dr. Cindi Croft

Phone: 603-275-9585
e-mail: NewdimensionsFC102@gmail.com
Website: drcindicroft.com
Office Manager: Karol Pennock

HEALTH SURVEY

This is a health survey designed to help us learn more about you and assess where you are on your healing journey.

Please complete this thoughtfully.

Name: _____ Age: _____

Birth date: _____Time of day born: _____ AM PM (please circle one)

Height: _____ Weight: _____

Usual Weight Range +/- 5 lbs.: _____ Desired Weight Range +/- 5 lbs.: _____

Highest Adult Weight: _____ Lowest Adult Weight: _____

My main concern(s) for coming today is:

What do you hope to achieve in your visit with us?

If you had a magic wand and could erase three problems, what would they be?

1.	
2.	
3.	

When was the last time you felt well? _____

I haven't been well since: _____

Did something trigger your change in health? _____

_____

_____

What makes you feel worse? _____

_____

_____

What makes you feel better? _____

_____

_____

Please list current and ongoing problems in order of priority: _____

_____

_____

Describe the prior treatments/approaches & if any success or failures: _____

_____

_____

SOCIAL CIRCUMSTANCES

Relationships can make or break your health.

If you have a partner, how often do you go out on regular dates in a month's time? _____

Do you like your partner? ☐ Yes ☐ No ☐ Maybe

Sometimes people love their partners, but don't particularly like them.
If you DON'T like your partner what don't you like? _____

Do you have any conflicts with your spouse, partner or relative(s) ☐ Yes ☐ No
If so, please briefly explain the core issue: _____

What was your last act of kindness toward your spouse/partner?

_____

INTIMACY

Note: If you have lost your sex drive, it is often the use of medications, stress, hormonal shifts due to menopause, pregnancy, miscarriage, or other emotional traumas. High blood pressure medications can cause impotence in men.

My sex drive is:
☐ Low (<2x / wk)
☐ Medium (2x / wk)
☐ High (>3x / wk)

Has there been a change in sex habits or desire over the last few weeks or months? ☐ Yes ☐ No

☐ Less interested in sex
☐ More interested in sex

Have you discussed this with your partner? ☐ Yes ☐ No
Have you seen a sex therapist? ☐ Yes ☐ No
Would you like this issue addressed? ☐ Yes ☐ No ☐ Maybe

EMOTIONAL/SPIRITUAL BACKGROUND

How much time do you spend each day to commune with your inner self or God? (These activities can include prayer, meditation, scripture study, etc.) This is a part of your physical health, just as surely as any other part.

☐ Daily
☐ Weekly
☐ Occasionally
☐ Never

Resources for emotional support? Check all that apply:

☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

How well have things been going for you? (Complete *all that apply):*

Overall	
At school	
In your job	
In your social life	
With close friends	
With your attitude	
With your boyfriend/girlfriend	
With your children	
With your parents	
With your spouse	

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago?	☐ Yes	☐ No
Are you happy & satisfied?	☐ Yes	☐ No
Do you feel your life has meaning and purpose?	☐ Yes	☐ No
Do you believe stress is presently reducing the quality of your life?	☐ Yes	☐ No
Do you like the work you do (wake excited to go to work)?	☐ Yes	☐ No
Are there any past major losses in your life that are still fresh for you?	☐ Yes	☐ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations?	☐ Yes	☐ No
Would you describe your experience as a child in your family as happy and secure?	☐ Yes	☐ No

STRESS/COPING

Have you ever sought counseling?	☐ Yes	☐ No
Are you currently in therapy?	☐ Yes	☐ No
Describe: _____		
Do you feel you have an excessive amount of stress in your life?	☐ Yes	☐ No
Do you feel you can easily handle the stress in your life?	☐ Yes	☐ No

Daily Stressors: Rate on scale of 1-10

Work _____ Family _____ Social _____ Finances_____ Health_____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐ Yes ☐ No

SLEEP/REST

Average number of hours you sleep per night: ☐ >10 ☐ 8-10 ☐ 6-8 ☐ < 6

Do you snore? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

If YES (explain): _____

Quality of Sleep:

☐ Restful
☐ Not restorative
☐ I have trouble with waking during the night.
☐ I have trouble falling to sleep.
☐ I am bothered with mind chatter.
☐ I have kids or pets that interrupt my sleep.
☐ I tend to wake between 1-3 am like clockwork.
☐ I watch TV or read in bed.

EXERCISE

Current Exercise Program: *(CHECK the type of activity, number of sessions/week, & duration)*

☐ Stretching _____
☐ Cardio/Aerobics _____
_____
☐ Strength (yoga, Pilates, gyro tonics, etc.) _____
☐ Sports or Leisure (golf, tennis, rollerblading, etc.) _____

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High

What exercise do you like to do? _____
List problems that limit your activity: _____
_____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

If yes, please describe: _____

Do you usually sweat when exercising? ☐ Yes ☐ No

WEIGHT

Any recent or chronic weight issues: ☐ Yes ☐ No
If Yes, please detail: _____

What have you done already to help yourself with your weight? _____
_____

What are your weight goals & how are you planning to achieve these goals?_____
_____

☐ Binge Eating ☐ Eating Disorder (Explain): _____
☐ Can't Gain Weight ☐ Can't Lose Weight ☐ Can't Maintain Healthy Weight

☐ Frequent Dieting ☐ Poor Appetite ☐ Salt Cravings
☐ Chocolate Cravings ☐ Caffeine Dependency
☐ Carbohydrate Craving (breads, pastas)
☐ Sweet Cravings (candy, cookies, cakes)

BOWEL HABITS & DIGESTION

You may have heard the saying, "All disease starts in the gut." Absorption, digestion & elimination are crucial. We'd like to know more about your bowel habits.

How many bowel movements do you have daily? _____

Do you have issues with hemorrhoids? ☐ Yes ☐ No

Do you have other bowel challenges?
Check all that apply:
☐ Constipation
☐ Using laxatives
☐ Diarrhea (watery)
☐ Irritable Bowel Disease (Crohn's or Ulcerative Colitis)
☐ Irritable Bowel Syndrome
☐ Colon polyps
☐ Bowel Cancer_____

Any past foreign travel? ☐ Yes ☐ No
Where? _____
Wilderness Camping? ☐ Yes ☐ No
Where? _____

Do you feel like you digest your food well? ☐ Yes ☐ No
Do you feel bloated after meals? ☐ Yes ☐ No

☐ Abnormal Liver Function Tests
☐ Alternating Diarrhea and Constipation
☐ Anal Spasms
☐ Bad Teeth
☐ Bleeding Gums
☐ Burping ☐ Canker Sores ☐ Cold Sores ☐ Cracking at Corner of Lips
☐ Cramps
☐ Dry Mouth
☐ Excess Flatulence/Gas
☐ Fissures
☐ Indigestion
☐ Mucus in Stools ☐ Periodontal Disease ☐ Sore Tongue ☐ Strong Stool Odor
☐ Undigested Food in Stools

SKIN CONDITION

☐ Acne on Back ☐ Acne on Chest ☐ Acne on Face ☐ Acne on Shoulders
☐ Athlete's Foot ☐ Bumps on Back of Upper Arms
☐ Cellulite
☐ Dark circles under eyes: *how long* _____
☐ Ears get Red ☐ Easy Bruising
☐ Eczema
☐ Hair Loss
☐ Hives ☐ Jock Itch
☐ Lack of sweating ☐ Lackluster skin ☐ Moles w/color/size change
☐ Oily skin
☐ Pale skin ☐ Patchy dullness ☐ Rash

☐ Red face: *When:* _____
☐ Sensitivity to bites: *What kind*: _____
☐ Sensitivity to Poison Ivy/Oak
☐ Shingles ☐ Skin Darkening
☐ Skin itchy
☐ Skin Dryness ☐ Strong Body Odor ☐ Vitiligo

NAILS

☐ Bitten ☐ Brittle ☐ Curve Up
☐ Frayed
☐ Fungus-Fingers
☐ Fungus-Toes ☐ Pitting
☐ Ragged Cuticles
☐ Ridges
☐ White Spots/Lines

NUTRITION HISTORY

Foods affect all aspects of health: physical, mental, emotional, and spiritual.

I generally eat breakfast at: _____ Lunch at: _____ Dinner at: _____
I like to snack on: _____
I have this many snacks most days: _____
If I had to change anything about my diet, I would first work on_____
Because this would _____
Throughout my day, I mostly drink_____
I have a _____ feeling of thirst. ☐ low ☐ strong

Caffeine Intake: ☐ Yes ☐ No

Coffee cups/day: ☐ 1 ☐ 2-4 ☐ > 4

Tea cups/day: ☐ 1 ☐ 2-4 ☐ > 4

Caffeinated Sodas or Diet Sodas Intake: ☐ Yes ☐ No

12-ounce can/bottle ☐ 1 ☐ 2-4 ☐ > 4 per day

List favorite type (ex. Diet Coke, Pepsi): _____

Do you have an adverse reaction to caffeine? ☐ Yes ☐ No

When you drink caffeine do you feel: ☐ Irritable or Wired ☐ Aches & Pains

I have food cravings at _____ time of the day.

Have you ever had a nutrition consultation? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? Describe: _____ ☐ Yes ☐ No

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium
☐ Diabetic ☐ No Dairy ☐ No Gluten ☐ Some Gluten
☐ Vegetarian ☐ Vegan ☐ Ultra-metabolism
☐ Specific Program for Weight Loss/Maintenance _____
☐ Other_____

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No
If yes, describe symptoms: _____

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

List all: _____

_____

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Have you ever had your metabolism (resting metabolic rate) checked? ☐ Yes ☐ No

If yes, what was it? _____

If you could only eat a few foods a week, what would they be?

_____

_____

Do you grocery shop? ☐ Yes ☐ No

If no, who does the shopping? _____

Do you read food labels? ☐ Yes ☐ No

Do you cook? ☐ Yes ☐ No

If no, who does? _____

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater ☐ Erratic eating pattern ☐ Eat too much ☐ Late night eating

☐ Dislike healthy food ☐ Time constraints ☐ Eat more than 50% meals away from home

☐ Travel frequently ☐ Non-availability of healthy foods

☐ Love to eat

☐ Eat because I have to

☐ Have a negative relationship to food

☐ Do not plan meals or menus

☐ Reliance on convenience items

☐ Poor snack choices

☐ Significant other or family members don't like

☐ Significant other or family members have special dietary needs or food preferences

☐ Struggle with eating issues

☐ Emotional eater (eat when sad, lonely, depressed, bored)

☐ Eat too much under stress

☐ Eat too little under stress

☐ Eating in the middle of the night

☐ Don't care to cook

☐ Confused about nutrition advice

Do you adversely react to (*Check all that apply):*

☐ Monosodium glutamate (MSG) ☐ Aspartame (NutraSweet)

☐ Caffeine ☐ Bananas ☐ Garlic ☐ Onion

☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol

☐ Red Wine ☐ Sulfite Containing Foods (wine, dried fruit, salad bars)

☐ Preservatives (ex. sodium benzoate)

☐ Other: _____

Which of these significantly affect you? *Check all that apply:*

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes

☐ Other: _____

In your work or home environment, are you exposed to:

☐ Chemicals ☐ Electromagnetic Radiation

☐ Mold Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No

Have you ever been told you have Gilbert's syndrome or a liver disorder? ☐ Yes ☐ No

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐Herbicides ☐ Insecticides (frequent visits of exterminator)

☐ Pesticides ☐ Organic Solvents

☐ Heavy Metals ☐ Other: _____

Chemical Name, Date, Length of Exposure: _____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures?

☐ Yes ☐ No

Do you have any pets or farm animals? ☐ Yes ☐ No

PREVENTIVE TESTS AND DATE OF LAST TEST

Check the box if 'YES' and provide date

☐ Full Physical Exam _____

☐ Bone Density _____ Results: ☐ High ☐ Low ☐ Within Normal Range

☐ Mammogram _____ ☐ Normal ☐ Abnormal

☐ PAP Test _____ ☐ Normal ☐ Abnormal

☐ Breast Biopsy _____ ☐ Normal ☐ Abnormal

☐ Colonoscopy _____ ☐ Normal ☐ Abnormal

☐ Cardiac Stress Test _____ ☐ Normal ☐ Abnormal

☐ EBT Heart Scan _____ ☐ Normal ☐ Abnormal

☐ EKG _____ ☐ Normal ☐ Abnormal

☐ Hemoccult Test-stool test for blood _____ ☐ Normal ☐ Abnormal

☐ MRI _____ ☐ Normal ☐ Abnormal

☐ CT Scan _____ ☐ Normal ☐ Abnormal

☐ Upper Endoscopy _____ ☐ Normal ☐ Abnormal

☐ Ultrasound _____ ☐ Normal ☐ Abnormal

☐ Functional lab testing _____

PAST INJURIES:

Check box if YES: ☐ Back Injury ☐ Neck Injury

☐ Other _____

DENTAL SURGERY

☐ Silver Mercury Fillings

☐ Gold Fillings

☐ Root Canals
☐ Implants
☐ Tooth Pain
☐ Bleeding Gums
☐ Gingivitis
☐ Problems with Chewing

Do you floss regularly? ☐ Yes ☐ No

MEDICATION SURVEY

Have your medications or supplements ever caused you unusual side effects or problems (Describe)? ☐ Yes ☐ No

---

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No

Frequent antibiotics > 3 times/year ☐ Yes ☐ No

Long term antibiotics ☐ Yes ☐ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ☐ Yes ☐ No

Use of oral contraceptives ☐ Yes ☐ No

READINESS ASSESSMENT

How ready are you to change and improving your health today?

On a scale from 1-10 how willing are you to: (**1 being not willing, 10 being 100% committed**)

	1	2	3	4	5	6	7	8	9	10
Significantly modify my diet	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Take nutritional supplements daily	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Keep a detailed diet dairy for awhile	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Modify my lifestyle (i.e., work demands, sleep)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Practice a relaxation technique	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Engage in regular exercise	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have periodic lab tests to assess my progress	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At the present time, how supportive do you think the people in your household will be to your implementing the above changes?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

I am committed in improving my health	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

I need the most help in this area: _____

_____

I am not prepared to _____

Thank you for your honesty and time completing this survey!

To your health,

Dr. Cindi Croft

NEW DIMENSIONS FAMILY CARE, PLLC – *the future of medicine*

Dr. Cindi Croft

Phone: **603-275-9585**
e-mail: NewdimensionsFC102@gmail.com
Website: drcindicroft.com

NAME (Please print): _____ **DATE**: _____

WOMEN'S HEALTH SURVEY

We'd like to know more about your cycling and hormone balance.

How often do you menstruate?

- ☐ ***Prepuberty*** (not just yet)
- ☐ ***Regular month cycles***
- ☐ ***Irregular cycles***
- ☐ ***Menopausal*** (stopped cycling)
- ☐ ***I'm currently pregnant and/or nursing***
- ☐ ***Other:*** _____

The FLOW of my period is:

- ☐ ***Light:*** only need a panty liner
- ☐ ***Average:*** a pad/tampon every 3-4 hours
- ☐ ***Heavy:*** a pad/tampon every 2 hours
- ☐ ***Severe:*** I soak through clothes regularly and have to stay home

Symptoms I usually have with my cycles:

- ☐ Bowel changes
- ☐ Breast swelling
- ☐ Clots
- ☐ Cramping
- ☐ Edema: Fluid retention/weight gain
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Food cravings
- ☐ Headache
- ☐ Irritable / Angry
- ☐ Nausea
- ☐ Pain

☐ Sad/weepy

☐ I am not menstruating

☐ Other: _____

Fertility Issues:

☐ None

☐ Chemical: I have been using birth control for a long time.

☐ I'm a Mom and very busy so think it is just life stress.

☐ I'm currently nursing my baby. ☐ I have PCOS.
☐ I have seen a fertility specialist.

☐ Other: _____

Are you in menopause? ☐ ***Yes*** ☐ ***No***

Age at Menopause _____

Check any associated symptoms you are experiencing in menopause:

☐ Concentration/Memory Problems

☐ Decreased Libido

☐ Headaches

☐ Heavy Bleeding

☐ Hot Flashes

☐ Joint Pains

☐ Loss of Control of Urine

☐ Mood Swings

☐ Palpitations

☐ Use of hormone replacement therapy. ***How long?*** _____

☐ Vaginal Dryness

☐ Weight Gain

Comments: _____

Thank you!

NEW DIMENSIONS FAMILY CARE, PLLC – *the future of medicine*

Dr. Cindi Croft

Phone: **603-275-9585**
e-mail: NewdimensionsFC102@gmail.com
Website: drcindicroft.com

NAME (Please print): _____ **DATE**: _____

Men's Health Survey

This questionnaire is about symptoms of low testosterone (Androgen deficiency in the aging male). This basic questionnaire can be very useful for men to describe the kind and severity of their low testosterone symptoms.

Do you have a decrease in libido (sex drive)?	☐ Yes ☐ No
Do you have a lack of energy?	☐ Yes ☐ No
Do you have a decrease in strength and/or endurance?	☐ Yes ☐ No
Have you lost height?	☐ Yes ☐ No
Have you noticed a decreased "enjoyment of life"?	☐ Yes ☐ No
Are you sad and/or grumpy?	☐ Yes ☐ No
Are your erections less strong?	☐ Yes ☐ No
Have you noticed a recent deterioration in your ability to play sports?	☐ Yes ☐ No
Are you falling asleep after dinner?	☐ Yes ☐ No
Has there been a recent deterioration in your work performance?	☐ Yes ☐ No

If you answered 'Yes' to number 1 or 7 or if you answered 'Yes' to more than 3 questions, you may have low Testosterone.

Have you had a PSA done? ☐ Yes ☐ No

PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ > 10 ☐ Prostate enlargement

☐ Prostate infection
☐ Impotence
☐ Difficulty obtaining an erection
☐ Difficulty maintaining an erection
☐ Nocturia (urination at night). How many times at night? _____
☐ Urgency/hesitancy/change in urinary stream
☐ Loss of control of urine. How long? _____

PEDIATRIC HEALTH SURVEY

This is a health survey designed to help me learn about you before our first visit.

PLEASE COMPLETE & SEND THIS FORM 7+ days BEFORE YOUR VISIT.

Cancellations: 72-hour notice is required for canceling appointments to avoid fees.

Name: _____ Age: _____
Birth date: _____ Time of day born: _____ am pm
Occupation: _____
Sex: □ Male □ Female

My main concern(s) for coming today is:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

If female, check all that apply:

Pre-puberty (not menstruating)

Menstruating If not, why?_____

How many days between menstrual periods? _____
Menstrual period is: Regular Irregular Heavy bleeding Clots Cramping

Breast Swelling Edema Food cravings Irritable/Angry Sad/weepy

PMS symptoms: _____

PRESCRIPTION MEDICATIONS

Drug name What Year Started For What Reason is it Rx

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

9._____
10._____
11._____
12._____
13._____
14._____
15._____

NON PRESCRIPTION MEDICATIONS (Over-the-counter)

Drug name Year Started For What Reason

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Note: Antacids (acid blockers) stop stomach acid needed for proper digestion and are often a cause or contributor of anemia, mineral mal-absorption, and OSTEOPOROSIS. GERD or heartburn may be a sign of stomach irritation, not too much stomach acid. It just feels that way.

NATURAL SUPPLEMENTS (Vitamins, Herbs, etc.)

Supplement name Dose taking For What Reason

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____
13._____
14._____
15._____
16._____
17._____
18._____

Social circumstances:

Conflicts with family relatives or others?

_____
_____
_____
_____
_____

Bowel habits:

How many bowel movements are you having daily? _____ weekly? _____

Do you have hemorrhoids? YES NO

Do you have other bowel challenges?

Using laxatives YES NO

Diarrhea YES NO

IBD YES NO

Polyps YES NO

IBS YES NO

Other (specify) _____

Emotional/Spiritual:

How much time do you spend each day to commune with your inner self or God?
(These activities can include prayer, meditation, scripture study, etc.)
This is a part of your physical health, just as surely as any other part.

Every day Once a week Occasionally Almost Never

Sleep schedule:

In general, what time do you go to sleep? _____ pm am

In general, what time do you wake up? _____ am pm

How many hours of sleep do you get per night? _____

Quality of sleep is _____ (Restful or restless?) Check all that apply:

I have trouble with waking during the night – what time? _____

I have trouble falling to sleep. YES NO

I have to urinate during the night – how many times? _____

I am bothered with mind chatter YES NO

I have pets that interrupt my sleep YES NO

I tend to wake at _____am in the middle of the night like clock work.

I watch TV or read in bed YES NO

Exercise:

How often do you exercise at least 30 minutes?

Daily 2 – 4 x a week 1 x a week Not at all, sedentary

What do you like to do? _____

If you are not exercising, why not?_____
_____

Weight:
Any weight changes in the last couple of years? _____
_____ How much change? _____ Weight goals_____
_____
Why is weight an issue for you?_____
_____
How are you planning to achieve these goals?_____
_____
_____
_____

Major Illnesses & Health Conditions: since birth. Please give age affected.
1._____
2._____
3._____
4._____
5._____

Injuries: What type of injury (falls, fractures, auto accidents,...) and when did it happen?
1._____
2._____
3._____
4._____
5._____

Surgeries: What type of surgery and when did you have it?
1._____
2._____
3._____
4._____
5._____

TRAUMA: Old traumas that changed your life... **I haven't been well since**:
_____
happened to me.
I was a certain way and am now_____
_____

Family Health History

Please list all major health conditions for the following family members (if known):
Father _____
Paternal Grandfather_____
Paternal Grandmother_____
Mother _____

Maternal Grandfather_____
Maternal Grandmother_____
Siblings_____
_____
_____

Dietary habits: Foods affect **all aspects** of health: physical, mental, emotional, and spiritual.

I generally eat breakfast at _____ am, Lunch_____pm & dinner _____pm.
I like to snack on _____
If I had to change anything about my diet, I would first work on_____
_____
Because it would_____.

I drink mainly _____ through the day. I have a _____ feeling of thirst.

Building foods: Concentrate your diet with these foods to heal from serious diseases or for more energy. If raw foods give you gas, lightly steam them. Use these foods as your main staple.
Check all the ones you currently eat.

- ☐ Organic foods
- ☐ Vegetables
- ☐ Raw foods
- ☐ Fresh, ripe fruits
- ☐ Green foods
- ☐ Raw seeds, raw nuts

Maintaining foods: These generally **don't** particularly improve your health.
Use them in moderation. Check all the ones you currently eat.

- ☐ Breads
- ☐ Cooked foods
- ☐ Spicy foods
- ☐ Meats _____x/week: **circle** which ones: deli meat, beef, bison, turkey, chicken, pork
- ☐ Fish
- ☐ Legumes
- ☐ Dairy
- ☐ Frozen foods
- ☐ Peanut butter
- ☐ Boxed or prepared foods
- ☐ Pasta
- ☐ Potato (in any form)
- ☐ Rice
- ☐ Sugar: any desert, candy or sweet treat. I have _____x a week
- ☐ Soda pop: I drink _____cans of _____ every _____
- ☐ Margarine
- ☐ Canned foods
- ☐ Coffee _____ cups a day. Energy Drinks _____ cans x day.
- ☐ Fried foods

Food cravings_____
_____

I would say I am addicted to _____
because _____
Food sensitivities _____
_____

Foods I avoid _____
because_____
_____

Fast foods: I eat out _____times per _____

Tobacco: started at _____ years old and smoke _____ packs per day.
Alcohol: I drink _____every _____.
Recreational drugs: I have used_____ in the past and currently use _____.

On a scale from 0-10 (**10 being 100% committed**) rate the following:

I am _____ committed in improving my health.

I need the most help in this area_____
_____

I am not prepared to _____
_____

Thank you for taking the time to complete this Health Survey!
I look forward in working with you.

To your health,
Dr Cindi Croft