1740 Weir Drive, Suite 24 Woodbury, MN 55125 (ph) 651-232-6830 (fax) 651-702-2636 www.NaturalCareWoodbury.com

**NEW PATIENT INTAKE FORM**

**Patient Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth**:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(Last, First, Middle Initial) Gender at Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Gender and Pronouns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** (C):\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_(H):\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_(W):\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**Email**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security Number**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Healthcare Provider and/or Clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By checking the box to the right you consent to us communicating with your PCP if needed.

Who referred you to our clinic?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your reason for seeking care at our clinic?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When did your condition/symptoms begin?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

1. Current Health Concerns:

**Please list your primary health concerns or goals** (e.g., weight management, exercise instruction, hot flashes, energy levels, mood swings, sleep, a specific condition, etc.).

1. Medical History:

• Do you have any diagnosed medical conditions?

[ ] Yes [ ] No

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Have you undergone any surgeries (including hysterectomy)?

[ ] Yes [ ] No

If yes, please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Menstrual/Menopause History:

• Are you currently:

[ ] Menstruating

[ ] Pregnant

[ ] Perimenopausal

[ ] Menopausal

[ ] Postmenopausal

• Last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Time Between Periods\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Perimenopause/Menopause Symptoms experienced if applicable (check all that apply):

[ ] Hot flashes

[ ] Night sweats

[ ] Fatigue

[ ] Mood changes

[ ] Brain fog

[ ] Weight gain

[ ] Sleep disturbances

[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Hormone Replacement Therapy (HRT):

• Are you currently taking HRT or any hormone-related treatments?

[ ] Yes [ ] No

If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Allergies/Sensitivities:

• Do you have any food, medication, or environmental allergies?

[ ] Yes [ ] No

If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle Information**

1. Dietary Habits:

• Describe your typical daily diet (e.g., meals, snacks, beverages – minimum of one week of food tracking ideal):

• Any dietary restrictions or preferences?

[ ] Vegetarian

[ ] Vegan

[ ] Gluten-free

[ ] Dairy-free

[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Physical Activity:

• How often do you exercise?

[ ] Daily

[ ] A few times per week

[ ] Rarely

• What types of exercise do you do/enjoy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Sleep Patterns:

• Average hours of sleep per night: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Do you experience difficulty falling or staying asleep?

[ ] Yes [ ] No

4. Stress and Mental Well-being:

• Current stress level (1 = very low, 10 = very high): \_\_\_\_\_\_\_\_\_\_\_\_\_

• Primary sources of stress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Do you practice relaxation techniques (e.g., meditation, yoga)?

[ ] Yes [ ] No

**Medications and Supplements**

1. Medications:

Please list any medications you are currently taking (include dosage):

2. Supplements:

Please list any vitamins, herbs, or supplements you are currently taking:

**Health Goals**

1. What are your top health and wellness goals?

2. What motivated you to seek a health consultation/plan at this time?

3. Are there specific outcomes you hope to achieve (e.g., symptom relief, lifestyle changes)?

**Acknowledgments and Consent**

• I understand that health coaching/consultations are not a substitute for acute medical care/advice, diagnosis, or treatment. I will consult any relevant healthcare providers before making significant lifestyle or dietary changes.

• I consent to sharing the above information for the purposes of health coaching/consultations and understand that my data will be kept confidential. I consent to my Primary Care Doctor being contacted if needed.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_