



new patient intake form

Date ___/___/___

Name _____ Date of Birth _____

Address _____ Age _____

City, State, Zip _____ Sex M F

Email Address _____

Home Phone _____ Work Phone _____ Occupation _____

How did you hear about Natural Flow? _____

Are you currently under the care of any other health professional?

If yes, name and reason _____

Reason for visit today _____

Do you have any chronic health problems or other diagnoses? (please list, include date diagnosed)

Please list all current medications and supplements

(include name brand, dose, reason for taking, and prescriber)

1. _____

2. _____

3. _____

4. _____

5. _____

What are your top 2 health goals you wish to address at today's visit?

1. _____

2. _____

What is your current level of commitment to addressing these issues?

I am willing to make any changes and do whatever is necessary

I am willing to make some changes in my lifestyle to feel better

I may consider change if absolutely necessary to feel better

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Family Medical History

(M= Mother, F= Father, G= Grandparents, B= Brother, S= Sister, C= Children, Sp= Spouse)

- Allergies Arthritis Cancer Diabetes Seizures
 Asthma Alcoholism Heart Disease Stroke

Your Past Medical History

- | | | | |
|-------------------------------------|--|--|--|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fatigue | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Colon | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Alzheimers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> IBS | <input type="checkbox"/> STD |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migrane | <input type="checkbox"/> Other, list _____ |

Rate Current Stress 0-10

(Mild 1-3 Moderate 4-6 Severe 7-10)

- Job or school _____
Financial _____
Primary Relationship _____
Family/Parents/Children _____
Divorce/Separation/Death _____
Overall _____

Have you ever used

- Vitamin Therapy
- Herbal Medicines
- Homeopathic Medicine
- Acupuncture
- Spinal Manipulation
- Colonic Therapy
- Massage Therapy
- Naturopathic Physician