*Willowbend Natural Medicine*
*405 D Street, Suite 1 ❖ Petaluma, CA 94952 ❖ 707.780.6033 ❖ Fax: 707.283.0064*

# ADULT INTAKE FORM

All contact information is for professional use only and will be held in strict confidence.

Name ______ Date of Birth ______ Age ______

Address ______ City ______ State ______ Zip ______

Cell phone ______ Home phone ______ Work phone ______

Email ______

How did you hear about this practice? ______

Occupation ______ Employer ______

Marital Status ______ Spouse/partner's name ______

Emergency contact ______ Relationship ______ Phone ______

| Other current healthcare providers | Phone |
| --- | --- |
| | |
| | |
| | |

PRESENT HEALTH CONCERNS:
Please list your health concerns in order of their significance to you.

1. ______
2. ______
3. ______
4. ______
5. ______

What do you think is causing your symptoms? ______

What other treatments have you tried? ______

CHILDHOOD HEALTH HISTORY

***As a child did you have:***

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Constipation
- ☐ Digestive problems
- ☐ Ear infections
- ☐ Eczema
- ☐ Frequent colds
- ☐ Head injury
- ☐ Hives
- ☐ Meningitis
- ☐ Mercury fillings
- ☐ Mononucleosis
- ☐ Polio
- ☐ Seizures
- ☐ Strep throat
- ☐ Tonsillitis

***Vaccination History***

- ☐ Had all recommended vaccines
- ☐ Had certain vaccinations, listed here: ______________________________
- ☐ No vaccines
- ☐ Had vaccine reaction. Explain: ______________________________

PAST MEDICAL HISTORY

***Have you ever been diagnosed with any of the following?***

- ☐ Addiction
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Bladder infection/condition
- ☐ Bowel condition/disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Gall bladder disease
- ☐ Headaches
- ☐ Heart disease
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Lyme disease
- ☐ Menopausal symptoms
- ☐ Menstrual problems
- ☐ Musculoskeletal condition
- ☐ Neurological condition
- ☐ Psychological condition
- ☐ Reproductive system disease
- ☐ Rheumatic fever
- ☐ Sinus infections
- ☐ Skin condition/acne
- ☐ Stomach condition/disease
- ☐ Thyroid disorder
- ☐ Ulcers
- ☐ Other____________
- ☐ Other____________
- ☐ Other____________

Please describe details of above______________________________

______________________________

***Allergies***

- ☐ Drugs Name and reaction ______________________________
- ☐ Foods Name and reaction ______________________________
- ☐ Environment (pollen, dander, etc.) Type and reaction ______________________________

| ***Hospitalizations, Surgeries, X-rays, other Imaging, and reasons for*** | ***Year*** |
|---|---|
| | |
| | |
| | |
| | |
| | |

CURRENT MEDICATIONS * **Herbs, Vitamins, Contraceptives, Pharmaceuticals** *

| ***Name*** | ***Dose*** | ***Number of times daily*** | ***For how long*** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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| | | | |

PREGNANCY HISTORY (WOMEN ONLY)

# of pregnancies ________ # of births ________ # of miscarriages ________ # of terminations ________

| ***Children's names*** | ***Gender*** | ***Age*** | ***Date of birth*** |
|---|---|---|---|
| ______________________________ | ______ | ______ | __________ |
| ______________________________ | ______ | ______ | __________ |
| ______________________________ | ______ | ______ | __________ |
| ______________________________ | ______ | ______ | __________ |

FAMILY HISTORY

| **Condition** | **Has a relative had this?** | **Relative** | **Condition** | **Has a relative had this?** | **Relative** |
|---|---|---|---|---|---|
| Allergies | ☐ | ______________ | High blood pressure | ☐ | ______________ |
| Hay fever/hives | ☐ | ______________ | Kidney disease | ☐ | ______________ |
| Asthma | ☐ | ______________ | Liver disease | ☐ | ______________ |
| Eczema | ☐ | ______________ | Gastrointestinal disease | ☐ | ______________ |
| Anemia | ☐ | ______________ | Food allergies | ☐ | ______________ |
| Bleeding disorder | ☐ | ______________ | Epilepsy | ☐ | ______________ |
| Birth defect | ☐ | ______________ | Alzheimer's | ☐ | ______________ |
| Cancer | ☐ | ______________ | Depression or Anxiety | ☐ | ______________ |
| Diabetes | ☐ | ______________ | Addiction | ☐ | ______________ |
| Heart disease | ☐ | ______________ | Schizophrenia | ☐ | ______________ |
| Heart attack | ☐ | ______________ | OCD | ☐ | ______________ |
| Stroke | ☐ | ______________ | Tonsillectomy | ☐ | ______________ |
| Obesity | ☐ | ______________ | Tuberculosis | ☐ | ______________ |
| High cholesterol | ☐ | ______________ | Other/specify | ☐ | ______________ |

Diet guidelines you follow ____________________________________________

What have you eaten in the past 24 hours?

Breakfast: ____________________________________________

Lunch: ____________________________________________

Dinner: ____________________________________________

Daily water intake: ____________ Source: ____________________

Other fluids? (coffee, sodas, juices, alcohol, etc.)____________________________________________

Digestive health: ☐ Constipation ☐ Reflux ☐ Diarrhea ☐ Indigestion ☐ Hemorrhoids ☐ Gas ☐ Bloat

#BM daily ________________ Frequency of urination/day ______________________________

Exercise routine/frequency ______________________________

Hours of work/week ________

Hours of sleep/night ________ Trouble falling asleep? ☐ yes ☐ no Staying asleep? ☐ yes ☐ no

HABITS

| **Substance** | **Current** | **Past** | **Never** | **Frequency** |
|---|---|---|---|---|
| Alcohol | | | | |
| Coffee/caffeine | | | | |
| Tobacco | | | | |
| Marijuana | | | | |
| Other recreational drugs | | | | |

**For the 1st office visit, please bring the following:**

1. This completed and signed intake form
2. Recent labs and imaging that are pertinent
3. Any supplements or medications you may be taking

This is a scent-free office. Please do not wear perfume or lotions that are scented. Thank you!

**Consent for Purposes of Treatment, Payment, and Health Care Operation**

I consent to the use or disclosure of my identifiable health information by Sara Thyr, N.D. for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Sara Thyr, ND may be conditioned upon my consent as by my signature on this document.

My *identifiable health information* means health information collected from me and created or received by my practitioner, another health care provider, a health plan, my employer. This *identifiable health information* relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Sara Thyr, ND is not required to agree to the restrictions that I may request. However, if Sara Thyr, ND agrees to a restriction that I request, the restriction is binding upon Sara Thyr, ND and Willowbend Natural Medicine.

I have the right to revoke this consent, in writing, at any time except to the extent that Sara Thyr, ND and Willowbend Natural Medicine has taken action in reliance of this consent.

I understand I have the right to review Willowbend Natural Medicine Notice of Privacy Practices prior to signing this document. This notice describes the types of uses and disclosures of my *identifiable health information* that will occur in my treatment, payment of my bills or in the performance of health care operations of Willowbend Natural Medicine.

Willowbend Natural Medicine reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

**Emergency Care:**

Our clinic does not administer emergency medical care. In the case of an emergency, please see your family medical/osteopathic physician or the emergency room of the nearest hospital. After emergency care has been administered, patients often respond well to Naturopathic care to accelerate the healing process.

**Payment:**

**We are currently unable to bill insurance.**

Payment is expected at the time of service. We accept personal checks, cash, Mastercard, Visa, American Express & Discover.

**Cancellation Policy:**

**This office requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. Missed appointments without notification will be charged the visit fee. Cancellations with less than 24 hours notice will be billed 50% of the visit fee.** ________ Initial

- I agree to pay for services rendered at the time of services. I acknowledge that I may request the fees for various procedures before they occur and include that information in my decision regarding my healthcare.
- I am aware that my practitioner may charge for telephone consultations.
- I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- I consent to treatment as agreed upon between the doctor and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the doctor

______________________________________ ____________

Signature of Patient or Authorized Representative Date

______________________________________

Printed Name and Relationship