4219 W Emerald Street, Boise, ID 83706 | 208-338-0405 | www.boisenaturalhealth.com

New Patient Checklist

1. Please print this 9-page document, complete it as best you can, and bring it with you to your appointment.
   - If you are unable to print out the New Patient Intake Form, please contact our office at 208-338-0405 to discuss other options.
   - Please allow ~ 30 minutes to complete the New Patient Intake Form.
2. Please bring recent **laboratory reports**, if available.
   - To request records transferred from other providers, you can find a Release of Records form on our web page.
3. Please bring bottles of **supplements and medications** that you are currently taking.
4. Please be aware our office is **Fragrance Free**. When you visit our office, please do not wear scents that are perceptible by others, such as: perfume, cologne, scented hair spray, scented deodorant, scented lotion, or strong essential oils. We appreciate your respect to our chemically sensitive patients and staff.
5. Please be aware of our **Cancellation Policy:**
   - You may cancel or reschedule at *no charge* if you call **at least 24 hrs (1 business day)** before your appointment. If notice is given less than twenty-four hours, you will be charged half price of the visit. If you do not cancel and fail to come for your appointment, you will be billed the full price of the visit.

If you have any questions, please contact us at 208-338-0405.

Thank you! We look forward to meeting you and helping you on your journey to good health!

ADULT PATIENT INTAKE FORM

Today's Date_______________________

PERSONAL INFORMATION

Full Name____I like to be called ___________________________
(First Middle Initial Last)

Age________________________Date of Birth_____________________________________Gender_____________________

Address____

City______________________________State_____________________________ Zip_____________________________

Phone (best)_ ____(alternate)____________________________________

May we leave a confidential message? Yes / No

Email ____

Occupation____ Hours per week?____________

Employer ____

Education____ Military Service?____________

Who do you live with?____

Do you have children? Yes / No If YES, what are their ages:____

Emergency Contact____Relationship______________________

Contact's Phone ____

Who is your primary care provider?____

Please list other providers/specialists involved in your care:____

____

How did you hear about our clinic? (check all that apply)

- ☐ Friend/Family
- ☐ Walk/Drive by
- ☐ Other ____________________
- ☐ Event/Talk
- ☐ Website
- ☐ Social Media
- ☐ Physician/Health Care Provider referral ____

Would you like to receive our Monthly Email Newsletter with clinic news and event listings? Yes / No

What goals and health concerns bring you to the clinic today?

____ ____

____ ____

____ ____

MEDICAL HISTORY

When was your last physical?______________________ When did you last have bloodwork?_______________________

What is your blood type (A/B/O)?__________________

Do you have any implants (including medical devices), transplants, or artificial joints?_____________________________

Do you have any missing body parts?____

Height__________Weight__________Weight 1 year ago__________Maximum Weight__________When?____________

Did you have standard childhood immunizations? Yes / No

Have you had immunizations for military or travel outside the US? Yes / No

Any negative reactions to vaccines? Explain:____

Approximately how many times in your life have you had antibiotics?_____________________________________

Please list any surgeries or reason for hospitalization: Approximate date, year, or age

____ __________________________

____ __________________________

____ __________________________

Are you allergic to any medications or have had an allergic reaction to anything else? Yes / No (food reactions, see pg 3)

If Yes, please explain:____

PERSONAL AND FAMILY MEDICAL HISTORY

Have **YOU or a FAMILY MEMBER** ever had any of the following medical conditions?

Condition	Self	Family	Condition	Self	Family
Alcoholism/Addiction	☐ Self	☐ Family ___________	Heart Attack	☐ Self	☐ Family ___________
Asthma	☐ Self	☐ Family ___________	Heart Disease	☐ Self	☐ Family ___________
Autoimmune Disease	☐ Self	☐ Family ___________	High Cholesterol	☐ Self	☐ Family ___________
Birth Defects	☐ Self	☐ Family ___________	High Blood Pressure	☐ Self	☐ Family ___________
Cancer, Type?____________	☐ Self	☐ Family ___________	HIV/AIDS	☐ Self	☐ Family ___________
			Mental Illness	☐ Self	☐ Family ___________
Chemical Sensitivity	☐ Self	☐ Family ___________	Obesity	☐ Self	☐ Family ___________
Deep Vein Thrombosis	☐ Self	☐ Family ___________	Osteoporosis/ Osteopenia	☐ Self	☐ Family ___________
Depression	☐ Self	☐ Family ___________	Pulmonary Embolism	☐ Self	☐ Family ___________
Diabetes/ Pre-Diabetes	☐ Self	☐ Family ___________	Sickle Cell Anemia	☐ Self	☐ Family ___________
			Skin Disease	☐ Self	☐ Family ___________
Easy Bleeding	☐ Self	☐ Family ___________	Sleep Apnea	☐ Self	☐ Family ___________
Eczema	☐ Self	☐ Family ___________	Stroke	☐ Self	☐ Family ___________
Emphysema	☐ Self	☐ Family ___________	Suicide/Attempt	☐ Self	☐ Family ___________
Epilepsy or Seizures	☐ Self	☐ Family ___________	Tuberculosis	☐ Self	☐ Family ___________
Food Allergies	☐ Self	☐ Family ___________	Thyroid Disease	☐ Self	☐ Family ___________
Glaucoma	☐ Self	☐ Family ___________	Ulcers	☐ Self	☐ Family ___________
Gout	☐ Self	☐ Family ___________	Other	☐ Self	☐ Family ___________
Hay Fever	☐ Self	☐ Family ___________			

THERAPIES

Please list all supplements and medications you are currently taking. Attach another page if needed.
Bringing bottles to your visit is helpful.

Name of current medication/supplement (such as Synthroid, Vitamin D, etc.)	**Strength** (such as 250 mg)	**Directions** (such as 1 tablet twice a day, as needed, etc)

Have you tried other therapies for your health concerns? Yes / No. If yes, please describe:___________________________

____

____

NUTRITION & LIFESTYLE

Do you follow any particular diet philosophy? Yes / No If Yes, please describe:_____________________________________

____

Please list foods you commonly eat:

Breakfast____

Lunch____

Dinner____

Snacks____

How much water and other fluids do you drink a day?________________________Do you use a water filter?_____________

What food(s), condiments(s), or any other substances (e.g. tobacco, alcohol, coffee, etc.) do you crave?

____

Do you have a sensitivity/intolerance/allergy to any foods? Yes / No Explain:____

____

How much sleep do you get a night?__________________Is it enough? Yes / No Do you wake during the night? Yes / No

Do you wake refreshed in the morning? Yes / No

Do you smoke? Yes / No Do you vape? Yes / No

Are you exposed to chemicals? Yes / No Explain:____

Do you exercise regularly? Yes / No How often?_____________________ What type?_________________________________

REVIEW OF SYMPTOMS

Please circle 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you:

	Now	Past		Now	Past	
General	1 2 3	1 2 3	swollen or painful lymph nodes	1 2 3	1 2 3	excessive hair growth
	1 2 3	1 2 3	poor wound healing	1 2 3	1 2 3	bruise easily
	1 2 3	1 2 3	difficulty stopping bleeding	1 2 3	1 2 3	heat intolerance
	1 2 3	1 2 3	anemia	1 2 3	1 2 3	cold intolerance
	1 2 3	1 2 3	weakness	1 2 3	1 2 3	cold hands or feet
	1 2 3	1 2 3	fatigue	1 2 3	1 2 3	excessive thirst
	1 2 3	1 2 3	unexplained weight loss/gain	1 2 3	1 2 3	excessive hunger
	1 2 3	1 2 3	chemical sensitivity	1 2 3	1 2 3	excessive sweating

Gastrointestinal How often do you have bowel movements? ____________________________

	Now	Past		Now	Past	
	1 2 3	1 2 3	nausea	1 2 3	1 2 3	vomiting
	1 2 3	1 2 3	blood in stool	1 2 3	1 2 3	diarrhea
	1 2 3	1 2 3	constipation	1 2 3	1 2 3	hemorrhoids
	1 2 3	1 2 3	hard, dry stools	1 2 3	1 2 3	excessive gas
	1 2 3	1 2 3	ulcer	1 2 3	1 2 3	bloating
	1 2 3	1 2 3	anal itching	1 2 3	1 2 3	heavy, full feeling after eating
	1 2 3	1 2 3	heartburn	1 2 3	1 2 3	parasites
	1 2 3	1 2 3	excess belching	1 2 3	1 2 3	abdominal pain
	1 2 3	1 2 3	trouble swallowing			
	1 2 3	1 2 3	alternating constipation and diarrhea			
	1 2 3	1 2 3	change in bowel movements			

	Now	Past		Now	Past	
Skin and Nails	1 2 3	1 2 3	pimples/acne	1 2 3	1 2 3	hives
	1 2 3	1 2 3	color changes in nails	1 2 3	1 2 3	loss of hair
	1 2 3	1 2 3	skin infections	1 2 3	1 2 3	skin cancer
	1 2 3	1 2 3	skin rough, dry, scaly, bumpy, itchy (circles which apply)			
	1 2 3	1 2 3	rashes, warts, moles, cysts (circle which apply)			
	1 2 3	1 2 3	light or dark patches of skin (circle which apply)			
	1 2 3	1 2 3	increased hair growth in unusual places			
Head	1 2 3	1 2 3	dizziness	1 2 3	1 2 3	head injuries/concussion
	1 2 3	1 2 3	headaches	1 2 3	1 2 3	fainting spells
	1 2 3	1 2 3	migraines	1 2 3	1 2 3	seizures
Eyes	1 2 3	1 2 3	blurry vision	1 2 3	1 2 3	eye injuries
	1 2 3	1 2 3	double vision	1 2 3	1 2 3	eye pain, irritation
	1 2 3	1 2 3	corrective lenses	1 2 3	1 2 3	eye discharge / drainage
	1 2 3	1 2 3	eye infections	____________		approx. date of last eye exam
Ears	1 2 3	1 2 3	discharge	1 2 3	1 2 3	infections
	1 2 3	1 2 3	pain in ears	1 2 3	1 2 3	motion sickness/vertigo
	1 2 3	1 2 3	hearing trouble	1 2 3	1 2 3	ringing or roar in ear
	1 2 3	1 2 3	itching	1 2 3	1 2 3	stopped up ears

Please mark 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you:

	Now	Past		Now	Past	
Nose	1 2 3	1 2 3	nosebleeds	1 2 3	1 2 3	difficulty breathing through nose
	1 2 3	1 2 3	sinus infections	1 2 3	1 2 3	loss of smell
	1 2 3	1 2 3	seasonal allergies	1 2 3	1 2 3	post-nasal drip
	1 2 3	1 2 3	snoring	1 2 3	1 2 3	sleep apnea or wake gasping for air
Mouth	1 2 3	1 2 3	cold sores/canker sores	1 2 3	1 2 3	root canals
	1 2 3	1 2 3	speech difficulties	1 2 3	1 2 3	infections
	1 2 3	1 2 3	loss of teeth	1 2 3	1 2 3	dryness
	1 2 3	1 2 3	grinding teeth	1 2 3	1 2 3	bad breath
	1 2 3	1 2 3	sore jaw	1 2 3	1 2 3	bad taste
	1 2 3	1 2 3	gum problems	1 2 3	1 2 3	amalgam (silver) fillings
Throat	1 2 3	1 2 3	loss of voice	1 2 3	1 2 3	pain
	1 2 3	1 2 3	infections	1 2 3	1 2 3	swelling/constriction
	1 2 3	1 2 3	persistent hoarseness	1 2 3	1 2 3	difficulty swallowing
	1 2 3	1 2 3	tonsils or adenoids removed			
Neck	1 2 3	1 2 3	stiffness/pain	1 2 3	1 2 3	injuries / whiplash
	1 2 3	1 2 3	swollen glands	1 2 3	1 2 3	enlarged thyroid
Respiratory						
	1 2 3	1 2 3	shortness of breath	1 2 3	1 2 3	wheezing/asthma
	1 2 3	1 2 3	coughing spells	1 2 3	1 2 3	infections
	1 2 3	1 2 3	expectoration (mucus, blood)	1 2 3	1 2 3	chest pain with breath
Cardiovascular						
	1 2 3	1 2 3	heart disease	1 2 3	1 2 3	high cholesterol
	1 2 3	1 2 3	chest pain	1 2 3	1 2 3	leg vein trouble
	1 2 3	1 2 3	shortness of breath	1 2 3	1 2 3	murmur
	1 2 3	1 2 3	irregular heart beat or palpitations	1 2 3	1 2 3	ankle or foot swelling
Urinary	1 2 3	1 2 3	frequent urination	1 2 3	1 2 3	painful urination
	1 2 3	1 2 3	night urination	1 2 3	1 2 3	foul odor/unusual color of urine
	1 2 3	1 2 3	trouble starting urine	1 2 3	1 2 3	trouble holding urine
	1 2 3	1 2 3	prolapsed bladder	1 2 3	1 2 3	frequent urinary tract infections
	1 2 3	1 2 3	kidney stones			
Male	1 2 3	1 2 3	discharge from penis	1 2 3	1 2 3	painful erection
	1 2 3	1 2 3	infertility	1 2 3	1 2 3	infection
	1 2 3	1 2 3	prostate problems	1 2 3	1 2 3	injury
	1 2 3	1 2 3	sexually transmitted disease	1 2 3	1 2 3	lumps, swelling, or pain in testicles
	1 2 3	1 2 3	difficulty achieving or maintaining an erection			

What kind of contraception do you use?____

Do you want birth control information? Yes / No

Please mark 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you:

	Now	Past		Now	Past	
Female	1 2 3	1 2 3	discharge from vagina	1 2 3	1 2 3	painful intercourse
	1 2 3	1 2 3	pelvic pain	1 2 3	1 2 3	flushes of heat
	1 2 3	1 2 3	infertility	1 2 3	1 2 3	prolapsed uterus
	1 2 3	1 2 3	menstrual flow is excessive	1 2 3	1 2 3	difficulty feeling sexually aroused
	1 2 3	1 2 3	menstrual flow is absent	1 2 3	1 2 3	no lubrication when aroused
	1 2 3	1 2 3	menstrual flow is irregular	1 2 3	1 2 3	never or seldom have orgasms
	1 2 3	1 2 3	spotting between periods	1 2 3	1 2 3	sexually transmitted disease
	1 2 3	1 2 3	infection: Type/Location?________________When?_________________			

Breasts: (circle) lumps, swelling, soreness, biopsies, family history of breast cancer

Premenstrual symptoms: (circle) cramping, water retention, breast tenderness, headaches, depression, irritability, others________________________________How severe?_________________________

What kind of contraception do you use?____

Do you want birth control information? Yes / No

First day of last menstrual period?__________________

Usual # of days of spotting & bleeding?______________How often does your period come?______________

Have you had a hysterectomy? Yes / No Date: ______________ Do you still have your ovaries? Yes / No

Number of pregnancies?________ Number of births?________ Any incomplete pregnancies? Yes / No

Approximate date of last pap test?_________________Ever had an abnormal pap smear? Yes / No

Approximate date of last mammogram or thermography? _____________________

Musculo-	1 2 3	1 2 3	pain or stiffness. Where?_________________________________
skeletal	1 2 3	1 2 3	swelling. Where?____
	1 2 3	1 2 3	injury. Where?____
	1 2 3	1 2 3	muscle cramps. Where?___________________________________
	1 2 3	1 2 3	other. Describe:____

Neurological

1 2 3	1 2 3	loss of balance	1 2 3	1 2 3	paralysis
1 2 3	1 2 3	faintness	1 2 3	1 2 3	lack of strength
1 2 3	1 2 3	involuntary movement	1 2 3	1 2 3	speech slurred
1 2 3	1 2 3	loss of consciousness	1 2 3	1 2 3	convulsions (seizures)
1 2 3	1 2 3	tremor (shaking, trembling)	1 2 3	1 2 3	numbness. Where?_________

Mental & Emotional

In the past few months, how often have you been bothered by any of the following problems?	**Not at all**	**Occas-ional Days**	**More Than Half the Days**	**Nearly Every Day**
Under excess stress				
Loss of interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling asleep, staying asleep or sleeping too much				
Difficulty with concentration or memory				
Feeling jumpy or easily started				
Excessive worry or anxiety				
Traumatic experiences in the past that still affect you				
Overuse of drugs or alcohol				
Thoughts you would be better off dead or of hurting yourself				

Do you currently suffer with an eating disorder				
Have you suffered in the past with an eating disorder				

FINAL NOTES

What do you think causes or has contributed to your health problems?____

What do you feel needs to happen for you to get better?____

What do you enjoy most in your life?____

What potential obstacles do you foresee in your journey to better health?_____________________________________

____

How much change are you willing to make at this time for improving your health? (circle)

MINIMAL SOME COMPLETE

Is there anything else you wish to add?____

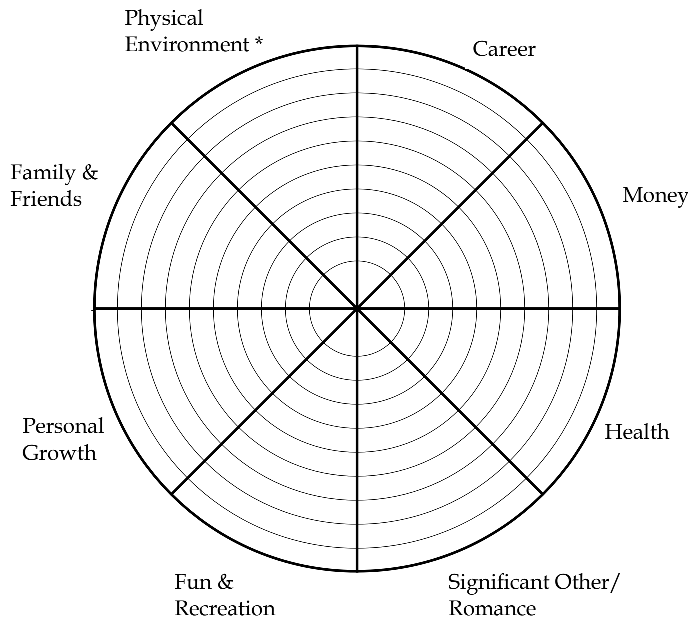
____

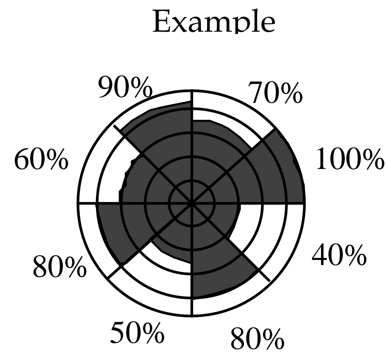
____

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.
For example, if you are extremely happy in your career, shade the entire pie shape for career.
Do the same for each area, starting from the center point radiating outwards.

*Physical Environment means – Do you like your home, your work space, do you get enough fresh air, good light?





Thank you for taking the time to complete this form.
We look forward to providing you the best possible care.