Dakota
Natural Health Center
705 E Main Ave. Bismarck, ND 58501
701.258.9418| 800.290.7028

PATIENT INTAKE FORM

PLEASE PRINT

Date: _____

Name(First, Middle, Last):

_____

Address: _____City: _____

State: _____ Zip Code:_____Birthdate:_____

Sex/Gender: M / F Occupation:_____

Please circle: single / married, partnered / divorced / widowed / other

CELL phone #: _____

Alternate phone # (home / work) : _____

Email address: _____

Emergency Contact: _____Phone:_____

How did you hear about us? _____

***It may be necessary for Dakota Natural Health Center (DNHC) to contact you via phone, text message or email. Choose the following option (s):**

( ) YES you may leave a voicemail ( ) YES you may send me a text message to confirm my appointment

( ) YES you may email me.

****If none selected, then no voicemail, text message or emails will be sent. ****

Health History Questionnaire

Primary reason(s) for today's appointment? _____

_____

_____

_____

What types of therapy have you tried for this problem(s) (i.e. medical doctor visit, medications, diet modification, supplements, etc.)?

_____

_____

_____

Please indicate with an "**X" if yourself** or an "**F" if an immediate family member** has been diagnosed with any of the following conditions:

___ Blood pressure disorder ___Thyroid disorders ___Asthma/Allergies

___Heart disease/attack(s) ___Cancer ___Stroke/dementia/Alzheimer's

___Diabetes ___Anxiety or depression ___Liver or kidney disease(s)

___High Cholesterol ___ Irritable bowels ___ Autoimmune Disease

___ Eating Disorder ___ Fibromyalgia ___ Ear, Nose or Throat problems

___ Sinus problems ___ Obesity ___ Skin problems

___ Varicose veins ___Bleeding/Clotting Disorders Other:_____

Are there any other medical conditions that you have been diagnosed with? _____

_____

Current medications (include dosage and how often you take each): _____

_____

_____

_____

Current vitamins, supplements, herbs, etc.: _____

_____

Operations or hospitalizations (please include dates):_____

_____

Allergies (medications, foods, environmental): _____

_____

Current weight: _____ Height: _____

Do you consider yourself underweight, overweight or just right? _____Have you had unintentional weight loss or gain of 10# or more in the past 3 months? _____

Do you experience any of the following symptoms **EVERY DAY**?

____ Extreme fatigue ____ Shortness of breath ____ Insomnia ____ Nausea

____ Depression ____ Panic attacks ____ Vomiting ____ Diarrhea

____ Disinterest in eating ____ Headaches ____ Incontinence ____Itching/Rash

____ Disinterest in sex ____ Dizziness ____ Chronic pain

Please list your other health care providers (primary care, specialists, chiropractor, etc.):

Name: Field/Specialty:

_____

_____

_____

Lifestyle and Health Habits:

On a scale of 1-to-10 (10 is highest):

How stressful is your: **work** environment? _____**home** environment? _____

Identify the major causes of stress (work, home, finances, legal): _____

Do you follow any type of modified diet (vegan, vegetarian, etc.)? _____

Do you exercise? Y / N If yes, frequency: _____ Duration: _____

How many hours, on average, do you sleep per night? _____

Is your sleep disturbed? Y / N Do you wake feeling rested? Y / N

Do you use tobacco? Y / N Do you use recreational drugs? Y / N

Do you drink alcohol? Y / N If yes, what type(s)?_____ How often? _____

How many drinks? _____

Do you consume caffeine? Y / N What type(s)? _____ How often? _____

Have you been a victim of abuse (domestic violence, sexual abuse, verbal abuse, physical abuse, etc.)? Y /N

Do you currently feel safe in your home and/or relationships? Y / N

Is your job associated with potentially harmful chemicals (pesticides, solvents, etc) or health and/or life-threatening activities (police, fire fighter, farmer, miner, etc.)? Y / N

Women Only: *Please indicate if you experience/experienced any of the following:*

( ) PMS/PMDD ( ) breast changes (cysts, fibrocystic tissue)

( ) Infertility ( ) uterine fibroids, ovarian cysts ( ) loss/change in libido

( ) bloating/water retention ( ) irregular menstrual cycles ( ) bladder function changes

( ) hot flashes/ night sweats ( ) excessive menstrual bleeding ( ) unusual changes in vaginal discharge

( ) itching/burning with urination or intercourse

Age of first menstrual cycle:_____ Age of menopause (if applicable): _____

# of pregnancies: _____ # children: _____ # of pregnancies lost: _____Are you, or could you be, pregnant currently? YES NO

Men Only: *Please indicate if you experience/have experienced any of the following:*

( ) urinary changes
( ) excessive moodiness
( ) frequent nighttime urination
( ) unusual discharge from penis
( ) loss/change in libido
( ) itching or burning with urination or intercourse
( ) erectile dysfunction
( ) pain or swelling in penis or testicle(s)

***HIPPA PRIVACY STATEMENT: An extended HIPPA Privacy Statement is available upon request to be mailed or emailed to you. In short, Dakota Natural Health Center, will not sell, give out or in any other way release your private medical or personal information without your written permission, except where required by law.**

*** I am responsible for paying all appointment fees at the time of service and for appointments I fail to cancel prior to 24 hours.**

*** I understand that the care I receive today is complimentary to my existing healthcare plan. I am responsible for notifying my medical provider about the changes I choose to make.**

Your signature below indicates that you understand the above HIPPA statements

_____ _____

(Client Signature) (Date)

Release of information:

I, the undersigned individual consent to the release of information from Dakota Natural Health Center to: (list all that apply)

_____

Patient Signature Date

Authorized persons to receive information on my behalf:

Name and relation to patient Phone #

_____

_____

_____

_____