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) _______________________

Is it ok to leave a message?______ Email__________________________________

Age ____ Date of Birth ___________ Social Security Number________________

Gender____

Single Married Partnership Separated Divorced Widowed

Live with: Spouse Partner Parents Children Friends Alone

Occupation ___________________ Hours per week ______ Retired ______

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.

I have fully read and understand the above agreements and authorizations.

Patient (18 years or older) Date

Parent, Guardian, Responsible Party Date

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.

Signature of patient or patient's responsible party Date

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.

Signature of patient or patient's responsible party Date

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.

Signature of patient or patient's 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) ____

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?_______________

Do you watch television?___________ Hours per day/week?_____________/____________

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

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								
Mental Illness								
Asthma/Hayfever/Hives								
Allergies								
Eczema/Psoriasis								
Anemia								
Kidney Disease								
Glaucoma								
Tuberculosis								
Auto Immune								

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
Immunizations					
Polio	Y N	Pertussis	Y N	Flu	Y N
Tetanus	Y N	Diphtheria	Y N	Chicken Pox	Y N
Measles/Mumps/Rubella	Y N	Hep B	Y N	H. Influnzae (HIB)	Y N
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	Thrombophlebitis	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
Endocrine					
Hypothyroid	Y N P	Diabetes	Y N P	Heat/Cold intoler.	Y N P
Hyperthyroid	Y N P	Excessive thirst	Y N P	Weight loss/gain	Y N P
Hypoglycemia	Y N P	Fatigue	Y N P	Seasonal Depression	Y N P
Immune					
Chronic Fatigue Synd.	Y N P	Chronic Infections	Y N P	Slow wound healing	Y N P
Chronic swollen glands	Y N P	Imm. compromised	Y N P	Auto-Immune dz.	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	Loss of balance	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					
Spots in Eyes	Y N P	Cataracts	Y N P	Impaired vision	Y N P
Glasses or contacts	Y N P	Blurriness	Y N P	Eye pain/strain	Y N P
Color blindness	Y N P	Tearing or dryness	Y N P	Double vision	Y N P
Glaucoma	Y N P				
Ears					
Impaired hearing	Y N P	Ringing	Y N P	Earaches	Y N P
Dizziness	Y N P				
Nose and Sinuses					
Frequent colds	Y N P	Nose bleeds	Y N P	Stuffiness	Y N P
Hayfever	Y N P	Sinus problems	Y N P	Loss of smell	Y N P
Mouth and Throat					
Frequent sore throat	Y N P	Copious saliva	Y N P	Teeth grinding	Y N P
Sore tongue/lips	Y N P	Gum problems	Y N P	Hoarseness	Y N P
Dental cavities	Y N P	Jaw clicks	Y N P		
Neck					
Lumps	Y N P	Swollen glands	Y N P	Goiter	Y N P
Pain or stiffness	Y N P				
Respiratory					
Cough	Y N P	Sputum	Y N P	Spitting up blood	Y N P
Wheezing	Y N P	Asthma	Y N P	Bronchitis	Y N P
Short of breath lying down	Y N P	Pleurisy	Y N P	Emphysema	Y N P
Difficulty breathing	Y N P	Pain on breathing	Y N P	Shortness of breath	Y N P
Short of breath at night	Y N P	Tuberculosis	Y N P	Pneumonia	Y N P
Cardiovascular					
Heart disease	Y N P	Angina	Y N P	Murmurs	Y N P
High/Low blood pressure	Y N P	Blood clots	Y N P	Fainting	Y N P
Palpitations/fluttering	Y N P	Phlebitis	Y N P	Rheumatic fever	Y N P
Swelling in ankles	Y N P	Chest pain	Y N P		
Gastrointestinal					
Trouble swallowing	Y N P	Heartburn	Y N P	Change in thirst	Y N
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	Pain or cramps	Y N P

Belching or passing gas	Y N P	Constipation	Y N P	Diarrhea	Y N P
Gall bladder disease	Y N P	Black stools	Y N P	Ulcer	Y N P
Jaundice (yellow skin)	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	Frequent infections	Y N P	Kidney stones	Y N P
Condyloma (genit. warts)	Y N P	Chlamydia	Y N P	Gonorrhea	Y N P
Herpes	Y N P	Syphilis	Y N P	Yeast infections	Y N P
Male Reproduction					
Testicular masses	Y N P	Hernias	Y N P	Prostate disease	Y N P
Testicular pain	Y N P	Discharge	Y N P	Sores	Y N P
Premature ejaculation	Y N P	Impotence	Y N P		
Are you sexually active?	Y N	Sexual orientation?		Birth control type?	
Female Reprod./Breast					
Age of first menses		Age of last menses		Time between cycles	
Duration of bleeding		Are cycles regular?	Y N	Clotting	Y N P
Bleeding between cycles	Y N P	Painful menses	Y N P	Discharge	Y N P
Heavy or excessive flow	Y N P	Light flow	Y N P	PMS	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			
Current Medications					
Laxatives	Y N P	Pain relievers	Y N P	Antacids	Y N P
Cortisone	Y N P	Sleeping Pills	Y N P	Thyroid medications	Y N P

Please list any prescription medications, over the counter medications, vitamins, or supplements you are currently taking:

1)______________________________ 6)______________________________
2)______________________________ 7)______________________________
3)______________________________ 8)______________________________
4)______________________________ 9)______________________________
5)______________________________ 10)______________________________

Allergies

Are you hypersensitive to:

Any drugs?____

Any foods?____

Any environmentals?____________________________________

Hospitalization and Surgery

What hospitalizations or surgeries have you had?

____________________ year:________ ____________________ year:________

____________________ year:________ ____________________ year:________

X-rays and Special Studies

X-rays, CAT scans, or other studies you have had:

____

____

____

Electrocardiogram	Y	N	Electroencephalogram	Y	N
Bone Density Scan	Y	N	Mammogram	Y	N

How does your condition affect you? ____

____

____

What do you think is happening? ____

____

____

Why? ____

____

____

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

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