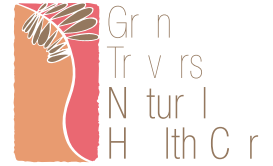


PATIENT INTAKE FORM

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 disease _____

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

Trouble with sexual function / libido Y / N

Family's Health History

| | 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"/> Overweight | <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:

Appointments must be changed or cancelled at least 24 hours in advance or a \$35 fee will be billed to your account. Please note that emergency situations do occur and we are flexible in such cases.

Responsibility of Payment of Account

I am responsible for payment of account for goods and services received from this clinic. 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 _____