Collaborative Natural Health Partners

NEW PATIENT INTAKE

Legal Name ______________________________ Preferred Name________________ Pronouns_________

Today's Date______________ Date of Birth _______________ Age ____

Gender Identity: __ Male __ Female __ Transgender __ Genderqueer/Gender Nonconforming __Something Else

Sex Assigned At Birth: __ Male __ Female __Intersex __Decline to Answer

Address ____ City _______________ State ____ Zip _________

Home phone __________________ Cell _____________________ Work phone ___________________

Occupation ________________________________ Employer _____________________________________

Email Address ______________________________________

What is your preferred number? C H W Can we leave messages on this voicemail? Y N

Preferred Pharmacy __________________________________

Insurance:

Subscriber's name ___________________________________ Relationship _________________________

Insurance Carrier_____________________________ Subscriber's phone number _____________________

Subscriber's address (if different) ____

List of providers (e.g. primary care physician, oncologist, therapist, rheumatologist)

Name/Group	Location	Phone number
_______________________	_______________________	______________________
_______________________	_______________________	______________________
_______________________	_______________________	______________________
_______________________	_______________________	______________________

Date of last blood work: ____________________

Are you transferring care for primary care? ___ Yes ___ No

Emergency Contact:

Name (Relation)____ Phone_______________________

Family Information:

Relationship Status: Single Married Partnered Divorced Widowed
Partner's name ____________________________ Children: Y N Number_____ Age(s) _____________

How did you hear about our practice? ____

Present Health Concerns (in order of importance):

1. ____
2. ____
3. ____
4. ____

Past Medical History (list year diagnosed):

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

Current Medications (including O-T-C):

Name of Drug	Reason for taking	Dose	Date Started	Prescribed by	Refills Needed
____________	____________	______	______	____________	Y N
____________	____________	______	______	____________	Y N
____________	____________	______	______	____________	Y N
____________	____________	______	______	____________	Y N
____________	____________	______	______	____________	Y N
____________	____________	______	______	____________	Y N
____________	____________	______	______	____________	Y N

Current supplements, vitamins, & Herbs:

Name of Drug	Reason for taking	Dose	Date Started	Prescribed by
____________	____________	______	______	____________
____________	____________	______	______	____________
____________	____________	______	______	____________
____________	____________	______	______	____________
____________	____________	______	______	____________
____________	____________	______	______	____________

Allergies to drugs, environmental, food, etc.:	**Reaction:**
______________________________	______________________
______________________________	______________________
______________________________	______________________

Females/Birth Sex Female:

Interval between periods: _______days
Sexual active: Y N
Date of last pap smear: ___________
Date of last mammogram: _________
History of abnormal pap: Y N
Date of last menstrual period: ______
Date of last bone scan: _______
Menopausal: Y N

History of sexually transmitted diseases: Y N
Form of birth control: ______________
Total pregnancies: ________________
Number of miscarriages: ___________
Number of abortions: ______________
Are you pregnant: Y N
Are you considering pregnancy? Y N
Breastfeeding: Y N

Hospitalizations, Procedures, Injuries (surgeries/special diagnostic studies):

Date	Procedure	Reason	Outcome
______	__________________	__________________	______
______	__________________	__________________	______
______	__________________	__________________	______

Date of last colonoscopy: ________________ **Results:** __________________

Family History: Indicate whether a family member has the following conditions. Please indicate maternal (M) vs paternal (P):

	Diabetes	High Blood Pressure	Heart Disease	Stroke	Mental Disorder	High Cholesterol	Cancer (specify)	Autoimmune disorder (specify)	Digestive disorder
Father									
Mother									
Grandfather									
Grandmother									
Aunt									
Uncle									
Sibling									
Children									

Use the space provided to address any other significant personal or family medical history:
____

____

LIFESTYLE

General:
When was the last time you had excellent/optimal health? ________________________________

How long do you think it will take for you to return to optimal health? _______________________

What is your present level of commitment to address any underlying causes of your signs and symptoms? (Rate 0-10, 10 being 100% committed) ______________

Weight:
Current weight ___________ Highest weight __________ When? ________ Ideal weight _____________

Tobacco: Y N #cigarettes/day_____ Past Smoker_____ Recreational Drugs: Current Past
Alcohol: Wine #glasses/day or wk______ Beer #glasses/day or wk______ Liquor #ounces/day or wk______
Caffeine: Coffee #8oz cups/day______ Water #8oz glasses/day_________

Nutrition and Diet: (circle all that apply)
Omnivore (animal and plant based) Vegetarian Vegan Fat restriction Salt restriction
Carbohydrate restriction Specific restrictions: Wheat Dairy Soy Gluten Other_________________

Exercise: (circle all that apply)
5-7 days/wk 3-4days/wk 1-2days/wk 45min or more duration per workout 30-45min less than 30min
walk - #days/wk____ run/aerobic - #days/wk___ weights - #days/wk___ stretching___ other____________

Stress:
Circle the level of stress you are usually experiencing (1 is the lowest) 1 2 3 4 5 6 7 8 9 10
Indicate the causes of stress: Work Family Relationship Financial Residence Legal problems

Sleep:
Hours of sleep per night _________ Usual Bedtime __________ Do you wake refreshed? Y N

Energy:
Average daily energy level – Rate 0-10 (10 being the greatest) _______

Environmental:
List any major chemical or toxic exposures ____

Review of Systems – Circle C for Current, P for Past

General:

change in appetite	C	P
chills	C	P
fatigue	C	P
fever	C	P
night sweats	C	P
difficulty falling asleep	C	P
difficulty staying asleep	C	P
weight gain	C	P
weight loss	C	P

Allergy:

hives	C	P
congestion	C	P
itching	C	P
watery eyes	C	P

Ears/Eyes/Nose:

decreased hearing	C	P
difficulty swallowing	C	P
dry mouth	C	P
ear pain	C	P
nosebleeds	C	P
ringing of ears	C	P
sinusitis	C	P

Endocrine:

cold intolerance	C	P
excessive sweating	C	P
excessive thirst	C	P
frequent urination	C	P
heat intolerance	C	P
hair thinning	C	P

Respiratory:

cough	C	P
coughing up blood	C	P
pain with breathing	C	P
shortness of breath	C	P
sputum production	C	P
wheezing	C	P

Cardiac:

chest pain at rest	C	P
chest pain with exertion	C	P
cyanosis (blue skin)	C	P
difficulty laying flat	C	P
irregular heartbeat	C	P
palpitations	C	P

Gastrointestinal:

abdominal pain	C	P
blood in stool	C	P
constipation	C	P
decreased appetite	C	P
diarrhea	C	P
heartburn	C	P
nausea	C	P
vomiting	C	P
gas/bloating	C	P

Female/Male/Trans Health:

breast lump	C	P
breast pain	C	P
nipple discharge	C	P
heavy menstrual bleeding	C	P
irregular menses	C	P
missed periods	C	P
hot flashes	C	P
painful intercourse	C	P
genital infection	C	P
genital pain	C	P
low sex drive	C	P
erectile trouble	C	P

Genitourinary:

blood in urine	C	P
difficulty urinating	C	P
frequent urination	C	P
painful urination	C	P
frequent UTIs	C	P

Musculoskeletal:

joint pain/stiffness	C	P
muscle cramps	C	P
sciatica	C	P
swollen joints	C	P
TMJ pain	C	P
reduced range of motion	C	P

Skin:

acne	C	P
dry skin	C	P
rash	C	P
itching	C	P

Neurological:

balance difficulty	C	P
difficulty speaking	C	P
dizziness	C	P
fainting	C	P
loss of strength	C	P
memory loss	C	P
seizures	C	P

Psychiatric:

anxiety	C	P
depressed mood	C	P
eating disorder	C	P
mental abuse	C	P
physical abuse	C	P
substance abuse	C	P
suicidal thoughts	C	P

SIGNATURE ______________________________ **DATE** ______________