

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

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? _____

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	<input type="checkbox"/>	_____	High blood pressure	<input type="checkbox"/>	_____
Hay fever/hives	<input type="checkbox"/>	_____	Kidney disease	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	_____	Liver disease	<input type="checkbox"/>	_____
Eczema	<input type="checkbox"/>	_____	Gastrointestinal disease	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	_____	Food allergies	<input type="checkbox"/>	_____
Bleeding disorder	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	_____
Birth defect	<input type="checkbox"/>	_____	Alzheimer's	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____	Depression or Anxiety	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____	Addiction	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	_____	Schizophrenia	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	_____	OCD	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	_____	Tonsillectomy	<input type="checkbox"/>	_____
Obesity	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	_____	Other/specify	<input type="checkbox"/>	_____

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:

Missed appointments represent a cost to us, but more importantly it is a disservice to other patients who could have been seen in the time set aside for you.

This office requires at least 48 hours notice of cancellation in advance for our Initial Office Visit and 24 hours notice for Return Office visits. 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