Collaborative Natural Health Partners

NEW PATIENT INTAKE

Name _____ Gender _____ Date of Birth _____ Age ____

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

Who do we have permission to discuss your care with? _____

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 for primary care? __ Yes __ No

Emergency Contact:

Name (Relation)_____ Phone_____

Family Information:

Marital Status: Single Married Partner Divorced Widow(er)
Spouse'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. _____

Current Medications (including O-T-C):

Name of Drug	Reason for taking	Dose	Date Started	Prescribed by

Do you need refills on your current medications? Y N
If yes, please list what you need: _____

Current supplements, vitamins, & Herbs:

Name of Drug	Reason for taking	Dose	Date Started	Prescribed by

Allergies to drugs, environmental, food, etc (state reaction):

_____
_____
_____

Females only (indicate what is applicable):

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: _____
Menopausal: Y N
Breastfeeding: 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

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

Date	Procedure	Reason	Outcome

Family History: Indicate whether a family member has the following conditions

	Diabetes	High Blood Pressure	Heart Disease	Stroke	Mental Disorder	High Cholesterol	Cancer	Autoimmune disorder	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 Health (as applicable)
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** _____