Dr. Heather Swallow, N.D.
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p 831.648.1870 | f 831.648.1872

New Patient Intake Form

Date: _____

First name: _____ Last name: _____

If under 18 years old, parent/guardian name: _____

Date of Birth: _____ Age: _____ Sex at birth: M☐ F☐

Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone: _____ Mobile☐ Home☐ Work☐

May we leave a message at this number? Yes☐ No☐

Secondary Phone: _____ Mobile☐ Home☐ Work☐

May we leave a message at this number? Yes☐ No☐

Email: _____

Emergency contact name: _____

Relationship: _____ Phone: _____

How did you hear about Wellspring Natural Health? _____

Relationship Status:

Single☐ Partner☐ Married☐ Separated☐ Divorced☐ Widowed☐

How many children do you have? _____

Age(s): _____

Employer: _____ Phone: _____

Occupation: _____

Primary Physician: _____

Please list your most important health concerns (these can be physical, mental or emotional):

1. _____

2. _____

3. _____

Please list your short and long-term health goals:

1. _____

2. _____

3. _____

Please rate the amount of stress you experience in the following areas of your life on a scale of 1 to 5, with 1 being little to no stress and 5 being extremely stressful:

Work Life _____ Family Life _____ Social Life _____ Financial _____

How do you rate your overall health? Excellent☐ Good☐ Fair☐ Poor☐

How do you rate your overall mental health? Excellent☐ Good☐ Fair☐ Poor☐

Please list the most significant stressful events of your life (from birth to now):

1. _____

2. _____

3. _____

What behaviors/lifestyle choices do you currently engage in that support your health?

_____

What choices do you make that do **NOT** support your health and well-being?

_____

What do you think needs to change in order for you to heal?

_____

What do you love to do and how often do you do it?

_____

What is your present level of commitment to address/change your current lifestyle?

Not So Much *Very Committed*

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

Are you allergic to any medications or other substances? Yes☐ No☐

If yes, please list: _____

_____

Please list all of your current medications and supplements with dosage:

Prescriptions: _____

_____

Supplements/OTC: _____

_____

Did you have any of these childhood illnesses?

Asthma☐ Chickenpox☐ Diphtheria☐ Eczema☐ Measles☐

Mononucleosis☐ Mumps☐ Polio☐ Rheumatic Fever☐ Roseola☐

Rubella☐ Scarlet Fever☐ Strep Throat☐ Whooping Cough☐

Frequent Ear Infections or Colds☐

Other (please explain): _____

Were there any difficulties with your mother's pregnancy/birth with you? _____

_____

Past surgeries or hospitalizations:

_____

_____

Have you ever been on oral steroids? If so, when and for how long?

_____

_____

Have you ever taken antibiotics more than once per year? If so, please explain:

_____

_____

Any known environmental toxicity (i.e., lead, mercury fillings, mold)?

_____

_____

Do any of these illnesses run in your family?

Addiction☐ Allergies☐ Alzheimer's☐ Anemia☐ Arthritis☐ Asthma☐

Auto-Immune☐ Cancer☐ Crohn's/Ulcerative Colitis☐ Dementia☐

Depression☐ Diabetes☐ Epilepsy☐ Gout☐ Heart Disease☐ Hepatitis☐

High Blood Pressure☐ High Cholesterol☐ Kidney Disease☐ Liver Disease☐

Mental Illness☐ Obesity☐ Parkinson's☐ Thyroid Disorders☐ Tuberculosis☐

Urinary Disorder☐

Other (please explain): _____

Nutrition – Please list what a typical meal consists of:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Dessert: _____

Beverages – Please list how many cups/ounces per day you drink:

Coffee_____ Tea_____ Soda_____ Water_____ Alcohol_____ Juice_____

Other drinks _____

Do you ever eat fast-food? _____ If so, how many times per week? _____

How often do you eat frozen/pre-packaged foods? _____

Have you ever had an eating disorder? _____

Do you have a positive relationship with food? _____

Exercise – Type: _____

Times per week: _____ Duration of workout: _____

Do you break a sweat? _____ Do you enjoy your activities? _____

Women's Health – Date of last menstrual period: _____

Are you trying to conceive? Yes☐ No☐

PMS/Menopausal symptoms: _____

Last Pap: _____ Any abnormals? _____

Last Mammography: _____ Any abnormals? _____

Men's Health – Have you ever had a prostate exam? Yes☐ No☐

If so, when? _____

Any current issues with Erectile Dysfunction (ED)? Yes☐ No☐

Have morning erections diminished or disappeared? Yes☐ No☐

Any changes in urination (dribbling, difficulty voiding bladder, etc.)? Yes☐ No☐

Sexual Health -

Are you currently sexually active? Yes☐ No☐

Type of contraception used: _____

STD History: _____

Please rate your sex drive on a scale of 1 to 5:

Non-Existent *Overactive*

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

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Office Policies and Procedures

Please initial each section below.

____ **New Patient Scheduling Policy:** Completed intake forms must be returned to us at least 72 hours before your first appointment. If the office does not receive the forms on time, your appointment will be automatically cancelled and we will require the documents prior to rescheduling.

____ **Cancellation Policy**: We have a 24-hour cancellation policy. This allows us to fill that time slot with patients from our waiting list and honor the doctor's time as well. You will be charged in full for any appointment that is missed or cancelled without 24-hour notification. Please make sure you call the office if you need to cancel or reschedule. **We are unable to accept cancellations via email.**

____ **Email Policy**: You can email the staff at wnh.staff@gmail.com with questions regarding your protocol or side effects. Please allow 72 hours for a response. If there is an urgent issue, please call the office during normal business hours and your call will be returned within 24 hours. If you have a question outside of your protocol and want the doctor's advice, there will be a $35 charge for the time spent returning your email.

____ **Prescription Policy**: In order to follow our commitment to exceptional and safe patient care, our policy regarding any prescription medications (including Nature-Throid) is as follows:

1. You must have an appointment every 6 months to follow up on your current prescription and in order to keep it active.

2. The appointment may require lab tests to evaluate your hormone levels and monitor your overall well-being.

Please contact your pharmacy at least one week prior to needing a refill on any prescriptions.

____ **Medicare Patients**: Please understand that we are not a licensed Medicare provider and Naturopathic doctors are typically restricted from ordering lab work for patients covered by Medicare if you do not have a secondary insurance. It is your responsibility to notify the office if you have crossed over to Medicare. In the event our office receives a bill from the lab regarding your blood work, please understand that you will be held financially responsible. We have cash based labs we work with or you can ask your primary doctor to run labs so they will be covered.

____ **Labs**: In an ongoing effort to ensure that you stay on track on your journey to health we request that you complete your blood draw **2 weeks before** your scheduled follow up visit. This gives the doctors plenty of time to receive your results, analyze them and compile your treatment plan. If labs are not done in a timely manner and results in a missed/cancelled appointment within the 24-hour cancellation window, patient will be responsible for the full cost of the appointment.

____ I hereby acknowledge by this statement that I have been fully informed that some, if not all, of the medical services including appointments, lab work and supplements provided by Wellspring Natural Health may be deemed non-covered, unreasonable or unnecessary by Medicare or other medical insurance companies. I understand that it is my responsibility to contact my insurance provider to determine what services will be covered and that I am fully responsible for all costs associated with the above.

Print Name: _____

Patient Signature: _____ Date: _____

Legal Guardian: _____ Date: _____

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Financial Agreement

I understand that payment in full is due at the time of service. I also understand that Wellspring Natural Health has a 24-hour cancellation policy and failure to comply will result in an automatic charge to my account for the full amount of the missed appointment.

I agree to keep an active debit/credit card on file and understand that this card will be charged in the event that I do not show up for an appointment or comply with the 24-hour cancellation policy.

Card: _____

Expiration: _____ CVV: _____ Zip Code: _____

Print Name: _____

Card Holder Signature: _____ Date: _____

Patient Name (if different than card holder): _____