NEW PATIENT INTAKE FORM

Legal Name	Preferred Name (if different)	Date of birth
Gender	Identified sex (if different)	Preferred pronoun (if different)
Preferred Phone	Okay to leave a detailed message?	Email
Address	City/State	Zip
Emergency Contact Name	Emergency Contact Phone	

Preferred Pharmacy? *(Name/city/phone):*

How did you hear about us?

- ◯ Referral from a friend or physician (We'd love to thank them!) _____
- ◯ Internet Search
- ◯ Insurance Website
- ◯ Other: _____

Your personal insurance info

Primary Insurance Co	Member ID	Group No	Customer Service Phone No
Secondary Insurance Co	Member ID	Group No	Customer Service Phone No
◯ No Insurance / Self Pay			

Payment; Insurance Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above-listed companies and assign directly to the provider, Inspire Health, payment of all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges for all services provided, whether or not paid by insurance. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due. I hereby authorize the provider to release any medical or other information necessary to secure the payment of benefits. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers. I authorize the use of this signature on all insurance submissions.

Digital Signature: _____ *Date:* _____

What are your long-term personal goals for our work together?

What are your current concerns?

Concern	Started when?	How often?	How severe?

Tobacco & recreational drug use?

- ◯ Never Smoker
- ◯ Former tobacco use: Age _____ to _____ Type (cigarettes / chewing): _____
- ◯ Current tobacco use: Type/Amount per day: _____

Additional recreational drug use?

_____

Alcohol use (drinks per day):

_____

Prior Medical History & Current Illness/Conditions

Hospitalizations or surgeries	Dates	Current condition (i.e. asthma, hypothyroid)	Date of diagnosis

Family Health History

Condition	Who?	Condition	Who?
☐ Asthma ☐ Autoimmune Condition ☐ Cancer ☐ Diabetes ☐ Digestive Concerns ☐ Heart Disease		☐ Hepatitis ☐ High Blood pressure ☐ Lung disease ☐ Seizures ☐ Thyroid Condition ☐ Other? ☐ Other?	

Preventative Health History

Have you had a:	Y/N	Most recent date	Findings
Mammogram *(women only)*			
Pap *(women only)*			
Colonoscopy			
Prostate exam *(men only)*			
Other:			

Any known allergies?

Drug Allergy(ies)	Reaction(s)	Environmental Allergy(ies)	Reaction(s)

Food Allergy(ies)	Reaction(s)	Food Sensitivity(ies)	Reaction(s)

What medications are you currently taking? (Both prescriptions and over the counter)

Medication and dose	Reason	Start date	Prescribed by

What supplements are you currently taking?

Supplement / brand / dose	Reason	Start date	Recommended by

About your food plan

Sodas, oz./day: _____

Coffee, oz./day: _____

Water, oz./day: _____

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Food Ethics: ◯ Vegan ◯ Vegetarian ◯ Kosher

◯ Other:

Food Cravings: _____

Snack Foods: _____

How often do you eat out? Where?

Bowel movements per day _____

Any bowel concerns?

More about you

What is your occupation?

What are the major stressors in your life?

How is your sleep? When do you go to sleep, and wake up?

What do you do to relax? What are your hobbies?

What types of physical activity do you do?

Women only: When was you last menstrual period?

Do you have a religious or spiritual affiliation?_____What type?

Any additional pertinent information you'd like to share?