Michelle Crowder, ND
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New Patient Intake

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations.

This is a CONFIDENTIAL questionnaire. Date of Initial Visit: _____

First Name: _____Middle Name: _____Last Name: _____

How would you like to be addressed? _____

Address:_____City: _____State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/_____ Age: _____

Place of Birth: _____ city/state/country

Mobile Phone :(_____) _____-_____ Home Phone: (_____) _____-_____

Best number to call: _____May we leave a message? Y or N Email address_____

Birth Sex: ____ Gender identity: _____ Preferred Gender Pronouns:_____ Relationship Status: _____

Primary Care Physician: _____ Referred by:_____

Emergency contact: _____Relationship to you: _____

What aspects of your health are most important to address at this time? Please List your health concerns in order of importance to you.

_____

_____

_____

Name some positive elements in your life

_____

What 3 expectations do you have for this first visit?

1._____

2._____

3. _____

Last time you saw a physician and reason:_____

Names of any specialists you see with specialty:

_____

MEDICAL HISTORY TIMELINE: Please indicate the timing with approximate YEAR of any major events (births, deaths, marriage, divorce, abuse, job changes, health issues, surgeries, traumatic events).

Your birth: Full term_____ Premature_____ Vaginal delivery_____ C-Section_____ Breast Fed_____ Bottle fed_____

Any issues during the pregnancy or birth? _____

Childhood (birth→17y) Events/health issues _____

Young adult (18→29) Events/health issues _____

Adult (30→ 59) Events/health issues_____

Adult (60→80+) Events/health issues_____

For Females:

Number of Pregnancies: _____ **Number of live births**: _____ **Last menstrual Period**: _____

Any problems related to menstrual cycles, breasts, uterus or ovaries?

_____

ALLERGIES:

To any medications or foods? Yes__ No__ If yes, please list with reaction: _____

ALCOHOL USE:

Do you regularly consume alcohol? Yes_ No_ If yes, # __of drink(s) per day, week, month. Types_____

RECREATIONAL DRUG USE:

Have you ever used recreational drugs? Yes____ No____

What: _____

TOBACCO USE:

Have you ever used tobacco? Yes____ No____ If yes, number of years? ____ Amount per day _____ Year quit _____

FAMILY HEALTH HISTORY:

	Age if living	Age of death	Health problems
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

MEDICATIONS: What medications are you taking now? Include non-prescription drugs.

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SUPPLEMENTS: List all vitamins, minerals, and other nutritional supplements that you are taking now. (Indicate mg or IU)

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PERSONAL LIFE:
What level of education have you completed? _____

Current employment: _____

NUTRITION:
What is your typical -

- **Breakfast?** _____
- **Lunch?** _____
- **Dinner?** _____
- **Do you snack – if so, what and when?**_____

Are you on a special diet? _____

Do you have any history of disordered eating or emotional concerns related to food? If yes, please explain:

_____

How much water to you drink per day? _____

How much caffeine do you consume? _____

Do you use artificial sweeteners? If so, which one(s)? _____

EXERCISE/MOVEMENT:

What types of exercise do you do (i.e. cardio, strength, yoga)?

_____

How do you feel after exercise? _____

SLEEP/RELAXATION:

How many hours do you sleep per night? _____

Do you awaken refreshed? _____

STRESS/GRIEF:

Any significant life changes recently? _____

Does your stress level interfere with your enjoyment of life, your sleep or your relationships?

_____

RELIGION/SPIRITUALITY:

Do you engage in regular prayer or meditation? _____

LEISURE/REJEUVENATION:

What brings you joy? _____

How do you manage your stress? _____

RELATIONSHIPS:
Are you in a supportive relationship_____ In a relationship you would like to change_____
Have you ever been physically, emotionally, or sexually abused? (Y/N) If you are experiencing physical, emotional or sexual harm from someone, please talk to you me so that I can help.

Review of Systems

***please select any symptoms that you have experienced in the past 7 days**

Constitutional □fever □ difficulty managing weight □ poor appetite □ binge eating/drinking □fatigue □ restlessness □ general weakness □ low stamina □ rapid Hunger □ no Thirst □ frequent Thirst □ food cravings
if yes, please list_____

Body Temperature: □Cold □ Warm □ Neutral □ Hot

Skin/Nails; □ rash □ acne □ vitiligo □ rosacea □ eczema □ psoriasis □itching □hives □ thin/cracking/peeling nails □ nail fungus □ discolored nails □ nails with ridges □ nails with pits

HENT: □ hearing loss □ ringing in ears □ ear pain □ sore throat □ hoarse voice □ clearing throat □ canker sores □ dental cavities □ Grind Teeth □ TMJ □ gums sore/swollen □ tongue sore □ nasal congestion □ bad breath

Eyes; □itching □ watering □ redness □ drainage □ bags under eyes □ dark circles □ change in vision □ light sensitivity □ floaters □ eyelid irritation

Cardiovascular: □chest pain □ palpitations

Respiratory; □cough □ wheezing □ difficulty breathing

Gastrointestinal; □reflux □ belching □nausea □ vomiting □ cramping □Burning sensation □ pain □diarrhea □ constipation □ excess gas □ bloating □ hemorrhoids □ mucus in stool □ blood in stool □ black stools □ rectal pain □ stool incontinence □Stool pattern: How often? _____ Color? _____ Consistency? _____

Genitourinary: □frequency □ pain with urination □ up at night to urinate □ incontinence □ blood in urine □ genital discharge □ genital itching Color of urine? _____

Do you get up to urinate during the night? □ No □Yes How many times? _____

Musculoskeletal: □joint pain □ joint stiffness □ muscle pain □ muscle stiffness □ neck pain □ back pain □ muscle cramps □ muscle twitching

Endo/heme: □easy bruising □ easy bleeding □ easily over heated □ cold intolerant □ low libido □ erectile dysfunction □ breast abnormality □ irregular periods □ heavy periods □PMS symptoms □ frequent thirst □ sweating □ hot flashes □ hair loss

Allergy/Immune: □food allergies □ environmental allergies □ frequent infections

Neurologic: □headache □ dizziness □ numbness/tingling □ fainting □ tremor □ memory loss □ vertigo (spinning/movement sensation) □ difficulty with balance

Psychiatric: □anxiety □depression □ hallucinations

In seeking care from Michelle Crowder, Naturopathic Doctor, I understand the following:

1. The State of Michigan does not currently regulate or license Naturopathic Physicians or the practice of Naturopathic Medicine. Therefore, Michelle Crowder, ND cannot diagnose, treat, or cure any condition. Instead, she provides health information and recommendations.

2. Michelle Crowder, ND is licensed in the State of Oregon and regulated by the Oregon Board of Naturopathic Medicine.

3. I should remain under the care of my primary care physician and will discuss any changes to my current treatment with my primary care physician.

4. My consultations with Michelle Crowder, ND are confidential and will not be disclosed except where required by law or with prior authorization.

5. Payment is due at the time of service. Signing below serves as acknowledgement that you have received and reviewed current office visit fees.

6. Because Naturopathic Physicians are not currently licensed in the state of Michigan, their services may not be covered under a Health Savings Account or Flex Spending Account. If you choose to use these methods as forms of payment, it is at your own risk.

7. If you would like to submit a claim to your insurance company for services provided by Michelle Crowder, ND, you must obtain proper documentation. Please inquire with our billing department.

8. Late and missed appointments: Please allow at least 24 hours' notice if you need to reschedule or cancel your appointment. Missed appointments are subject to the following fees: $250 for new patient visits; $90 for follow-up visits. If you are late to your appointment, your appointment time will be shortened to what remains during your originally scheduled appointment, and you will be charged for the full amount of the scheduled appointment.

9. Please use our patient portal system for communication in between appointments. Depending on the number or complexity of your questions, you may be asked to schedule an office visit so that we have ample time to discuss your concerns.

10. If you would like Michelle Crowder, ND to communicate about your care with other physicians or practitioners, please provide their contact information below:

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

Signed: _____ Date: _____

Printed Name: _____