GREEN HOUSE
NATURAL MEDICINE

Intake Form

Patient Name: _____ _____ _____
Last First MI

Address: _____ Date of Birth: _____

_____ Age: _____

Phone: _____ (cell)_____ (work)_____
□ it's ok to leave message about my care

Email: _____ Occupation: _____
Gender Identity: (circle one)
Male Female Transgender Male Transgender Female

Additional category _____ Declines to specify
Sexual Orientation: (circle one)
Heterosexual Homosexual Bisexual Something else _____

Not sure Declines to specify

Responsible Party/Policy Holder: _____ Date of Birth: _____

Emergency Contact: _____Relation: _____Phone: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE BELOW

Parent's (or Guardian) Names: _____

Address if different: _____

Phone: _____ (Cell) _____ (work) _____

Email: _____ Who does the child live with: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE ABOVE

PCP/Pediatrician/Specialist: _____ Phone: _____

Pharmacy: _____ Phone: _____ Zip Code:_____

Any allergies to medication, food or environmental influences: (Please specify reaction) _____

_____

List all the **medications** that you are currently taking, including dosages: _____

_____

List all **vitamins, minerals, herbs, homeopathic remedies and nutritional supplements** you are currently taking:

_____

_____

_____

Please tell us what forms of therapy you are interested in receiving or learning more about as part of your care: *(circle all that apply)*

Antibiotic Therapy	Herbal Therapy	Oral Nutrient Therapy
Shamanic Healing	Reiki	Biomagnetic Pair Therapy
Intravenous Nutrient Therapy	Heavy Metal Chelation	Homeopathy
Somatic Re-education	Low Dose Immunotherapy	Essential Oils
	Applied Kinesiology	

Are you comfortable talking about Energy Healing Treatment regarding your care? YES NO

Medical Release for Messages

I _____ give Greenhouse Natural Medicine permission to send text messages, e-mails and leave voice mail messages regarding my medical care at the following number and e-mail address:

_____

_____

Signature: _____ Date: _____