***New Patient Intake Form***

***Please e-mail this completed form to:*** *reception@mtwholehealth.com*

|  |  |
| --- | --- |
| Name | Date of Birth |
| Today’s Date | Gender |
| Primary Phone (underline: home / cell / work) | Alternate Phone (underline: home / cell / work) |
| May we leave messages at these numbers? Yes ⃝ No ⃝ |
| Mailing AddressCity State Zip |
| Email  | Skype name |
| Relationship status / their name | Occupation (underline: part time / full time / other) |
| Emergency Contact Name / relationship | Emergency Contact Phone |
| Are you currently receiving healthcare at another location/s? Please name other healthcare providers and their role in your medical care: |
| How were you referred to us? |

Insurance Form

*If you are requesting Montana Whole Health to submit a claim to your insurer, please fill out the following form.*

|  |  |
| --- | --- |
| Patient Name: | Date of Birth: |
| Address: | Phone Number:*Please circle preferred contact number*Cell:­Home:Work: |
| Primary Insurance Company: | Policy Number: |
| Name of Insured: | Insured’s DOB: |
| Insured’s Relationship to Patient: | Group Number: |
| Send Claim To: | Deductible:Individual:Family: |
| Insured’s Employer: |
| Policy Notes: |

**CONTEXT OF CARE OVERVIEW**

1. Why did you choose to come to Montana Whole Health?  What do you know about our approach?

2. What **three** expectations do you have from *this* visit to our clinic?  What **long-term** expectations do you have? What expectations do you have of me personally as your physician?

3. Are you interested in a) relieving your symptoms, or in b) long-term, gradual improvement in your health (addressing the underlying cause)? (Or both?)

4. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0-10, 10 being 100% committed)

 1 2 3 4 5 6 7 8 9 10

5. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

 b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (please list)

6. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols we will be sharing with you?

7. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

8. What do you LOVE to do?

***Primary Concerns:*** *List in order of priority. Describe your concerns below if necessary.*

|  |  |  |  |
| --- | --- | --- | --- |
| ***Concern****Example: Headaches* | ***Onset****Example: June 2010* | ***Frequency****Example: Daily* | ***Severity****Example: 5/10 or mild/mod/severe* |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

***Past Medical History:***

***Mark (x) those which apply to you.*** *Y=yes/condition you have now, N=no/never had, P= problem in the past, S=sometimes a problem now*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Cardiovascular** | Y | N | P | S | **Immune/Allergic** | Y | N | P | S |
| Heart disease  |   |   |   |   | Seasonal allergies/hay fever |   |   |   |   |
| Pacemaker |   |   |   |   | Chronic/frequent illnesses |   |   |   |   |
| High cholesterol |   |   |   |   | Night sweats |   |   |   |   |
| Chest pain/angina |   |   |   |   | Immune compromised  |   |   |   |   |
| High blood pressure |   |   |   |   | Other immune problems (list) |   |
| Shortness of breath with mild exercise (walking up stairs) |   |   |   |   | **Mental/Emotional** | Y | N | P | S |
| Shortness of breath lying down |   |   |   |   | Treated for emotional problem |   |   |   |   |
| Edema/swelling in ankles or feet |   |   |   |   | Depression |   |   |   |   |
| Palpitations |   |   |   |   | Anxiety/nervousness |   |   |   |   |
| Murmurs |   |   |   |   | Difficulty concentrating |   |   |   |   |
| Dizziness with standing or fainting |   |   |   |   | Mood swings/emotional lability |   |   |   |   |
| Other cardiovascular problems (list) |   | Have you considered suicide? |   |   |   |   |
| **Dermatologic (Skin)** | Y | N | P | S | Lack of pleasure or motivation |   |   |   |   |
| Rashes |   |   |   |   | Insomnia |   |   |   |   |
| Acne/boils |   |   |   |   | Other mental/emotional (list) |   |
| Eczema |   |   |   |   | **Musculoskeletal** | Y | N | P | S |
| Hives |   |   |   |   | Joint pain or stiffness |   |   |   |   |
| Itching |   |   |   |   | Arthritis |   |   |   |   |
| Hair loss |   |   |   |   | Muscle spasms or cramps |   |   |   |   |
| Concerning moles or growths |   |   |   |   | Back pain (chronic) |   |   |   |   |
| Other skin problems (list) |   | Motor Vehicle Accidents |   |   |   |   |
| **Ears/Nose/ Mouth/Throat** | Y | N | P | S | Other trauma |   |   |   |   |
| Impaired hearing |   |   |   |   | Unexplained pain/pain at night |   |   |   |   |
| Ringing in ears/tinnitus |   |   |   |   | Other musculoskeletal (list) |   |
| Sinus problems |   |   |   |   | **Neurologic** | Y | N | P | S |
| Nose bleeds |   |   |   |   | Numbness or tingling |   |   |   |   |
| Frequent sore throat |   |   |   |   | Loss of memory or difficulty concentrating |   |   |   |   |
| Teeth/gum problems |   |   |   |   | Vertigo or dizziness |   |   |   |   |
| Do you have regular dental exams/cleanings? |   | Loss of balance |   |   |   |   |
| Other ear/eye/nose/throat (list) |   | Headache |   |   |   |   |
| **Endocrine** | Y | N | P | S | Other neurological problems (list) |   |
| Heat or cold intolerance |   |   |   |   | **Respiratory** | Y | N | P | S |
| Excess hair growth |   |   |   |   | Chronic cough |   |   |   |   |
| Excessive thirst |   |   |   |   | Asthma |   |   |   |   |
| Excessive fatigue |   |   |   |   | Wheezing |   |   |   |   |
| Thyroid disease |   |   |   |   | Shortness of breath |   |   |   |   |
| Other endocrine problems (list) |   | Other respiratory problems (list) |      |
| **Eyes/vision** | Y | N | P | S | **Urinary** | Y | N | P | S |
| Blurred or loss of vision |   |   |   |   | Incontinence (type: ) |   |   |   |   |
| Do you have regular eye exams? |   | Increased frequency |   |   |   |   |
| Other eye problems (list) |   | Kidney stones |   |   |   |   |
| **Gastrointestinal** | Y | N | P | S | Pain on urination |   |   |   |   |
| Change in appetite/no appetite |   |   |   |   | Frequent urinary tract infections |   |   |   |   |
| Nausea or vomiting |   |   |   |   | Frequency at night |   |   |   |   |
| Heartburn/GERD |   |   |   |   | Kidney disease |   |   |   |   |
| Ulcer |   |   |   |   | Other urinary problems (list) |   |
| Abdominal pain or cramps |   |   |   |   |   |   |   |   |   |
| Gallbladder disease |   |   |   |   | **For Women Only:** | Y | N | P | S |
| Belching or passing gas |   |   |   |   | Age at first menses: |   |
| Hemorrhoids |   |   |   |   | Age at last menses (if menopausal) |   |
| Chronic/recurrent diarrhea |   |   |   |   | Length of cycle (in days) |   |
| Constipation |   |   |   |   | Duration of menses (in days) |   |
| Blood in stool or dark/tarry stools |   |   |   |   | Irregular cycles |   |   |   |   |
| Other gastrointestinal (list) |   | Painful menses |   |   |   |   |
| **Hematologic (Blood/lymph)** | Y | N | P | S | PMS |   |   |   |   |
| Anemia |   |   |   |   | Abnormal pap |   |   |   |   |
| Easy bleeding/bruising |   |   |   |   | Are you sexually active? |   |   |   |   |
| Cancer/tumors/growth (please explain) |   |   |   |   | Type of birth control used: |   |
| Other blood/lymphatic problems (list) |   | Pain with intercourse |   |   |   |   |
| **For Men only:** | Y | N | P | S | Sexually Transmitted Disease/Infection (STD) |   |   |   |   |
| Are you sexually active? |   |   |   |   | Sexual traumas |   |   |   |   |
| List type of birth control used: |   | Number of pregnancies |   |
| Discharge or sores |   |   |   |   | Number of live births |   |
| Sexually Transmitted Disease/Infection (STD) |   |   |   |   | Breast pain |   |   |   |   |
| Hernias |   |   |   |   | Lump/s in breasts |   |   |   |   |
| Prostate disease |   |   |   |   | Nipple discharge |   |   |   |   |
| Impotence |   |   |   |   | Other female reproductive problems (list) |   |
| Premature ejaculation |   |   |   |   |   |   |   |   |   |
| Sexual traumas |   |   |   |   |   |   |   |   |   |
| Other male reproductive problems (list) |   |   |   |   |   |   |

***Family Medical History:*** *List any diseases from above for each family member and age and cause of death if no longer alive.*

|  |  |  |
| --- | --- | --- |
| *Mother* | *Maternal Grandmother* | *Paternal Grandfather* |
| *Father* | *Paternal Grandmother* | *Paternal Grandfather* |
| *Siblings* |

***Surgeries & Hospitalizations:*** *Include when, where and injuries****. Note*** *any blood transfusions before 1990*

***Diet & Lifestyle:***

**What is your religious/spiritual affiliation? How does this affect your health?**

**Diet: What do you typically eat in a day?**

**Breakfast:**

**Lunch:**

**Dinner:**

**Snacks:**

**Beverages:**

**What are the least healthful foods in your diet?**

**Do you drink: Coffee \_\_\_\_ Black tea\_\_\_\_\_**

**Green tea \_\_\_\_ Juice\_\_\_\_ Soda\_\_\_\_ Milk** (**note** if dairy alternative)**\_\_\_\_**

**Alcohol \_\_\_\_\_\_\_ (Estimated drinks per week \_\_\_\_\_\_\_ Preferred drink\_\_\_\_\_\_\_\_\_)**

**Do you have any questions or concerns about your diet?**

**Do you exercise?** No ⃝ Yes ⃝ Hours per week: \_\_\_\_\_\_\_\_\_\_\_\_

Type of exercise (describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco:** No ⃝

Yes: Cigarettes ⃝ Age \_\_\_\_ to \_\_\_\_ / \_\_\_\_ packs per day

Yes: Cigars ⃝ Yes: Chewing tobacco ⃝

**Prescription drugs used for recreational purposes:** No ⃝ Yes ⃝ Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other drugs:**None ⃝ Yes ⃝ Type(s) and frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Medications & Supplements –*** *attach your own list if desired.*

|  |  |  |  |
| --- | --- | --- | --- |
| ***Medication*** *(Over the counter and prescription)* | ***Dosage & Frequency*** | ***Reason for taking*** | ***Cost/month*** |
| ***Supplements*** *(Including brand name)* | ***Dosage & Frequency*** | ***Reason for taking*** | ***Cost/month*** |

**Allergic reaction/intolerances to medications:** *Example: penicillin-hives*

**Allergic reaction/intolerances (foods, environment)** *Example: cow’s milk-bloating*

***Social History:***

**Occupation***:*

**What are the major stressors in your life?**

**Who is your support system?**

**What prior experiences have you had with alternative medicine?**