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PATIENT INTAKE FORM

Name: _____ Preferred name: _____ Date of Birth: _____

Family Ethnicity: _____ Parent(s)/Legal Guardian(s): _____

Street Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Maiden name: _____

May we leave a medically related message at home? _____ at work? _____ on cell? _____

What is your birth sex? (circle) M / F Other (specify) _____ Marital Status: _____

What gender do you identify as? (circle) M / F Other (specify) _____ Referred by: _____

Emergency contact: _____ Phone: _____

Pharmacy (include city): _____ How would you like to receive apt reminders? Email/Phone

GUARANTOR

Name: _____ Relationship to patient: _____

Address (if different): _____ Phone: _____

INSURANCE INFORMATION

Insurance Company: _____ Subscriber: _____

Address: _____ Subscriber DOB: _____

Patient ID#: _____ Subscriber ID#: _____

Group #: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer / Address /Phone: _____

I authorize the release of any medical or other information necessary to process claims to my insurance carrier. I also request payment of government benefits either to myself or to the party who accepts assignment: Mountain View Natural Medicine. I authorize payment of medical benefits to Mountain View Natural Medicine for services rendered at this clinic and submitted to my insurance carrier.

Signature

Date

Would you like us to be your primary care provider? Y / N

Name of other or prior PCP (Primary Care Provider) if applicable: _____

Please list your health concerns in order of priority along with other practitioners you may be seeing for the condition:

1. _____
2. _____
3. _____
4. _____

What do you believe is causing your most important health concerns?

PAST MEDICAL HISTORY: PLEASE LIST ANY SURGERIES AND/OR MAJOR ILLNESSES:

Age or date:	Description:

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

Medications:	Reason:	Dose	Date began

Supplements:	Reason:	Dose	Date began

**Please list any drug allergies: _____

**Please list any food allergies: _____

**Please list any environmental allergies: _____

**Patients often desire communication between their healthcare providers. Do we have your permission to communicate verbally and in writing with other providers regarding your healthcare?
yes / no**

FAMILY HEALTH HISTORY: (be sure to include current age or age of death, major illness history, including diabetes, heart disease, osteoporosis, cancer, allergies, etc.)

Member	Living?/Age	Major illness or chronic conditions
Mother		
Father		
Siblings		
Mat. Grandmother		
Mat. Grandfather		
Pat. Grandmother		
Pat. Grandfather		

PREVENTATIVE HEALTH:

Please fill in what you can:

	Recent	Past year	Past 5 years
Weight			
Height			
Cholesterol w/ HDL & LDL			
Blood pressure			

If tested in the past 2 years, please check:

Thyroid (normal? y/n) _____ Blood sugar (normal? y/n) _____ Anemia (normal? y/n) _____

Date of last: Tetanus shot _____ Colonoscopy _____ (normal? y/n)

DIET: Please describe a typical day’s diet for you, (be honest).

Breakfast	Lunch	Dinner	Snacks (what hour)

CURRENT HEALTH CONCERNS (Review of Systems)

Please check normal or abnormal and briefly explain.

N ABN

Constitutional (Energy, weight, body temperature, sleep, general sense of well-being) _____

Head: headaches, vertigo, injuries etc.) _____

Vision/eye problems: _____

Ear/nose/throat/mouth (allergies, infections etc.) _____

Cardiovascular: (high BP, cholesterol etc.) _____

Respiratory _____

Digestive tract issues: (changes in bowel habits, hemorrhoids, bloating, pain, etc.) _____

Musculoskeletal concerns (arthritis, joint problems, osteoporosis, muscle pain, weakness): _____

Skin (eczema, infections, rashes, etc.) _____

Psychological (mood changes, sadness _____

Neurological (numbness, tingling, balance problems, memory etc.) _____

Hormonal issues (diabetes, thyroid problems, menopausal, adrenal etc.) _____

Blood or lymph issues (current anemia, swollen glands etc.) _____

Allergies _____

Others: _____

Women

Onset of first menses was age _____. Periods generally last _____ days and occur every _____ days.

Date of last period _____ Bleeding is _____ Heavy _____ Moderate _____ Light?

Do you experience PMS symptoms? _____ List: _____

Are you currently sexually active? _____ Partner(s) is/are ___ Male ___ Female

Type of birth control: _____ Are you happy with this method? _____

Are you currently experiencing any gynecological symptoms or problems? _____

Any problems related to sexual function? _____

Do you have a history of sexually transmitted disease? _____ Genital warts? _____

Number of pregnancies? _____ Births? _____ Abortions? _____ Miscarriages? _____

Date of last Pap smear: _____ Abnormal Pap History? _____

Do you perform regular breast self exams? _____ Date of last mammogram, if any: _____

If menopausal or perimenopausal, list symptoms and concerns: _____

Men

Are you currently sexually active? _____ Partner(s) is/are ___ Male ___ Female

History of sexually transmitted diseases? _____ Genital warts? _____

Date of last prostate exam? _____ PSA test? _____

Trouble with urination? (frequency, hesitancy, pain, dribbling) _____

Trouble with sexual function/libido? _____ If yes, explain: _____

LIFESTYLE

What is your vocation? _____

What are your primary sources of stress? _____

How much do you think they impact your life? _____

How many hours do you work per week? _____ Number of play/relaxation hours? _____

What do you do in order to manage stress/ take care of yourself? _____

What is your exercise routine? _____

Do you wear seatbelts? Y/N A bike helmet? Y/N

What do you do for fun? _____

Caffeine/Amount? _____ Alcohol/Amount? _____

Smoking history and amount? _____ Recreational drugs? _____

Take a minute to imagine what good health means to you. What would it look like if all the health concerns you currently have were successfully solved? What would you be able to do? How would you feel?

What specific change(s) are YOU ready to make in order for you vision of health to happen?

What, if any, barriers to this exist? How could you overcome these?

How ready do you feel to make the changes above, on a scale from 1-10?

1 2 3 4 5 6 7 8 9 10

(1=not sure, 5=depends how hard it is, 10=I'll do what it takes!)

MENTAL HEALTH:

Over the last 2 weeks, how often have you been bothered by the following problems?:

Little interest or pleasure in doing things?

Not at all	Several days	More than half the days	Nearly daily
0	1	2	3

Feeling down, depressed or hopeless?

Not at all	Several days	More than half the days	Nearly daily
0	1	2	3

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Mountain View Natural Medicine has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact the **Office Manager @ 802-860-3366.**

I also understand that I am entitled to receive updates upon request if Mountain View Natural Medicine amends or changes its Notice of Privacy Practices in a material way.

Signature

Relationship to Patient, if other than patient

Date

Patient's name if not signed by patient

THIS SECTION IS TO BE COMPLETED BY Mountain View Natural Medicine IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

Patient declined to sign this Written Acknowledgment.

Other (specify): _____

Name and title of employee

Date

Financial Policy

PAYMENT IS EXPECTED WHEN YOU COME IN FOR AN APPOINTMENT

- Co-Payments, deductible, co-insurance and private pay fees, where applicable are due upon check out.
- Any deductible is due as soon as the amount can be determined
- You are responsible for understanding what your insurance plan will cover or not cover
- As a courtesy, we will bill non-participating insurance companies
- Postage and handling will be added to dispensary items. We will mail and require payment prior to mailing.

NOTIFY US OF ANY CHANGES IN YOUR ADDRESS AND/OR INSURANCE

- If your insurance changes, bring your new insurance card with you.
- Please contact your insurance company with insurance questions.

STATEMENTS ARE GENERATED FOR OUTSTANDING BALANCES

- If you are responsible for more than one patient account, we may offset an overpayment in one account to another account.
- We will assess a \$25 service fee for any checks returned unpaid.
- If payment is not received within 21 days of the statement date your account will be considered delinquent

RETRUNED SUPPLEMENTS

- Any unopened item may be returned for a full refund within 30 days of purchase.
- Mail order items must be postmarked by 30 days of the original date of purchase. Return postage is nonrefundable.

WE USE COLLECTION AGENCIES FOR DELINQUENT ACCOUNTS

- If your account is delinquent, we may list your default with our credit reporting agency. If we incur any collection costs, these will be added to the balance you owe.

NOTIFY US TO CANCEL AN APPOINTEMENT

- If you need to cancel an appointment, please notify us 24 hours before the appointment.
- If you miss an appointment or are late in cancelling it, we may assess a \$50.00 fee.
- If you frequently miss or cancel appointments, you may be discharged from the practice.

WE USE AND AUTOMATED SYSTEM FOR E-MAIL APPOINTMENT REMINDERS

- An automated e-mail will be sent to the listed e-mail address prior to your appointment.
 - Missed appointment fees apply regardless of whether a courtesy reminder was sent or not.
-

I've read the above financial policy of Mountain View Natural Medicine and agree to its terms. I am responsible for any balance due on my account or the patient I am responsible for.

Patient Name: _____

Responsibility party name: _____

Signature: _____ Date: ____ / ____ / ____