Nourish Natural Family Medicine
New Patient Intake Form

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name_____

Date of Birth_____ Birth place_____

Address_____City_____State_____Zip_____

Day Phone_____ Evening Phone _____ Cell_____

Is it ok to leave a message at one or all of these numbers?_____

E-mail address_____

Occupation_____

Relationship Status:

- ☐ Single
- ☐ Married To whom? _____
- ☐ Partnership To whom? _____
- ☐ Divorced
- ☐ Widowed

Emergency Contact _____

Phone_____ Relationship_____

Please describe the reason for your visit today (Chief Complaint)_____

_____

Is it getting better, worse, or staying the same? _____

Are you currently under the care of a medical provider? _____
If so, please explain who and the reason(s) for:

_____

Are you taking any medication or herbal supplements? If so, which ones? (Add dosage if known)

Are you in generally good health, or do you frequently fall ill? _____

MEDICAL HISTORY

Please circle any current or past health issues.

Allergies	Epilepsy	Polio
Anemia	Fatigue	Scarlet Fever
Appendicitis	Gout	Stroke
Arteriosclerosis	Heart Disease	Surgery (List):
Asthma	Hepatitis (A, B,C)	_____
Bleeding Disorder	Hypoglycemia	_____
Blood Pressure (Low or High)	Injuries	_____
Cancer	Insomnia	Thyroid Disorder
Chicken Pox	Intestinal Parasites	Trauma (falls, accidents)
Diabetes	Multiple Sclerosis	Tuberculosis
Digestive Disorders	Mumps	Ulcers
Emotional Difficulties	Pacemaker	Other_____
Emphysema	Weight Loss or Gain	_____

Do any of your family members suffer from: (Please list relationship to you)

Alcoholism	Arteriosclerosis	Heart Disease
Allergies (list)	Asthma	High Blood Pressure
_____	Cancer	Seizures
_____	Diabetes	Stroke

Are there any other concerns you would like to address?

_____

_____

I have provided correct and complete information to the best of my knowledge.

_____ _____

Patient's Signature Date

_____ _____

Guardian's Signature (under 18yo) Date