Rosetta Koach, ND
Patient Intake Form

Name_____Date_____

Age _____Date of Birth_____ Place of birth_____ Gender: female _____male _____

Address_____

City_____State_____Zip Code_____

Telephone # (home) _____ (work/cell) _____E-mail_____

Occupation _____ S.S.# _____

Employer _____Hours per week _____Date retired_____

(Work address) _____

Primary Health Care Physician _____ Phone_____

Live with: Spouse_____Partner_____Parents_____Children_____Friends_____Alone_____

Next of Kin or other to reach in an emergency_____ Relationship _____

Address if different_____ Phone_____

How did you hear about my services? _____

********** INSURANCE CASES **********

Health insurance company _____

Address_____

Telephone number _____Whose name is policy under_____

Policy/Group #_____Identification number_____

"********** AUTO ACCIDENTS**********

Claim #_____Date of Accident_____

Claim Representative_____ Phone #_____

Name and Address of Company representing your claim:

_____

Other physicians who have treated this injury_____

_____

GENERAL INFORMATION

Current weight _____lbs. Any recent weight loss Y N Weight gain Y N How many _____lbs

Current height_____ BP_____ Pulse. _____ Resp. _____Temp. _____

HEALTH HISTORY

What are your most important health problems? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

Are you currently receiving healthcare? Y N
If yes, where and from whom? _____

What is the reason? _____

What treatments have been prescribed? _____

If no, when and where did you last receive medical or health care? _____

ALLERIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental substances? _____

Any previous allergy testing and if so what type? _____

Current Medications

Do you take or use?

Antacids	Y N	Pain relievers	Y N	Tranquilizers	Y N
Laxatives	Y N	Anti-inflammatories	Y N	Sleeping pills	Y N
Diabetic drugs	Y N	Cortisone	Y N	Thyroid medication	Y N
Appetite suppressants	Y N	Antibiotics	Y N	Topical drugs	Y N

Please list prescription medications, over the counter medications, vitamins or other supplements you are taking?

1)_____ 6)_____

2)_____ 7)_____

3)_____ 8)_____

4)_____ 9)_____

5)_____ 10)_____