Inner Balance Natural Health

3530 Grand Ave, Suite 2, Oakland CA 94610 Tel. 619-540-1736

New Patient Intake Form

Patient Information

Last Name__________________ First Name _________________ D.O.B. _________ ☐M ☐F
Address ________________________________ City _______________ Zip Code _____________
Phone# ___________________ E-mail address _________________________________
Would you like to receive our free monthly newsletter via e-mail? ______________________
What is the best way to contact you? ________________________
Can we leave confidential messages at the above phone number? ___________________________
How did you hear about us? ____

****If there is a parent or caretaker present, please fill out the information below:**
Last Name__________________ First Name __________________ Relationship______________
Address (if different than above) ________________________ City _____________ Zip ____________
Phone# ___________________

Emergency contact ___________________ Phone#_____________ Relationship_____________

Primary Care

Primary Care Physician______________________ Phone# ______________________
Address ________________________________ City _______________ Zip Code ______________

Present Health Concerns

What is the main reason for your visit today?

____
____
____

Have you received any treatment for the condition, and if so what effects have you noticed?

____
____
____

Please list any other current health concerns in order of importance to you:

____
____
____

Describe any severe allergies you have to medications or anything else (e.g. food, pollen):

____
____

Body systems—Please check each symptom that you experience now or have experienced during the past month:

Overall health	*Head/Eyes*	*Ears/Nose*	*Mouth/Throat*	*Respiratory/Lungs*
□ Weight change □ Fever □ Weakness □ Fatigue □ Sweating □ Loss of appetite	□ Headache □ Injury □ Dizziness □ Eye pain □ Vision change/loss	□ Ringing in ear(s) □ Reduced hearing □ Ear pain □ Stuffy nose □ Nose bleeds □ Sinus pain □ Allergies	□ Mouth sores □ Bleeding gums □ Hoarse voice □ Painful swallow □ Sore throat □ Teeth pain	□ Short of breath □ Cough □ Wheezing □ Sputum/blood □ Asthma □ Pneumonia □ Tuberculosis
Cardiovascular	*Gastrointestinal*	*Genitourinary*	*Musculoskeletal*	*Skin and/or breast*
□ High blood pressure □ Palpitations □ Chest pain □ Heart disease □ Heart murmur □ Swelling in feet	□ Abdominal pain □ Nausea/vomiting □ Heartburn □ Constipation □ Diarrhea □ Blood in stool □ Jaundice	□ Pain/burning □ Urgency □ Frequency □ Incontinence □ Blood in urine □ Infections □ Kidney stones	□ Injury □ Pain □ Swelling □ Arthritis □ Osteoporosis □ Rigid/stiff neck □ Reduced movement	□ Itching □ Rashes/hives □ Eczema □ Psoriasis □ Acne □ Skin growths □ Breast mass/pain □ Nipple discharge
Neurological	*Psychiatric*	*Endocrine*	*Hematologic*	*Women's Health*
□ Fainting □ Convulsions □ Change in senses □ Uncoordination □ Speech problems □ Foggy head	□ Memory loss □ Mood changes □ Anxiety □ Depression □ Fears/phobias □ Eating disorders □ Drug/alcohol abuse	□ Diabetes □ Hypothyroidism □ Hyperthyroidism	□ Anemia □ Bleeding tendency □ Swollen lymph node(s)	□ Menstrual cramps □ PMS □ Spotting □ Irregularity □ Mood swings □ Menopause □ Date of last menstrual period: ________________

Please list current prescription medications you are taking along with dosages and length of time you've been taking them:

Rx 1	**Rx 2**	**Rx 3**	**Rx 4**
Rx 5	**Rx 6**	**Rx 7**	**Rx 8**

Please list current vitamins, supplements, herbs, or homeopathic remedies with doses and length of time you've been taking them:

1	2	3	4
5	6	7	8

Please check any of the following that apply regularly to your lifestyle:

☐ Alcohol ☐ Tobacco ☐ Coffee/caffeinated drinks ☐ Recreational drugs

☐ Special diets (describe)____

☐ Exercise (describe)____

☐ Stress (describe)____

☐ Low energy (describe)____

☐ Insomnia (describe)____

Medical History

Please list any hospitalizations, surgeries, or serious injuries (include dates):

____

____

____

Most recent health care:

Date of last physical exam___________________

Date of last blood labs______________________

Date of last pap or prostate exam____________________

Have you ever had a colonoscopy, and if so when?____________________

Have you ever had a bone density scan, and if so when?____________________

Please check any of the following conditions that apply to family members. If checked, write down who has the condition and whether it's in the past or current.

Family History				
☐ Hypertension	☐ Asthma	☐ Alcoholism	☐ Cancer	☐ Autoimmune
☐ Heart attack	☐ Mental illness	☐ Depression	☐ Seizures	☐ Alzheimer's
☐ Heart disease	☐ Diabetes	☐ Stroke	☐ Bleeding disorders	☐ Osteoporosis
☐ Thyroid disease	☐ Epilepsy	☐ Arthritis	☐ Allergies	☐ Drug Addiction

Please include any additional information you want us to know:

____

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Privacy and Financial Terms:

We keep a record of the healthcare services that we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. If you believe the information in your record is inaccurate, you may request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so, or applicable laws authorize or compel us to do so.

Mosaic Integrative Health and Homeopathy is required to provide you with this information on privacy (please refer to Privacy Practices handout) and obtain written acknowledgement that you have received it. It outlines the types of uses and disclosures that may occur involving your healthcare information, and describes your rights as a patient and how you may exercise those rights. If you have questions about the management of your healthcare information at our office, or wish to view your medical record, please call Dr. Patel at 619-540-1736.

The patient is responsible for all charges at the time of the visit and may be billed for missed appointments or appointments cancelled with less than 24 hours notice. We accept cash, credit, and checks, and can provide you a superbill that you submit to your insurance provider to request coverage.

□ Please sign below to acknowledge that you have received a copy of the clinic's Privacy Practices and Financial Terms, and to affirm that the questions on this form have been accurately answered. Providing incorrect info can be dangerous to your health. It is your responsibility to inform the doctor of any changes in your medical status. By signing below, you are also authorizing the doctor to perform the necessary services you may need.

Patient (or guardian) Signature______________________________ Date________________