NW Olive Clinic LLC
Natural Medicine and Primary Care

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Intake Form

Name: _____ Date of Birth: _____ Age: ___ Gender: _____
Marital status: Single_____ Married_____ Other_____
Address: _____
City: _____State: _____Zip Code: ____
Telephone #(Cell): _____ (Home): _____(Work): _____
Email address: _____Occupation: _____
Is it ok to leave a message? _____
Is it ok to receive a text or voice message reminder for your appointment? _____
Emergency Contact: _____Relationship: _____ Phone: _____
Address: _____

Preferred Pharmacy**:** _____

What are your main concerns/health problems? List as many as you can in order of importance.
1) _____
2) _____
3) _____
4) _____

Patient history

Please mark (x) the box that applies to you:

Thyroid disease		Goiter		Other endocrinological diseases	
Asthma		COPD		Cough	
Difficulty breathing		Pneumonia		Headache	
High blood pressure		Chest pain		Palpitation or fluttering	
Heart murmur		Fainting		Blood clots	
Anemia		Skin lesion/rash/mole		Lump or lymph node enlargement	
Low back pain		Joint pain/swelling		Muscle pain	
Insomnia		Problem focusing		Fatigue	
Vision problems		Cataract or glaucoma		Eye pain	
Earaches		Impaired hearing		Ringing/vertigo	
Sore throat		Nose or gum bleeds		Sinus problems	
Abdominal pain		Heartburn/GERD		Nausea or vomiting	

Blood in stool		Trouble swallowing		Change in bowel movement	
Painful urination		Frequency of urination		Blood in urine	
Kidney stones		Stroke		Seizure	
Cancer		STI			
Depression		Anxiety /PTSD		Suicide history	
Female health					
Ovarian cysts		Breast lump		Last menstrual cycle	
Male health					
Hernia		Prostate disease		Testicular mass/pain	
I**mmunization**					
COVID-19 vaccine		Flu vaccine		Zoster vaccine	
Pneumonia vaccine		Tdap vaccine		Hepatitis B vaccine	

FAMILY HISTORY

	Mother	Father	Siblings	Aunts/Uncles	MGM	MGF	PGM	PGF
Cancer								
Diabetes								
High blood pressure or heart disease								
Thyroid disease								
Asthma								
Mental illness								
Allergy/eczema								
Kidney disease								
Autoimmune disease								
Other/genetic disease								

Allergies: Drugs_____
Any foods_____
Any environmentals_____

Please list any prescription medications, over the counter medications, vitamins, or supplements you are currently taking:
1)_____ 2)_____ 3)_____
4)_____ 5)_____ 6)_____

Hospitalization and Surgery: _____ Major Trauma/Injury: _____

_____ _____
Patient (18 years or older) Date

_____ _____
Parent, Guardian, Responsible Party Date