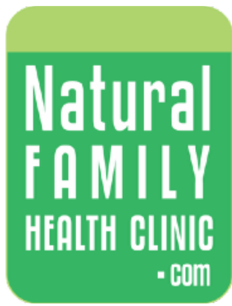

Office Use Only:

☐ Reviewed with Patient	Date:	Initials:
☐ Data Entry	Date:	Initials:
☐ Scan & File	Date:	Initials:

Today's Date: ______________________

Who is filling out this intake form? Self Spouse Parent Guardian

If you are not the patient, please provide your name:

____

Patient Demographics

First Name: ______________________________

Last Name: ______________________________

Date of Birth: ____________________________

Sex: Male Female

Gender: ___________________________

Street Address:____

City, State, Zip Code:____

Email Address: ____

Mobile Phone Number: ____

Home Phone Number: ____

Please write in your preferences, or circle "prefer not to respond":

Preferred Language: ___________________________________ Prefer not to respond

Ethnicity: ____ Prefer not to respond

Race: ____ Prefer not to respond

Emergency Contact Information

Name: ____ Contact Phone: ______________

Relationship to patient: ____

Patient Insurance Information

This section is required in order to bill eligible insurance plans.

Insurance Company Name:____

Member ID:____

Group Number:____

Primary Subscriber Name & Date of Birth (if different than the patient):

____

Insurance Consent - please read and sign below this statement:
By providing insurance information on this form I authorize Natural Family Health Clinic to bill my insurance. This includes the release of any medical information necessary to process claims. I further authorize my insurance company to make payments directly to Natural Family Health Clinic.

Signature: ____Date: ____________

Printed Name: ____

What is the main reason you are here today?

____

____

Allergies? List them all (or attach a list)!

____

____

____

Medications? Supplements? List them all (or attach a list)!

____

____

____

Required:

Last Name, First Name: DOB:

Are you currently experiencing any of the following?
Please check the box(es) below to indicate if you have experienced any of the following conditions within the last 24 hours.

- ☐ Fever
- ☐ Sweats or Chills
- ☐ Myalgia (Muscle Pain)
- ☐ Weakness or Fatigue
- ☐ Weight loss.
- ☐ Ear Pain
- ☐ Mouth Pain
- ☐ Tooth Pain
- ☐ Sore Throat
- ☐ Hearing Loss
- ☐ Nasal Discharge
- ☐ Nasal Congestion
- ☐ Hoarse Voice
- ☐ Sinus Pressure.
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Pain in Eyes
- ☐ Redness of Eyes
- ☐ Tearing of Eyes
- ☐ Matting of Hair
- ☐ Swelling
- ☐ Itching
- ☐ Crusting.
- ☐ Headache
- ☐ Numbness
- ☐ Local Weakness
- ☐ General Weakness
- ☐ Dizziness.
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing
- ☐ Coughing Blood
- ☐ Lung Pain
- ☐ Chest Pain
- ☐ Chest Pressure
- ☐ Shortness of Breath While Laying Down
- ☐ Palpitations
- ☐ Bilateral Leg & Foot Edema
- ☐ Severe Shortness of Breath while Sleeping
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Pain while Urinating
- ☐ Abnormal Urinary Frequency Inability to Urinate
- ☐ Vaginal or Penile Discharge
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Back Stiffness
- ☐ Neck Pain
- ☐ Neck Stiffness.
- ☐ Rash or Itch
- ☐ Redness,
- ☐ Tenderness
- ☐ Swelling.
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Swollen glands

Required:

Last Name, First Name: DOB:

Personal Medical History:

Please check the box(es) to indicate any conditions you have had, or are currently experiencing. If you have never experienced any conditions please indicate "No Disease/Conditions".

☐ No Disease/Conditions
☐ ADD/ADHD
☐ AIDS/HIV
☐ Abuse/Domestic Violence
☐ Allergies/Hayfever
☐ Anemia
☐ Anesthesia Complications
☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ Autism Spectrum Disorder
☐ Bedwetting
☐ Birth Defects or Inherited
☐ Disease
☐ Bladder or Kidney
☐ Problems
☐ Blood Diseases
☐ Blood Transfusion
☐ Breast Cancer
☐ Breast Problem
☐ COPD
☐ Cancer
☐ Chicken Pox
☐ Chronic Ear Infections
☐ Congestive Heart Failure
☐ (CHF)
☐ Constipation
☐ Coronary Artery Disease
☐ Depression
☐ Developmental or
☐ Behavioral Disorders
☐ Diabetes
☐ Difficulty Swallowing
☐ Diverticulitis
☐ Ear or Hearing Problems
☐ Eating Disorder
☐ Eczema
☐ Endometriosis
☐ Fibromyalgia
☐ GI Problems
☐ Gout
☐ Headaches
☐ Heart Disease
☐ Heart Problems
☐ Hepatitis
☐ High Cholesterol
☐ Hospitalizations
☐ Hypertension
☐ Hyperthyroidism
☐ Infertility
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lung Disease
☐ MRSA exposure
☐ Meziere's disease
☐ Mental Disorder
☐ Mental Illness
☐ Muscle, Joint, or Bone
☐ Problems
☐ Obesity
☐ Osteoporosis
☐ Ovarian Cancer
☐ Polyps
☐ Pre-Eclampsia
☐ Pulmonary Embolism
☐ Reflux/GERD
☐ Seizures/Epilepsy
☐ Skin Problems
☐ Stroke
☐ Thrombophilias
☐ Thyroid Problems
☐ Travel near Ebola
☐ Tuberculosis
☐ Varicosities
☐ Vision or Eye Problems

Do you engage in any potentially risky behaviors, such as illicit drug use, anonymous sex, binge drinking (over 4 drinks in one sitting), or intravenous drug use by yourself or a sexual partner? Circle one:
No Yes Prefer not to respond I need more information

What is your current activity level? Circle one:
Sedentary Low Medium High Extreme Sports!

What is your preferred level of exercise? Circle one:
None Occasional Moderate Heavy

How do you exercise? ____

Is there anything else you would like to share?_________________________________
____
____

Family History
Please check the box(es) next to any conditions that run in your family:

- ☐ Alcohol Abuse
- ☐ Alzheimer’s Disease
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ ADD/ADHD
- ☐ BRCA1 Mutation
- ☐ Carrier Detection Test
- ☐ BRCA2 Mutation
- ☐ Carrier Detection Test
- ☐ Blood Coagulation Disorder
- ☐ Cancer
- ☐ Cerebrovascular Accident
- ☐ Chronic Obstructive Lung Disease
- ☐ Coronary Arteriosclerosis
- ☐ Dementia
- ☐ Depressive Disorder
- ☐ Diabetes Mellitus
- ☐ Disorder of Nervous System
- ☐ Disorder of Thyroid Gland
- ☐ Epilepsy
- ☐ Headache
- ☐ Heart Disease
- ☐ Hypercholesterolemia
- ☐ Hypertensive Disorder
- ☐ Kidney Disease
- ☐ Mental Disorder
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Seizure Disorder
- ☐ Sleep Disorder
- ☐ Substance Abuse

What side(s) of the family experienced this history? Please describe:

Gynecological History

At what age did you first menstruate:

Age ____________________

Date of Last Menstruation

Date____________________

Duration of Flow (days)

#___________days

Menses Monthly? Y N

Have you been pregnant? Y N

Are you currently pregnant? Y N

Date of Last Pap Smear

Date____________________

Abnormal Pap? Y N

Date(s)________________________

HPV Vaccine Y N

Date____________________

If Post Menopausal, age at menopause:

#___________years

Surgical History

Type of Surgery Date(s) of procedure

____

____

____

____

____

Date of Last Colonoscopy, if applicable: __________________________

Immunization History

Do you receive an annual flu shot? Y N

Please check if you have received any of the following:

☐ DTap Date(s): __________________

☐ Hep B, unspecified formulation Date(s): __________________

☐ MMR Date(s): __________________

Additional Immunizations Date(s) of procedure

____

____

With my signature below I verify that the information submitted is correct to the best of my knowledge.

Signature: ____ Date: ____________

Printed Name: ____