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: ______________

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:

____

____

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

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:

____

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Signature: ___________________________ Date: _______________