NEW PATIENT INTAKE FORM

Patient Name:______________________________DOB:_______________Date of Service:_________________
Age: ________________Gender: _____________________Occupation:____
If patient is under 18 years of age: Name of parent or Guardian____
Health Insurance: PPO or HMO Insurance Co:____________________ Policy #: _____________ Group #:_____________

GENERAL PATIENT INFORMATION

Address: ____
City _____________________________State_____________Zip_______________

Mailing address: (if different from home address): ______________________________
City_____________________________State_____________Zip________________

Email Address:____
Email Correspondence (your email will never be sold, shared or traded)

Would you like to receive a copy of our free newsletter via email? Y or N

Home phone: __________________Work phone ___________________ Cell phone_____________________

May we leave a confidential voice message at any of the above numbers? ☐ No ☐ Yes
If yes, please specify: ☐ Home ☐ Work ☐ Cell

Are you (please circle): single partnership married separated divorced widowed
Live with (please circle): alone partner parents friends children relatives

List your current health care providers and other specialists that are part of your health care team (includes medical doctors, chiropractors, counselors, massage therapist, physical therapist, acupuncturist):

Name	Profession

Emergency Contact____
Name:__________________________________Relationship:___________________Phone#:_____________________

Current Health Concerns

What are your most important health concerns? List as many as you can, in order of importance to you.
1.____5.____
2.____6.____
3.____7.____
4.____8.____

CONTEXT OF CARE

How did you hear about Trio Natural Medicine? ____
What brought you to our clinic? ____
What expectations do you have of me personally as your physician? ____

What is your present level of commitment to addressing your health concerns? Rate from 0-10, 10 being 100% committed:
1 2 3 4 5 6 7 8 9 10
Is there anything else you would like us to know in order to serve you better? _____________________________________

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TRIO NATURAL MEDICINE

NEW PATIENT INTAKE FORM

Patient Name:____________________________DOB:______________Date of Service:________________

HEALTH OVERVIEW

Comprehensive health care requires a complete picture of your health. Please take the time to complete this questionnaire carefully. If you are unsure about a question, mark it and we can discuss it during your visit.

Patient Medical History: (check all that apply)
C = current condition within last 6 months P = problem of the past

C	P		C	P		C	P	
☐	☐	ALLERGIES	☐	☐	DRUGS/ALCOHOL USE	☐	☐	PNEUMONIA
☐	☐	ANEMIA	☐	☐	GLAUCOMA	☐	☐	RHEUMATIC HEART DZ
☐	☐	ARTHRITIS	☐	☐	HEART DISEASE	☐	☐	REPRODUCTIVE DISORDER
☐	☐	ASTHMA	☐	☐	HEART MURMUR	☐	☐	SEIZURES/EPILEPSY
☐	☐	CANCER	☐	☐	HIGH BLOOD PRESSURE	☐	☐	SINUS PROBLEMS
☐	☐	CHRONIC INFECTIONS	☐	☐	LIVER DISORDER	☐	☐	SKIN PROBLEMS
☐	☐	DEPRESSION	☐	☐	MENTAL HEALTH CONDITION	☐	☐	STOMACH ULCERS
☐	☐	DIABETES	☐	☐	PARALYSIS	☐	☐	STROKE

☐ OTHER condition not described above: ____

Childhood Illnesses (Check all that apply)
☐ Chicken pox ☐ Mumps/Measles ☐ Rubella ☐ Whooping cough
☐ Diptheria ☐ Scarlet fever ☐ Asthma ☐ Others:

Immunization history (Check all that apply)
☐ Tetanus ☐ Measles/Mumps/Rubella ☐ Pertussis ☐ Diptheria ☐ Hepatitis A
☐ Hepatitis B ☐ Polio ☐ Flu shot ☐ Others:

List known allergies or sensitivities and describe the reaction (e.g. hives, swelling, short of breath, rash, etc):
Medications:____
Foods:____
Environmental factors:______________________________Chemicals: ____________________________

List any injuries, surgeries or hospitalizations you have had:

Type of illness, injury or operation/procedure	Date	Hospital

What medical tests have you had (endoscopy, colonoscopy, MRI, CT scan, x-rays, ECG, etc.)?:____

Recent Laboratory Workup:____
____

MEDICATIONS AND SUPPLEMENTS

List all current prescription medications, non-prescription medications, and supplements:

Name	Prescribing Physician	Dosage

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TRIO NATURAL MEDICINE

NEW PATIENT INTAKE FORM

Patient Name:____________________________DOB:______________Date of Service:________________

HEALTH HABITS

Do you drink alcohol? ____________ If yes, what type of alcohol and how much? ☐ 0-1 drinks/week ☐ 1-5 ☐ 6-10 ☐ 10+

Do you smoke? ____________ If yes, how many packs? _______________If you used to, when did you quit:______________
Total number of years smoking?_____________

Do you use chewing tobacco? ____________________ If yes, how many cans? ___________________________
If you used to, when did you quit: _________________ Total number of years?___________________

Do you exercise? __________ What form____
How often?(hours/day and days/week)____

Do you regularly consume products containing caffeine? (Coffee, tea, soft drinks, or energy drinks) ☐ Yes ☐ No
If yes, please specify type and quantity/day: ____

How do you relax? ____

What are your primary interests or hobbies? ____

DIET:
Number of meals eaten per day: 1 2 3 more than 3

Typical Breakfast: ____
Typical Lunch: ____
Typical Dinner: ____
List the primary foods **excluded** from your diet: ____
____

FAMILY HISTORY

Have you or any of your blood relatives had any of the following:

Put an X in each box that applies	Mother	Father	Sibling	Grandmother	Grandfather
ALLERGIES					
ALZHEIMERS					
ARTHRITIS					
ASTHMA					
CANCER (list type)					
DIABETES					
DRUGS/ALCOHOL ABUSE					
EPILEPSY					
HEART DISEASE					
HIGH BLOOD PRESSURE					
MENTAL HEALTH DISORDER					
OSTEOPOROSIS					
REPRODUCTIVE DISORDER					
SKIN DISORDER					
STROKE					
THYROID DISORDER					
OTHER (please list)					

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