Willowbend Natural Medicine
Sara Thyr, ND
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ADULT INTAKE FORM

All contact information is for professional use only and shall be held in strict confidence, subject to the below Consent form duly signed by patient as to use and disclosure of patient's information.

_____ _____ _____
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. _____

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
- ☐ Cervical Dysplasia
- ☐ Ear infections
- ☐ Eczema
- ☐ Frequent colds
- ☐ Head injury
- ☐ Hives
- ☐ Meningitis
- ☐ Mercury fillings
- ☐ Mononucleosis
- ☐ Polio
- ☐ Seizures
- ☐ Strep throat
- ☐ Tonsillitis
- ☐ HPV

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***

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

Diet guidelines you follow _____

Food recall: In the past day, what have you eaten?

Breakfast: _____

Snacks:_____

Lunch: _____

Dinner: _____

Sugar consumption: _____

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 to Use and Disclosure of Patient Information

I consent to the use or disclosure of my identifiable health information by Sara Thyr, N.D. as my practitioner and doing business as Willowbend Natural Medicine 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 Willowbend Natural Medicine may be conditioned upon my consent as by my signature on this document.

My *identifiable health information* means health information collected from me and developed under the care of or received by Sara Thyr, ND or any another health care provider, health plan, or my employer. This *identifiable health information* relates to my past, present or future mental health or physical condition, and identifies me or provides reasonable grounds to believe the provided information may identify me.

I understand I have the right to request my practitioner as to the use and disclosure of my health information for the purposes of carrying out treatment, payment or health care operations of Willowbend Natural Medicine. I acknowledge and agree that Willowbend Natural Medicine is not required to agree to the restrictions that I may request. However, if Willowbend Natural Medicine agrees to my request , the restriction shall be binding upon Willowbend Natural Medicine. I acknowledge and agree that I have the right to revoke this consent, subject to written notification to

Willowbend Natural Medicine at any time, except to the extent that Willowbend Natural Medicine has already taken action in reliance of this consent.

I understand I have the right to review Willowbend Natural Medicine's 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.

I acknowledge and agree that such Notice of Privacy Practices is subject to revision at any time and that I will be informed of any revision. I acknowledge and agree that I will be provided with a revised Notice of Privacy Practices during my office visit upon request.

I agree to the delivery of health care via telehealth by Sara Thyr, ND and Willowbend Natural Medicine. I understand that Sara Thyr, ND and Willowbend Natural Medicine shall (1) use the same standard of care; (2) retain the same responsibilities of providing informed consent to treatment; (3) ensure the privacy of my medical information and (4) assume any other duties associated with practicing medicine, whether via telehealth or face to face, via in person visits.

I understand that in the emergency context of the COVID19 crisis, State regulations issued under the Health Insurance and Accountability Act of 1999 (HIPAA) tolerate the use of certain popular applications allowing video chats in order to provide telehealth care. I understand further that such use of applications potentially induces privacy risks. However, while I understand Sara Thyr, N D and Willowbend Natural Medicine will do their best efforts to avoid such use of applications, I expressly agree to the use of those applications to provide telehealth care in the specific context of the COVID 19 crisis.

Emergency Care:

Willowbend Natural Medicine or Sara Thyr, ND do not administer emergency medical care. In the event of an emergency, please see your family medical/osteopathic physician or the emergency room of the nearest hospital. After emergency care has been administered, Willowbend Natural Medicine will be willing to propose Naturopathic care, to which patients often respond well , in order 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 Willowbend Natural Medicine, but more importantly it is a disservice to other patients who could have been examined 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 a quote of Willowbend Natural Medicine's expected fees for various procedures before they occur and include that information in my decision regarding my healthcare.

_____ I am aware that Willowbend Natural Medicine may charge for telephone consultations.

_____ I understand that Willowbend Natural Medicine requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.

_____ I consent to treatment as agreed upon between Willowbend Natural Medicine and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with Sara Thyr, ND.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Printed Name and Relationship