Inner Balance Natural Health

3530 Grand Ave, Suite 2, Oakland CA 94610 Tel. 510-965-3311

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*
□ Trouble sleeping □ 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:

_____

_____

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.

Inner Balance Natural Health is required to provide you with this information on privacy 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 510-965-3311.

The patient is responsible for all charges at the time of the visit and may be billed for missed appointments or appointments canceled with less than 24 hours notice. We accept cash 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_____

Consent For Treatment

General Information: Inner Balance Natural Health is a naturopathic health practice employing a diversity of modalities including any of the following: naturopathic medicine, physical medicine, homeopathy, and naturopathic counseling. Some appointments will involve only one modality, but many appointments may involve multiple modalities.

Methods, Procedures and Therapeutic Approaches: Your doctor may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, and address or treat your health concerns.

General Diagnostic Procedures: Includes physical examinations, radiography, blood and urine labwork, musculoskeletal and neurological assessments
Naturopathic Counseling
Herbs/Natural Medicines: Includes supplements, tinctures, teas, capsules, topical creams, powders, suppositories.
Dietary/Nutrition Advice
Soft Tissue Manipulation: Includes soft tissue massage, neuromuscular techniques, muscle energy stretching

Potential Risks: Risks are minimal but may include adverse reaction to herbs or supplements, or aggravation of physical symptoms due to physical medicine treatment

Potential Benefits: Restoration of health and the body's functioning, relief of pain and symptoms of disease, prevention of disease or progression of disease

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect they are pregnant, or plan to become pregnant in the near future, since some of the therapies present a potential risk to the pregnancy.

I understand I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures. I understand that a record will be kept of the health services provided to me. I understand that no guarantees have been given to me regarding cure or level of improvement in my condition. This record will be kept confidential and will not be released to others unless directed by myself or my representative, or otherwise required or permitted by law.

_____	_____
Guardian/Personal Representative's Name (Print)	Patient's Name (Print)
_____	_____
Guardian/Personal Representative's Signature	Patient's Signature
_____	_____
Relationship/Representative's Authority	Date

Inner Balance Natural Health
Dr. Aarti Patel, N.D.
3530 Grand Ave, Ste 2
Oakland, CA 94610
(510) 965-3311