Willowbend Natural Medicine

ADULT INTAKE FORM

All contact information is for professional use only and will be held in strict confidence.

Name ___________________________________ Date of Birth ___________ Age _________

Address ____________________________ City ______________ State________ ZIP ________

Telephone: Home _________________ Work ___________________ Cell _________________

Email ____ I would like receive e-newsletter ☐

How did you hear about this practice?____

Occupation ____________________________ Employer ______________________________

Marital Status _________________ Spouse/partner's name ______________________

Emergency contact ____________________ Relationship _______________ Phone _________

Other current healthcare practitioners ____

____

How were you referred to us? ____

PRESENT HEALTH CONCERNS:
Please list your health concerns in order of their significance to you.

1. ____
2. ____
3. ____
4. ____
5. ____

What do you think is causing your symptoms? _______________________________________

____

What other treatments have you tried? ____

____

MEDICAL HISTORY

As a child did you have:			Vaccinated	
Condition	**# of times**	**Childhood diseases**	**yes**	**no**
ADD/ADHD		Chicken Pox (Varicella)		
Allergies		Diptheria		
Asthma		German Measles		
Bronchitis		Pertussis		
Ear infections		Polio		
Eczema		Rheumatic Fever		
Strep Throat		Rubella		
Tonsillitis		Scarlet Fever		

Have you ever been diagnosed with any of the following?					
	Asthma		Heart disease		Musculo/skeletal problems
	Arthritis		High blood pressure		Neurological condition
	Bladder Infection		Kidney disease		Psychological condition
	Cancer		Liver disease		Rheumatic fever
	Diabetes		Lung disease		Skin problems
	Gall bladder disease		Menopausal symptoms		Other
	Headaches		Menstrual problems		

Please describe details of above:____
____

Hospitalizations, surgeries, x-rays & other imaging: (year & reason)
____
____

Allergic reactions: (drugs, foods, pollen, other) ____
____

What happens when there is a reaction? ____
____

Current Medications: herbs, vitamins, contraceptives, pharmaceuticals			
Medication/supplement name	Dose	Frequency	How long?

Pregnancy History (women only)			
# of pregnancies	# of births	# of miscarriages	# of abortions
Children's names	**Gender**	**Age**	**Date of birth**

FAMILY HISTORY					
Condition	**Mother**	**Father**	**Sister**	**Brother**	**Other**
Allergies					
Anemia					
Asthma					
Birth defects					
Bleeding disorders					
Cancer					
Diabetes					
Eczema					
Epilepsy					
Hay fever/hives					
Heart disease					
Kidney disease					
Mental illness					
Tuberculosis					
Age at death					

Do you follow any dietary guidelines? ____

____

What have you eaten in the past 24 hours?_(B-fast)___________________________________

Lunch:____

Dinner:____

Daily water intake ____________________ Source ___________________________________

Other fluids? (coffee, sodas, juices, alcohol, etc)_______________________________________

How often do you have a bowel movement? _____ _______________________________________

Frequency of urination/day? ____

Exercise routine/frequency ____

Hours of work/week ________________

Hours of sleep/night ____________ Trouble falling asleep? ______ Staying asleep? __________

HABITS				
Substance	**Current**	**Past**	**Never**	**Frequency**
Alcohol				
Coffee/caffeine				
Tobacco				
Marijuana				
Other recreational drugs				

Consent for Purposes of Treatment, Payment, and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Sara Thyr, N.D. for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Sara Thyr, ND may be conditioned upon my consent as by my signature on this document.

My *identifiable health information* means health information collected from me and created or received by my practitioner, another health care provider, a health plan, my employer. This *identifiable health information* relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Sara Thyr, ND is not required to agree to the restrictions that I may request. However, if Sara Thyr, ND agrees to a restriction that I request, the restriction is binding upon Sara Thyr, ND and Willowbend Natural Medicine.

I have the right to revoke this consent, in writing, at any time except to the extent that Sara Thyr, ND and Willowbend Natural Medicine has taken action in reliance of this consent.

I understand I have the right to review Willowbend Natural Medicine Notice of Privacy Practices prior to signing this document. This notice describes the types of uses and disclosures of my *identifiable health information* that will occur in my treatment, payment of my bills or in the performance of health care operations of Willowbend Natural Medicine.

Willowbend Natural Medicine reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

Emergency Care:

Our clinic does not administer emergency medical care. In the case of an emergency, please see your family medical/osteopathic physician or the emergency room of the nearest hospital. After emergency care has been administered, patients often respond well to Naturopathic care to accelerate the healing process.

Payment:

We are currently unable to bill insurance.

Payment is expected at the time of service. We accept personal checks, cash, Mastercard, Visa & Discover.

Cancellation Policy:

This office requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. Missed appointments without notification will be charged the visit fee. Cancellations with less than 24 hours notice will be billed 50% of the visit fee.

- I agree to pay for services rendered at the time of services. I acknowledge that I may request the fees for various procedures before they occur and include that information in my decision regarding my healthcare.
- I am aware that my practitioner may charge for telephone consultations.
- I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- I consent to treatment as agreed upon between the doctor and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the doctor

____ ____________________

Signature of Patient or Authorized Representative Date

____

Printed Name and Relationship