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***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?

***What brings you in? (Please describe your chief concerns)***

*List in order of priority.*

**My main reason for seeking care is:**

**When did it start?**

**How often do you experience it**?
(ex: daily, monthly, occasionally?)

**On a scale of 1-10, 10 being the worst, how much does it bother you**? 1 2 3 4 5 6 7 8 9 10

**What, if anything, have you tried to make this better?**

**My second reason for seeking care is:**

**When did it start?**

**How often do you experience it**?
(ex: daily, monthly, occasionally?)

**On a scale of 1-10, 10 being the worst, how much does it bother you**? 1 2 3 4 5 6 7 8 9 10

**What, if anything, have you tried to make this better?**

**My third reason for seeking care is:**

**When did it start?**

**How often do you experience it**?
(ex: daily, monthly, occasionally?)

**On a scale of 1-10, 10 being the worst, how much does it bother you**? 1 2 3 4 5 6 7 8 9 10

**What, if anything, have you tried to make this better?**

**Is there anything else we should know?**

***Past Medical History:***

*Mark (x) those which apply to you by* ***circling or changing the font to bold.***

|  |  |
| --- | --- |
| ***Mental Emotional***Treatment of emotional problems DepressionAnxiety/nervousnessDifficulty concentratingMood swings/emotional labilityHave you ever considered suicide?Loss of pleasureOther mental/emotional problems?***Dermatologic*** *(skin)*RashesAcne/boilsEczemaHivesItchingHair lossConcerning moles or growthsOther skin problems?***Eyes/vision***Blurred or loss of visionDo you have regular eye exams?Other eye problems (list)***Ear/Nose/Throat***Impaired hearingRinging in ears/tinnitusSinus problemsNose bleedsFrequent sore throatTeeth/gum problemsDo you have regular dental exams/cleanings?Other ear/eye/nose/throat (list)***Cardiovascular***Heart disease PacemakerHigh cholesterolChest pain/anginaHigh blood pressureShortness of breath with mild exertion (walking up stairs)Shortness of breath when lying downEdema/swelling in ankles or feetPalpitationsMurmursDizziness or fainting when rising to standOther cardiovascular problems?***Respiratory***Chronic coughAsthmaWheezingShortness of breathOther respiratory problems (list) | ***Gastrointestinal***Change in appetite/no appetiteNausea or vomitingHeartburn/GERDUlcerAbdominal pain or crampsGallbladder diseaseBelching or passing gasHemorrhoidsChronic/recurrent diarrheaConstipationBlood in stool or dark/tarry stoolsOther gastrointestinal (list)***Immune/Allergic***Season allergies/hay feverChronic/frequent illnessesNight sweatsImmune compromiseOther immune problems?***Neurologic***Numbness or tinglingLoss of memory or difficulty concentratingVertigo or dizzinessLoss of balanceHeadacheOther neurological problems?***Endocrine***Hot or cold intoleranceExcess hair growthExcessive thirstExcessive fatigueThyroid diseaseOther endocrine problems?***Musculoskeletal***Joint pain or stiffnessArthritis Muscle spasms or crampsBack pain (chronic)Motor Vehicle AccidentsOther traumaUnexplained pain or pain at nightOther musculoskeletal concerns?***Hematologic (Blood/lymph)***AnemiaEasy bleeding/bruisingCancer/tumors/growth (please explain)Other blood/lymphatic problems (list)***Urinary***Incontinence (type: )Increased frequencyKidney stonesPain on urinationFrequent urinary tract infectionsFrequency at nightKidney diseaseOther urinary problems (list) |

***Sexual Health***

Are you sexually active?

If so, are you ok with the possibility of pregnancy?

If not, what type of birth control used:

Discharge or sores

Sexually Transmitted Disease/Infection (STD)
Sexual traumas

Other sexual health/ reproductive problems:

***Women Only:***

Age at first menses:

Age at last menses (if menopausal)

Length of cycle (in days)

Duration of menses (in days)

Irregular cycles

Painful menses

PMS

Abnormal pap

Breast pain

Number of pregnancies

Number of live births

Pain with intercourse

Lump/s in breasts

Nipple discharge

***For Men only:***

Hernias

Prostate disease

Impotence

Premature ejaculation

***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*

***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*

***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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***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?**