



# new patient intake form

Date \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Sex M F

Email Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell 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

>

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"/> Migraine            | <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