The Healing Sanctuary
an affiliate of Mountain View Hospital

New Patient Intake Form

Name: _____ **DOB**:_____

Preferred Pharmacy: _____

What are your priorities for today's visit?

_____

_____

Do you have Advanced Directives? YES NO

Did you receive the flu vaccine in the prior flu season? YES NO
Did you receive the flu vaccine this current flu season? YES NO

How often have you been bothered by the symptoms <u>below</u> over the last two weeks?
Little interest or pleasure in doing things in the last 2 weeks? (please circle)

Not At All / Several Days / More than half the days / Nearly every day

Feeling down, depressed, or hopeless in the last 2 weeks? (please circle)

Not At All / Several Days / More than half the days / Nearly every day

Social History
(For pediatric patients, please mark yes or no if there has been exposure in the household to the below items)

Category	Yes	No	Usage
Tobacco			
Vaping			
Alcohol			
Substance			

Fall Risk Assessment *(Only answer if you are 65 years or older)*

Are you 65 years or older?	Yes	No
Have you had any falls within the past year?	Yes	No
Have you had a fall with injury?	Yes	No
Do you have a fear of falling?	Yes	No
Do you feel unsteady when standing or walking?	Yes	No

Please answer if you are 65 years or older:
Have you ever received a Pneumonia vaccine? YES NO
If yes, was it less than 5 years ago? YES NO

Patient Sticker
Last _____
First _____
DOB _____
FIN _____

NOT TO BE SCANNED IN THE MEDICAL RECORD

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PATIENT INFORMATION

Today's Date: ___/___/____ Name: _____

Last Name First Name Middle Initial

DOB: ___/___/____ Age: _____ Gender: ☐ M ☐ F Height: _____ Weight: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____ _____ _____ _____

Street City State Zip Code

Home: (_____)_____ Cell: (_____)_____

Work: (_____)_____ Preferred Contact Number: ☐ Home ☐ Work ☐ Cell

Email: _____

Primary Care Pysician: _____

Emergency Contact

Name: _____ Emergency Phone: (_____)_____

Relationship to Patient: _____

Insurance Carrier: _____

Member ID: _____

Group Number: _____

Valid Date: _____

Subscriber Name and DOB if someone other than yourself:

_____

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YOUR HEALTH

What are your main concerns for the visit today? Please list in priority from 1 to 4.

1. _____
2. _____
3. _____
4. _____

CURRENT MEDICATIONS AND SUPPLEMENTS *(Please list dose & Frequency)*	

ALLEGIES	
Medications/ Supplements/ Food/Environment:	**Reaction: (rash, nausea, shortness of breath, anaphylactic shock**

ALCOHOL CONSUMPTION	TOBACCO USE	E-CIGARETTE/VAPE USE
How often do you drink per week? *1 drink = 5 ounces wine, 12 oz beer, 1.5 oz spirits* □ None □ Daily □ 1-2/week □ 3-5/week □ 1-2/month □ 1-2/year	□ Never □ Past Smoker/Smokeless Tobacco □ Present Smoker/Smokeless Tobacco How many years? _____ Packs/Cans per day: _____	□ Never □ Past Smoker □ Present Smoker Does it contain Nicotine? □ Yes □ No

Recreational Drug Use: ☐ Current ☐ Former ☐ Never ☐ Unknown

01DEC2025

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REPRODUCTIVE HISTORY	
Age of 1st Menses:	Date of Last Period:
Date of Last Pap Smear:	Date of Last Mammogram:
Date of Last Colonoscopy:	Date of Last Bone Density Scan:
Number of Pregnancies:	Number of Live Births:
Number of C Sections:	

MEDICAL AND SURGICAL HISTORY

DIAGNOSIS	DATE OF ONSET RESOLUTION

SURGERIES	DATE

FAMILY HISTORY

Please list any conditions or illnesses (i.e., cancers, high blood pressure, diabetes, autoimmune diseases, heart diseases, blood diseases, asthma, depression, substanc3e, celiac, disease. IBS).

Family Member	Diagnosis	Age at Onset	If Deceased, Age of Death
Father			
Mother			
Brother			
Sister			
Maternal Grandfather			
Paternal Grandfather			
Maternal Grandmother			
Paternal Grandmother			

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