New Patient Intake Form

General Information

What do you prefer to be called?____

Legal Name:____________________________________ Date of Birth:_________________

Address:____

Phone:______________________________ Email__________________________________

Gender:_________ pronoun(s)_________________________

Sex designated on Insurance:_________ Relationship Status:_______________

Household members include:____

Who is your closest “Family”?____

Emergency Contact:________________________________ Phone: ____________________

Reason for Appointment:____

Who may I thank for your referral?____

Medical History

Who is your current health care team? ____

What Medications and Supplements do you take regularly? _________________________

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Do you have any Allergies?____

Any Surgeries or Hospitalizations?____

Any major illnesses?____

For Children
Birth Weight:____________________________ Breast fed?___________________________

How long?__________________ Vaccinations?____________________________________

Childhood illnesses?____

Personal History

What work/study do you do? ____

Does your work or hobbies expose you to toxic chemicals, heavy metals, mold or second-hand smoke? ____

Do you have a religious or spiritual practice? ______________________________________

Do you have problems falling or staying asleep? Why? ____________________________

How many hours do you sleep at night? ______ Do you awaken refreshed? ___________

How does your mood impact your life/function?____________________________________

What are your major stressors?____

Do you feel safe in your Home?_________ Do you feel safe at Work/School__________

Have you considered suicide at any time in your life?______________________________

Mind Altering Substances
Do you drink alcoholic beverages? _______ If yes, how many per week? _____
Do you drink caffeinated beverages?______ If yes, how many per week? _____
Do you smoke? ______________ If so, how much?_________________________
Use recreational drugs? _________Which ones?____________________________

Have you struggled with addiction? ______ If yes, please explain, and how can I help? ____

____

Your Body

Do you have a: Vagina___ Prostate____ Cervix___ Testes____ Ovaries___ Penis___ Breast(s)_____ No gonads_____

Are you having trouble with any of these body parts?_____________________________

____

I sign below indicating the above is true and correct.

Signature_____________________________________ Date_____________