Tree of Life Medicine

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ADULT INTAKE FORM

Name _____ Date of First Visit _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home)_____ (work/cell) _____

Email_____

Age ____ Date of Birth _____ Social Security Number_____

Birth Sex_____Gender_____

Insurance Provider_____ Member ID# _____

Single Married Partnership Separated Divorced Widowed

Live with: Spouse Partner Parents Children Friends Alone

Occupation _____ Hours per week _____ Retired _____

Are you in need of assistance communicating (interpreter/large text/etc)? Yes No

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

Emergency Contact _____

Relationship _____ Phone _____

Are you currently receiving healthcare? Y N

If yes, where and from whom?_____

Terms and Conditions of Treatment

Consent for Treatment:

I understand that my care as a patient at Tree of Life Medicine is directed by Naturopathic Physicians, licensed acupuncturists, and/or other licensed professionals. I consent to services rendered and provided to me under the instructions of these professionals assisting in my care.

I may be contacted by Tree of Life Medicine' physicians for voluntary participation in clinical research projects. I do, however, have the right to refuse these programs without jeopardizing my future care at Tree of Life Medicine in any way.

HIPAA Notice of Privacy Practices and Consent:

I hereby consent to the use and disclosure of my protected health information by Tree of Life Medicine for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

Statement of Financial Responsibility:

I understand and agree to the following:

- Payment for services rendered are my responsibility as the patient or patient's responsible party.
- I am responsible for paying for all services, including lab tests, rendered at the time of service.
- If I am receiving a discount of any sort, I am responsible for providing accurate and thorough documentation supporting it and I am responsible for paying in full at the time of service.

Insurance billing:

If I am billing insurance for services rendered, I understand and agree to the following:

- I authorize Tree of Life Medicine to release pertinent medical records related to billing directly to my insurance carrier. This release applies to support of the insurance billing process only.
- I am responsible for any and all charges that my insurance company will not cover.

_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date

What are your most important health problems? List as many as you can in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____

How do your conditions affect you?

_____
_____

What do you think is happening?

_____
_____

Why? _____
_____

General

Weight_____lbs. Weight one year ago_____lbs.

Maximum Weight_____lbs. When?_____ Height_____

Any major Traumas?_____

Do you Smoke Y N If yes, how much?_____

Are you exposed to second hand smoke in your home? Y N

Do you watch television?_____ Hours per day/week?_____/_____

Do you spend time on the computer?_____ Hours per day/week?_____/_____

Do you feel like you have an adequate support system (friends/family)? Y N

Do you need assistance with resources for any of the following? (please circle)

Housing Food Transportation Other _____

Do you eat at least 5 servings of fruits or vegetables per day? Y N

Do you receive regular dental care (regularly scheduled cleanings every 6 months)? Y N

Were you immunized as a child? Y N If yes, do you have a copy of your record? Y N

Do you have an advanced directive? Y N Are you interested in having one? Y N

Family History

	Mother	Father	Brothers	Sisters	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Age (if living)								
Health (G=good, P=poor)								
Age at death (if deceased)								
Cause of Death								
Check (√)those Applicable								
Cancer								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Epilepsy								
Asthma/Hayfever/Hives								
Substance Abuse								
Mental Health								
If yes to Mental Health, please elaborate:								
	Mother	Father	Brothers	Sisters	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Eczema/Psoriasis								
Anemia								
Kidney Disease								
Glaucoma								
Tuberculosis								
Auto Immune								
Allergies								

For all of the following sections:

Y = a condition you have **N** = never had **P** = a condition you had previously

Childhood Illnesses					
Scarlet Fever	Y N P	Diphtheria	Y N P	Rheumatic Fever	Y N P
Mumps	Y N P	Measles	Y N P	Pertussis	Y N P
Musculoskeletal					
Joint pain or stiffness	Y N P	Broken bones	Y N P	Weakness	Y N P
Muscle spasms/cramps	Y N P	Arthritis	Y N P	Sciatica	Y N P
Blood/Peripheral Vasc.					
Easy bleeding/bruising	Y N P	Varicose veins	Y N P	Cold hands/feet	Y N P
Deep leg pain	Y N P	Anemia	Y N P		
Mental/Emotional					
Treated for emotional problems	Y N P	Considered/ Attempted Suicide	Y N P	Anxiety or Nervousness	Y N P
Mood swings	Y N P	Depression	Y N P	Memory problems	Y N P
Poor concentration	Y N P	Tension	Y N P	History of Abuse	Y N P
Endocrine					
Thyroid Imbalance	Y N P	Diabetes	Y N P	Heat/Cold intoler.	Y N P
Weight loss/gain	Y N P	Excessive thirst	Y N P	Fatigue	Y N P
Hypoglycemia	Y N P				
Immune					
Chronic swollen glands	Y N P	Imm. compromised	Y N P	Slow wound healing	Y N P
Neurologic					
Seizures	Y N P	Paralysis	Y N P	Muscle weakness	Y N P
Numbness or Tingling	Y N P	Loss of memory	Y N P	Easily stressed	Y N P
Vertigo or dizziness	Y N P				
Skin					
Rashes	Y N P	Acne, Boils	Y N P	Lumps	Y N P
Itching	Y N P	Color Change	Y N P		
Perpetual hair loss	Y N P	Night sweats	Y N P		

Head					
Headaches	Y N P	Migraines	Y N P	Head Injury	Y N P
Jaw/TMJ problems	Y N P				
Eyes					
Impaired Vision	Y N P	Glasses or Contacts	Y N P	Cataracts	Y N P
Color blindness	Y N P	Double vision	Y N P	Eye pain/strain	Y N P
Glaucoma	Y N P	Tearing or dryness	Y N P		
Ears					
Impaired hearing	Y N P	Ringing/Tinnitus	Y N P	Earaches	Y N P
Nose and Sinuses					
Frequent colds	Y N P	Nose bleeds	Y N P	Stuffiness	Y N P
Loss of smell	Y N P	Sinus problems	Y N P		
Mouth and Throat					
Frequent sore throat	Y N P	Hoarseness	Y N P	Teeth grinding	Y N P
Dental cavities	Y N P	Gum problems	Y N P		
Neck					
Lumps	Y N P	Goiter	Y N P		
Respiratory					
Cough	Y N P	Asthma	Y N P	Spitting up blood	Y N P
Emphysema	Y N P	Pneumonia	Y N P	Shortness of breath	Y N P
Cardiovascular					
Heart disease	Y N P	Blood clots	Y N P	Murmurs	Y N P
High/Low blood pressure	Y N P	Chest pain	Y N P	Fainting	Y N P
Palpitations/fluttering	Y N P	Swelling in ankles	Y N P	Rheumatic fever	Y N P
Gastrointestinal					
Trouble swallowing	Y N P	Heartburn	Y N P	Change in thirst	Y N P
Change in appetite	Y N P	Nausea	Y N P	Vomiting	Y N P
Vomiting blood	Y N P	Blood in stool	Y N P	Abdominal Pain	Y N P
Belching or passing gas	Y N P	Constipation	Y N P	Diarrhea	Y N P
Gall bladder disease	Y N P	Liver disease	Y N P	Hemorrhoids	Y N P
Bowel movements	how often?		Is this a change? Y N		

Urinary						
Pain on urination	Y N P	Incr. frequency	Y N P	Incontinence	Y N P
Frequency at night	Y N P	Chlamydia	Y N P	Kidney stones	Y N P
Condyloma (genit. warts)	Y N P	Syphilis	Y N P	Gonorrhea	Y N P
Herpes	Y N P				
Male Reproduction						
Testicular masses	Y N P	Hernias	Y N P	Prostate disease	Y N P
Testicular pain	Y N P	Penile Discharge	Y N P	Are you sexually active?	Y N P
Sexual orientation?		Birth control type?			
Female Reproduction/Breasts						
Age of first menses		Are cycles regular?	Y N P		
Bleeding between cycles	Y N P	Painful menses	Y N P	Heavy or excessive flow	Y N P
Light flow	Y N P	PMS	Y N P	Frequent yeast infections	Y N P
PMS symptoms?:					
Pain during intercourse	Y N P	Endometriosis	Y N P	Ovarian cysts	Y N P
Are you sexually active?	Y N P	Sexual orientation?			
Birth control	Y N P	What type?			
Number of pregnancies		# of Live births		# of miscarriages	
Number of abortions		Abnormal PAP	Y N P	Breast self-exams?	Y N P
Breast pain/tenderness	Y N P	Breast lumps	Y N P	Nipple discharge	Y N P
Breast feeding	Y N P	Mastitis	Y N P		
Menopause	Y N P	Menop. symptoms			

Over the **last 2 weeks**, how often have you been bothered by the following problems?

	Not at all	Several Days	More than Half the days	Nearly every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

PHQ 2: _____ PHQ 9: _____

Think about your drinking in the past year. A drink means one beer, one small glass of wine (5oz.), or one mixed drink containing one shot (1.5oz.) of spirits.

How often do you have a drink containing alcohol?

Never Less than Monthly Monthly Weekly 2-3 times/week 4-6 times/week Daily

How many drinks containing alcohol do you have on a typical day that you are drinking?

1 drink 2 drinks 3 drinks 4 drinks 5-6 drinks 7-9 drinks 10 or more drinks

How often do you have 4 or more drinks on one occasion?

Never Less than Monthly Monthly Weekly 2-3 times/week 4-6 times/week Daily

Allergies

Are you hypersensitive to:

Any drugs?_____

Any foods?_____

Any environmentals?_____

Hospitalization and Surgery

What hospitalizations or surgeries (if any) have you had?

_____ year:_____ _____ year:_____

_____ year:_____ _____ year:_____

What medications are you currently taking? _____

_____

_____

Is there any information about your health you would like to add? _____

_____

_____

_____

Welcome! We're happy to serve you. If you have any questions, please ask!

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