

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 (If different from above)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip code

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Email address

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Marital Status

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Pronoun

Do you prefer phone, text 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

info@NaturalChoicesClinic.com

phone: (503) 445.7115

fax: (503) 445.7116

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What is the main reason for your visit today?

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What are you chiefly hoping to address?

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

If yes, from whom?

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For what reason? \_\_\_\_\_

Please list any hospitalizations or surgeries, including approximate dates:

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

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Please list all medications and supplements below:

Medication or Supplement	Dosage	Frequency

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