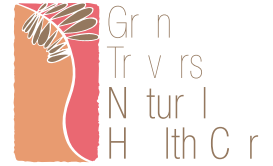


PATIENT INTAKE FORM

Grand Traverse Natural Health Care
626 East Eight Street, Suite 17
Traverse City, Michigan 49686
phone 231.929.8183

www.gtnaturalhealth.com clinic@gtnaturalhealth.com



Patient Information

Today's Date _____

Name _____ Age _____ Date of Birth _____

Address _____ City, State, Zip _____

Phone (H) _____ (M) _____ (W) _____

Email _____ SS# _____

Female Male Height _____ Weight _____

Primary Physician _____ Ob/Gyn Doctor _____

Emergency Contact _____ Phone _____

Have you been treated by acupuncture or Oriental medicine before? Yes No

How would you like us to contact you for follow-up questions, appointment confirmations or responding to messages? Home phone Mobile phone Work Phone

May we leave messages on your phone voicemail? Yes No

How did you hear about us: Doctor _____ Name of Friend _____

Phone book Article in Media Clinic Sign Internet

Primary Concerns

Please list your health concerns in order of priority:

When did it start:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Have you been given a diagnosis for any of these problems: If so, what? _____

What kinds of treatment have you tried? _____

Current Medications

| Item | Dosage Per Day | Date Began | For What Condition |
|------|----------------|------------|--------------------|
| | | | |
| | | | |
| | | | |
| | | | |

Current Supplements

| Item | Dosage Per Day | Date Began | For What Condition |
|------|----------------|------------|--------------------|
| | | | |
| | | | |
| | | | |
| | | | |

Health History

Check any that apply: Bleeding Disorder Blood Thinning Medication Pacemaker Pregnancy

Please list all known drug allergies: _____

Please list any dietary restrictions (red meat, sulfites, nuts) _____

Surgeries (age and description)

Significant Trauma (auto accidents, falls, blood loss etc.) _____

Exercise (times/week) _____ Servings of vegetables/day _____

Type of exercise _____

Hours of sleep/night _____ Cups of coffee/day _____ Servings of red meat/week _____

Glasses of water/day _____ Cigarettes/day _____ Glasses of alcohol/week _____

Stress level: Mild Moderate Severe

Women

Periods generally last _____ days and occur every _____ days.

Date of last period _____ Bleeding is Heavy Moderate Light

Do you experience PMS symptoms? Y / N Painful menses? Y / N Mood Changes? Y / N

Are you currently experiencing any gynecological symptoms or problems? _____

Vaginal dryness? Y / N History of sexually transmitted disease? _____

Any problems related to sexual function? _____

Number of pregnancies _____ Births _____ Abortions _____ Miscarriages _____

Date of last Pap Smear _____ Abnormal Pap? Y / N

If menopausal or perimenopausal: List symptoms and concerns: _____

Men

History of sexually transmitted diseases? _____

Date of last prostate exam _____

Trouble with urination? (frequency, hesitancy, pain, dribbling) _____

Trouble with sexual function / libido Y / N

Family's Health History

| | Self | Sibling | Parents | Grandparents |
|----------------|------|---------|---------|--------------|
| Cancer | | | | |
| Heart Disease | | | | |
| Thyroid | | | | |
| Epilepsy | | | | |
| Asthma | | | | |
| Mental Illness | | | | |
| Diabetes | | | | |
| Stroke | | | | |
| Osteoporosis | | | | |

Personal Health History

- | | | |
|---|---|----------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Ear/eye problems | <input type="checkbox"/> Recurrent colds, flu | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Skin problems | |
| <input type="checkbox"/> Poor digestion, gas | <input type="checkbox"/> High cholesterol | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> High blood pressure | |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Recurrent diarrhea | <input type="checkbox"/> Breast problems | |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Hot flashes | |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Abdominal bloating | |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Low blood sugar | |
| <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Other recurrent infections | |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Food sensitivities | <input type="checkbox"/> Cancer | |

Other: _____

Cancellation Policy:

Barring an emergency, appointments must be changed or cancelled at least 24 hours in advance or \$60 will be billed for first visits and \$35 for follow-up visits.

- 1. First Office Visit:**
Acupuncture: \$85.00
Naturopathic Medicine: \$85 to \$185.00
This initial consultation is an extended visit, between 45 minutes to 1.5 hours.
- 2. Return Office Visit:**
Acupuncture: \$70
Naturopathic Medicine: \$45.00 to \$85.00
A return visit is typically 15-45 minutes;
Appointments that extend past 45 minutes will incur additional charges
- 3. Phone Consultation:**
Naturopathic Medicine: \$45.00 minimum charge
Dr. Kotlarz conducts periodic phone consultations established patients only. This fee is charged for any phone consultation requiring **15 minutes**. If the call extends beyond 15 minutes there will be a greater charge. This fee is not charged if the patient is calling for clarification of ongoing therapy or if the doctor has asked you to report.

Payment is expected at time of service. A medical superbill is provided at time of payment, which contains all the insurance codes necessary for you to submit the claim to your insurance company. Unopened products purchased at the clinic will be accepted within one month of purchase for return. I realize that I am liable for payment even if insurance or some other party does not pay.

Signature _____ Date _____

Relationship to patient: (circle) self parent other _____