Boise Natural Health Clinic

4219 W. Emerald St, Boise, ID 83706 | 208-338-0405 | fax 208-422-9957 | www.boisenaturalhealth.com

New Patient Checklist

☐ **Intake Form -** Print and fill out form or create a PDF and fill out electronically.

- In-person appointment – Bring your intake form and other documents with you. Please wear a mask and see our web page for COVID-19 information.
- Video or phone appointment - The doctors need to have your completed intake form *24-hours before your first visit*.
- Ways you can send the intake form back to us:
    1. Secure Patient Portal (preferred). You will receive an email link to join when you schedule, then you can upload the document.
    2. Mail to BNHC, 4219 W. Emerald, Boise, ID 83706
    3. Drop off at the clinic during working hours.
    4. Fax (208) 422-9957
    5. Unsecure email boisenaturalhealth@gmail.com

☐ **Laboratory Reports**

- Please provide recent (last year) laboratory reports, if available.
- To request records to be transferred to BNHC from other providers, you can find a Release of Records form on our web page.

☐ **Supplements and Medications**

- You will save time in your appointment if you clearly list on the intake form or a separate sheet the exact names of your current medications and supplements, including the doses and brands.

Clinic Policies

Payment is due at time of service: Some insurance companies do cover some of our services, but many companies do not. We do not contract with any insurance companies and do not bill insurance on your behalf. We provide you with "insurance ready" forms for reimbursement. Please check with your insurance provider to see if our services are covered under your plan. Often Flexible Spending Accounts or Health Savings Accounts can be used for pre-tax dollar savings.

Cancellation Policy: You may cancel or reschedule at no charge if you call at least 24 hours (1 business day) before your appointment. If notice is given less than twenty-four hours, you will be billed half price of the visit. If you do not cancel or fail to come for your appointment, you will be billed the full price of the visit.

Fragrance Free: When you visit our office, please do not wear scents that are perceptible by others such as: perfume or scented hand lotion. We appreciate your respect to our chemically sensitive patients and staff.

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ADULT PATIENT INTAKE FORM

Please take the time to carefully and thoroughly complete this health history questionnaire.
Print all information and mark anything you don't understand with a question mark.

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 messages?_____

Email _____

Occupation_____ Hours per week _____

Employer & Work Address _____

Education_____ Military Service?_____

Are you: _____Married _____Separated _____Divorced
_____Single _____Cohabitating _____Widowed

Live with: _____Spouse _____Parents _____Alone
_____Children _____Partner _____Friends

Children's Ages_____

Emergency Contact (name and relation)_____

Contact's Phone _____

How did you hear about our clinic?_____

MEDICAL HISTORY

What are your most important health challenges? List as many as you can in order of importance.

_____ _____
_____ _____
_____ _____
_____ _____

Have you consulted any other physician or health practitioner? When and for what? _____

_____

_____

What is your blood type (A/B/O)_____

Do you have any body parts that are not your own? (Implants, transplants)?_____

Weight_____Weight 1 year ago_____ Maximum Weight_____When? _____

What childhood illnesses have you had? Please list approximate year or age:

_____

_____

Did you have standard childhood immunizations?_____

Immunizations for travel outside the US? Which ones and when?_____

Any negative reactions? Explain:_____

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

What hospitalizations or surgeries have you had? Please list dates:_____

_____

_____

FAMILY HISTORY

Do your close relatives (parents, siblings, children) have any of the following medical conditions?

Please circle:

High Blood Pressure, Heart Attack, Stroke, Obesity, Diabetes, Glaucoma, Asthma, Hay Fever, Eczema, Skin Disease, Food Allergies, Emphysema, TB, Lung Cancer, Breast Cancer, other Cancer, Birth Defects, Suicide, Depression, Mental Illness, Alcoholism, Epilepsy, Ulcers, Arthritis, Gout, Thyroid Disease, Easy Bleeding, Sickle Cell Anemia, Osteoporosis, Other _____

REVIEW OF SYMPTOMS

Please mark 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you *Now* or in the *Past*.

	Now	Past		Now	Past	
General	___	___	swollen or painful lymph nodes	___	___	excessive hair growth
	___	___	wounds heal slowly	___	___	bruise easily
	___	___	difficulty stopping bleeding	___	___	can't stand heat
	___	___	anemia	___	___	can't stand cold
	___	___	bleeding from unusual places	___	___	cold hands or feet
	___	___	unexplained fever	___	___	night sweats
	___	___	weakness	___	___	increased thirst
	___	___	fatigue	___	___	increased hunger
	___	___	unexplained weight loss/gain	___	___	excess sweating

Please mark 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you *Now* or in the *Past*.

	Now	Past		Now	Past	
Skin and Nails	___	___	pimples	___	___	hives
	___	___	color changes in nails	___	___	loss of hair
	___	___	infections			
	___	___	skin rough, dry, scaly, bumpy, itchy (circles which applies)			
	___	___	rashes, warts, moles, cysts (circles which applies)			
	___	___	light or dark patches of skin (circles which applies)			
	___	___	increased hair growth in unusual places			
Head	___	___	dizziness	___	___	double vision
	___	___	headaches	___	___	fainting spells
	___	___	seizures or fits	___	___	injuries
Eyes	___	___	corrective lenses	___	___	pain, irritation
	___	___	infections	___	___	discharge
	___	___	injuries	___	___	last exam
Ears	___	___	discharge	___	___	infections
	___	___	pain in ears	___	___	injuries
	___	___	hearing trouble	___	___	ringing or roar in ear
	___	___	itching	___	___	stopped up ears
	___	___	motion sickness	___	___	other
Nose	___	___	nosebleeds	___	___	injury
	___	___	sinus problems	___	___	loss of smell
	___	___	discharge/crusts	___	___	polyps
	___	___	sneezing attacks	___	___	ulcers
	___	___	difficulty breathing through nose	___	___	other
Mouth	___	___	sores	___	___	poor dentition
	___	___	speech difficulties	___	___	infections
	___	___	loss of teeth	___	___	dryness
	___	___	grinding teeth	___	___	bad breath
	___	___	sore jaw	___	___	bad taste
	___	___	gum problems	___	___	root canals
	___	___	amalgam fillings	___	___	other
Throat	___	___	loss of voice	___	___	pain
	___	___	infections	___	___	swelling/constriction
	___	___	persistent hoarseness	___	___	difficulty swallowing
Neck	___	___	stiffness	___	___	injuries
	___	___	swollen glands,	___	___	enlarged thyroid
Respiratory						
	___	___	shortness of breath	___	___	wheezing/asthma
	___	___	coughing spells	___	___	infections
	___	___	expectoration (mucus, blood)	___	___	chest pain with breath

Please mark 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you *Now* or in the *Past*.

	Now	Past		Now	Past	
Cardiovascular						
	___	___	chest pain	___	___	leg vein trouble
	___	___	shortness of breath	___	___	murmur
	___	___	irregular beat	___	___	ankle or foot swelling
	___	___	feel heart pounding/racing	___	___	leg pain walking
Gastrointestinal						
	___	___	nausea	___	___	vomiting
	___	___	blood in stool	___	___	diarrhea
	___	___	constipation	___	___	hemorrhoids
	___	___	hard, dry stools	___	___	vomiting blood
	___	___	ulcer	___	___	bloating
	___	___	anal itching	___	___	indigestion
	___	___	heavy, full feeling after eating	___	___	heartburn
	___	___	excess belching	___	___	parasites
	___	___	trouble swallowing	___	___	abdominal pain
	___	___	foul-odored stools	___	___	excessive gas
	___	___	irritable if late for meal	___	___	sleepy during day
	___	___	nervous shaky feelings, headaches, relieved by eating			
	___	___	alternating constipation and diarrhea			
	___	___	change in bowel movements			
	How often do you have bowel movements?_____					
Urinary	___	___	frequent urination	___	___	painful urination
	___	___	night urination	___	___	foul odor of urine
	___	___	trouble starting urine	___	___	trouble holding urine
	___	___	urine dark, cloudy, foamy, bloody (circle which applies)			
Male	___	___	discharge from penis	___	___	painful erection
	___	___	infertility	___	___	infection
	___	___	prostate problems	___	___	injury
	___	___	difficulty achieving or maintaining an erection			
	___	___	lumps, swelling, or pain in testicles			
	What kind of contraception do you use?_____					
	Do you want birth control information?_____					
Female	___	___	discharge from vagina	___	___	painful intercourse
	___	___	pelvic pain	___	___	flushes of heat
	___	___	infertility			
	___	___	difficulty feeling sexually aroused			
	___	___	no lubrication when aroused			
	___	___	never or seldom have orgasms			
	___	___	menstrual flow is excessive			
	___	___	menstrual flow is absent			
	___	___	bleeding/spotting before or after periods			
	___	___	breasts: lumps, swelling, soreness (circle)			
	___	___	infection: Type/Location_____When?_____			
	___	___	premenstrual symptoms: cramping, water retention, breast tenderness, headaches, depression, irritability, others, (circle)			

Female con't

What kind of contraception do you use?_____
First day of last menstrual period?_____
Usual length of cycle_____ days, Duration of menses_____days
Hysterectomy date_____ Do you still have your ovaries?_____
Number of Pregnancies_____ Number of Births_____
Date of last annual exam / PAP _____

Please mark 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you *Now* or in the *Past*.

Now	Past		Now	Past	
Musculoskeletal					
___	___	back pain			
___	___	spinal curvature or scoliosis			
___	___	muscle cramp. Where?_____			
___	___	joint pain or stiffness. Where?_____			
___	___	swelling. Where?_____			
___	___	injury. Where?_____			
___	___	other. Describe:_____			
Neurological					
___	___	loss of balance	___	___	paralysis
___	___	faintness	___	___	lack of strength
___	___	involuntary movement	___	___	speech slurred
___	___	loss of consciousness	___	___	convulsions (seizures)
___	___	tremor (shaking, trembling)	___	___	numbness. Where?
Mental					
___	___	restlessness	___	___	nervousness/anxiety
___	___	excessive worry	___	___	trouble sleeping
___	___	memory trouble	___	___	crying spells
___	___	trouble concentrating	___	___	depression
___	___	nightmares	___	___	manic episodes
___	___	excess stress	___	___	fogginess/confusion
___	___	feel like killing myself	___	___	easily angered
___	___	feel better from exercising	___	___	irritable
___	___	feelings of worthlessness	___	___	mood swings
___	___	trouble getting along with people	___	___	drug abuse
___	___	physical or sexual abuse			
___	___	difficulty expressing feelings			
___	___	loss of someone dear through death or separation			
___	___	don't know how to relieve stress			
___	___	other_____			

Have you had any experiences (traumatic or otherwise) that did or still do affect you deeply? Explain if you wish:_____

_____

_____

_____

THERAPIES AND LIFESTYLE

Current Medications: Please list any prescription medications, nutritional supplements, herbs or homeopathic remedies you are currently taking. Please list doses if known. Bringing bottles with you to your visit is helpful.

_____

_____

_____

_____

Please list any medications, natural or prescription that you have tried in the past._____

_____

_____

_____

Other therapies_____

Are you allergic to any drugs?_____

Do you use	YES	AMOUNT	Do you use	YES	AMOUNT
Alcohol	_____	_____	Hormones	_____	_____
Pain Relievers	_____	_____	Laxatives	_____	_____
Birth Control Pill	_____	_____	Coffee/Caffeine	_____	_____
Soda Pop	_____	_____	Fast Food	_____	_____
Cortisone	_____	_____	Tobacco	_____	_____
Electric Blanket	_____	_____	Sleeping Aids	_____	_____
Thyroid Medication	_____	_____	Appetite Suppressants	_____	_____
Antacids	_____	_____	Sugar	_____	_____
Recreational Drugs	_____	_____			

How much sleep do you get a night?_____ Is it enough?_____ Do you wake during the night?_____

Do you wake refreshed in the morning?_____

Are you exposed to chemicals? Explain:_____

Are you under stress? Explain:_____

Do you exercise?_____ How often?_____ What type?_____

NUTRITION

How much water do you drink a day?_____ Do you use a water filter? _____

Generally, what does your diet consist of?_____

_____

_____

What times or how frequently do you eat?_____

Who prepares your food?_____

Do you snack? On what?_____

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

_____

Are you repelled by, or do you dislike any foods? Please identify:_____

_____

Are there any foods that do not agree with you or aggravate you? Explain:_____

_____

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 addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?_____

_____

_____

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?_____

_____

_____

_____

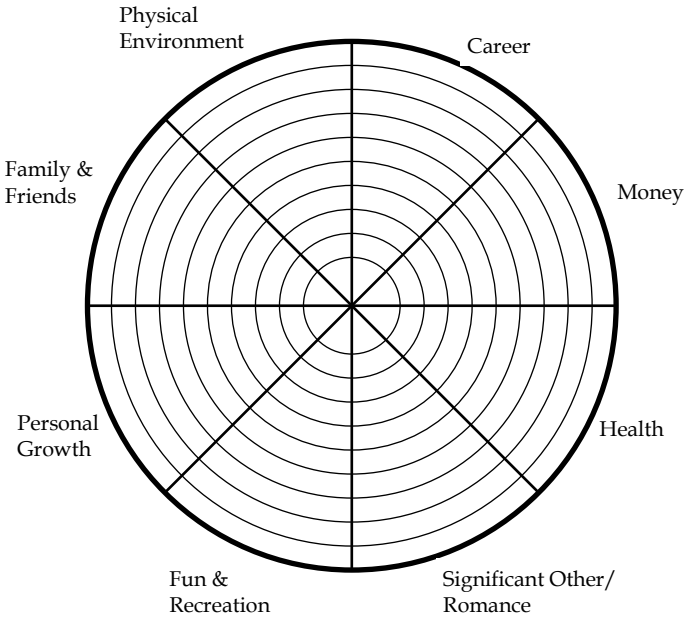
_____

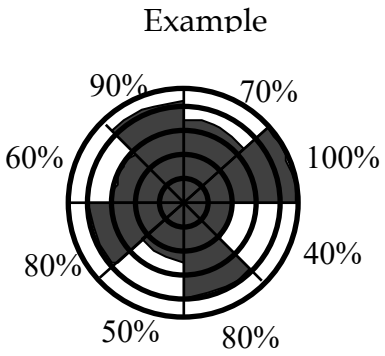
_____

_____

_____

_____





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.

ACKNOWLEDGEMENT OF RECEIPT OF PROVIDER NOTICE OF PRIVACY PRACTICES

I have read the HIPAA policies on the Boise Natural Health Clinic here:
https://boisenaturalhealth.com/wp-content/uploads/2015/12/hipaa-policies.pdf

Patient Name: _____

Signature:_____

Relationship to Patient:_____

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