PATIENT INTAKE FORM

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

Social Security Number:_____Driver's License Number: _____

Address: _____ _____ _____ _____
Street City State Zip Code

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

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

Email: _____

☐ Yes, you would like to receive clinic updates and informational material. It will solely be used within The Healing Sanctuary for clinic purposes only.

How did you hear about us? ☐ Friend ☐ Family ☐ Radio ☐ Search Engine ☐ Newspaper ☐ Social Media ☐ Other

Preferred Method of Communication: _____

Emergency Contact: _____ Emergency Phone: (_____) _____

Address: _____ _____ _____ _____
Street City State Zip Code

Relationship to Patient: _____

EMPLOYMENT INFORMATION

Patient Employer Name:_____Occupation: _____

Contact Number: (_____) _____

INSURANCE INFORMATION

Primary Insurance Carrier

Insurance Carrier:_____

Carrier Phone: (_____) _____

Co-Pay Amount:_____

Policy Number: _____

Group Number: _____

Policy Holder's Name:_____

Policy Holder's DOB:_____/_____/_____

Policy Holder's SSN: _____

Effective Date:_____/_____/ _____

Secondary Insurance Carrier (if applicable)

Insurance Carrier: _____

Carrier Phone: (_____) _____

Co-Pay Amount: _____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

Policy Holder's DOB:_____/_____/ _____

Policy Holder's SSN: _____

Effective Date:_____/_____/ _____

Please list names of anyone you would like us to treat as your Personal Representative on your behalf. This person would have all the same rights to your medical record access that you do.

_____ Name

_____ Relationship

_____ Name

_____ Relationship

I acknowledge that I have had the opportunity to review The Healing Sanctuary's Notice of Privacy Practices.

_____ Patient Signature

CONSENT FOR TREATMENT

I consent to examination, diagnosis and medical care including office lab services (blood draws), injections and imaging (ultrasound, AFI) to be performed by providers and employees of The Healing Sanctuary.

_____ (Signature of Patient or Parent/Guardian of Minor)

_____ (Date)

HEALTH QUESTIONNAIRE

Today's Date: _____ Name: _____

DOB: _____ Age: _____ Gender: _____ Height_____ Weight_____

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Preferred Pharmacy: _____

YOUR HEALTH

What are your goals for your wellness consultation today? Please list in priority from 1 to 4.

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

CURRENT MEDICATIONS AND SUPPLEMENTS (That you're taking)	

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

ALCOHOL CONSUMPTION	TOBACCO CONSUMPTION
How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz beer, 1.5 ounces spirits* ☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ > 10	How many years? _____ Packs per day: _____

YOUR HEALTH (CONT.)

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:_____/_____/ _____

REPRODUCTIVE HISTORY

Are you using any method to prevent pregnancy? ☐ Yes ☐ No

If yes, which type? ☐ Pill ☐ Tubal ☐ Vasectomy ☐ Condoms ☐ Depo-Provera ☐ IUD ☐ Diaphragm

Do you have pain with intercourse? ☐ Yes ☐ No

MEDICAL AND SURGICAL HISTORY

DIAGNOSIS	DATE OF ONSET OR RESOLUTION

SURGERIES	DATE

* Use additional sheet if needed.

PREGNANCY HISTORY

DATE	# WEEKS AT DELIVERY	HOURS IN LABOR	BIRTH WEIGHT	SEX	DELIVERY TYPE (VAGINAL, C-SECTION, FORCEPS)	COMPLICATIONS

FAMILY MEDICAL HISTORY

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

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

Medical Doctors or Providers Whom You See