Natural Choices Health Clinic *Your natural choice for health care*
3007 SE Belmont Street, Portland, OR 97214
www.NaturalChoicesClinic.com
Lita Buttolph, PhD, DSOM, LAc

New Patient Intake Form

_____
Legal Name (First Middle Last)

_____
Preferred Name (Nickname)

_____
Street Address

_____ _____ _____
City State Zip code

_____ _____
Phone number Email address

_____ _____ _____
Date of Birth Marital Status Preferred gender + pronoun

Do you prefer phone or email contact? _____

_____
Occupation/how do you spend your days? Employer? Number of hours per week?

_____ _____
Emergency contact name and relationship Emergency contact phone #

By signing below, I acknowledge that I am financially responsible for all charges. I understand that payment is due upon receipt of treatment. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Vital Life Acupuncture Clinic to release information necessary to secure payment to insurance billers, insurance companies and other related entities. I authorize the release of any medical or other information necessary to the process of this claim. I understand that a Missed Appointment Fee of $25.00 will be charged for missed appointments or late cancellations.

_____ _____
Client or Authorized Person's Signature Date of Signature

What is the main reason for your visit today?

_____

_____

What are you chiefly hoping to address?

_____

_____

Are you currently receiving healthcare? [ ] Yes [ ] No.

If yes, from whom?
_____

For what reason? _____

Please list any hospitalizations or surgeries, including approximate dates:
_____

_____

_____

Please list any major medical conditions that you are currently under treatment for:

_____

Please list all medications and supplements below:

Medication or Supplement	Dosage	Frequency

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Family Health History

Please indicate if a family member (i.e.; Mother, Father, Grandparents, or Siblings) has had any of the following. If yes, please specify which family member in the space provided.

Y=YES **N**=NO

Condition			Family Member	Condition			Family Member
Asthma	Y	N		Kidney Disease	Y	N	
Cancer	Y	N		Mental Illness	Y	N	
Diabetes	Y	N		Tuberculosis	Y	N	
Glaucoma	Y	N		Stroke	Y	N	
Heart Disease	Y	N		Substance abuse	Y	N	
Hypertention	Y	N					

ALLERGIES
Please list all allergies you are aware of:

Drugs:_____

Foods:_____

Environmental:_____

HABITS
Do you…
Awaken rested? Y N Average hours of sleep _____
Have you ever been treated for drug or alcohol abuse? Y N
Do you use recreational drugs? Y N
Do you drink alcoholic beverages? Y N # drinks per week _____

What are your main hobbies and interests?_____

_____

What forms of exercise do you get and how often?
_____

_____

CONDITIONS

C=Condition you currently have, **N=**Never had, **P=**Have had in the past

SKIN

Scarlet Fever	C	N	P	Boils	C	N	P
Psoriasis	C	N	P	Eczema	C	N	P
Hives	C	N	P	Itching	C	N	P
Rashes	C	N	P	Scaling	C	N	P

HEAD

Hair loss	C	N	P	Headaches	C	N	P
Skull fracture	C	N	P	Head injury	C	N	P

EYE

Eye pain	C	N	P	Cataracts	C	N	P
Double vision	C	N	P	Dryness	C	N	P
Glasses/contacts	C	N	P	Glaucoma	C	N	P
Impaired vision	C	N	P	Tearing	C	N	P

EAR

Discharges	C	N	P	Earaches	C	N	P
Dizziness	C	N	P	Ringing	C	N	P
Impaired hearing	C	N	P	Trauma	C	N	P

NOSE/SINUSES

Frequent colds	C	N	P	Hay fever	C	N	P
Nose bleeds	C	N	P	Sinus pain	C	N	P
Runny nose	C	N	P	Stuffiness	C	N	P

MOUTH/THROAT/NECK

Bleeding gums	C	N	P	Hoarseness	C	N	P
Difficulty swallowing	C	N	P	Swollen Glands	C	N	P
Dry mouth	C	N	P	Neck Pain/Stiffness	C	N	P
Sore throat	C	N	P	Difficulty speaking	C	N	P
Canker sores	C	N	P	Goiter	C	N	P

RESPIRATORY

Asthma	C	N	P	Bronchitis	C	N	P
Emphysema	C	N	P	Difficult breathing	C	N	P
Pleurisy	C	N	P	Pneumonia	C	N	P
Shortness of breath	C	N	P	Tuberculosis	C	N	P

CARDIOVASCULAR

Angina	C	N	P	High Blood pressure	C	N	P
Dizziness upon standing	C	N	P	Murmurs	C	N	P
Heart disease	C	N	P	Ankles swelling	C	N	P
Palpitations	C	N	P	Rheumatic fever	C	N	P
Chest pain/tightness	C	N	P	Bleeding disorder	C	N	P

DIGESTION

Belching/passing gas	C	N	P	Blood in stool	C	N	P
Change in appetite	C	N	P	Change in thirst	C	N	P
Heartburn	C	N	P	Gallbladder disease	C	N	P
Hemorrhoids	C	N	P	Jaundice	C	N	P
Liver disease	C	N	P	Ulcers	C	N	P
Nausea/Vomiting	C	N	P	Vomiting blood	C	N	P
Constipation	C	N	P	Diarrhea	C	N	P

URINARY

Urinary tract infections	C	N	P	Night frequency	C	N	P
Daytime frequency	C	N	P	Pain with urination	C	N	P
Urethral discharge	C	N	P	Cloudy urine	C	N	P
Dark colored urine	C	N	P	Blood in urine	C	N	P

FEMALE REPRODUCTIVE SYSTEM

Breast lumps	C	N	P	Difficulty conceiving	C	N	P
Sexually transmitted disease	C	N	P	Breast pain	C	N	P
Oral contraceptives	C	N	P	Painful menses	C	N	P
Scanty menses	C	N	P	Irregular menses	C	N	P
Premenstrual pain	C	N	P	Premenstrual irritability	C	N	P
Excessive flow	C	N	P	Painful intercourse	C	N	P
Breast surgery	C	N	P	Vaginal itching	C	N	P
Vaginal dryness	C	N	P		C	N	P

Age menses began: _____ Age of last menses (if menopausal)_____
Duration of menses:_____ Length between cycles: _____
Number of pregnancies: _____ Number of live births: _____
Number of miscarriages:_____ Number of abortions: _____

MALE REPRODUCTIVE SYSTEM

Hernias	C	N	P	Testicular pain	C	N	P
Sexually transmitted disease	C	N	P	Testicular masses	C	N	P
Prostrate disease	C	N	P	Discharge or sores	C	N	P
Erectile dysfunction	C	N	P	Low sperm count	C	N	P

MUSCULOSKELETAL

Joint pain/stiffness	C	N	P	Broken bones	C	N	P
Joint swelling	C	N	P	Muscle cramps/spasms	C	N	P
Arthritis	C	N	P	Weakness	C	N	P

PERIPHERAL VASCULAR

Cold hands/feet	C	N	P	Varicose veins	C	N	P
Deep leg pains	C	N	P	Numb hand/feet/digits	C	N	P

NEUROLOGICAL

Dizziness	C	N	P	Numbness/tingling	C	N	P
Fainting	C	N	P	Loss of memory	C	N	P
Seizures	C	N	P	Paralysis	C	N	P

ENDOCRINE/BLOOD

Anemia	C	N	P	Excessive thirst	C	N	P
Bruise/bleed easily	C	N	P	Hot/cold intolerance	C	N	P
Excessive hunger	C	N	P	Hypothyroid	C	N	P

IMMUNE

Positive test for HIV/AIDS	C	N	P	Autoimmune disease	C	N	P
Easily catches cold	C	N	P		C	N	P

MENTAL/ EMOTIONAL

Anxiety	C	N	P	Excessive fears	C	N	P
Depression	C	N	P	Mood swings	C	N	P
Excessive anger	C	N	P	Excessive sadness	C	N	P

FOR TELEMEDICINE VISITS:

What is your approximate height:_____

What is your approximate weight:_____

THANK YOU!