CHRYSALIS NATURAL MEDICINE CLINIC

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NEW PATIENT INTAKE FORM **Email:** _____

Name: _____ **Date of Birth:** ____ / ____ / ____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: ( ) _____ **Work Phone:** ( ) _____ **Cell:** ( ) _____

What health/nutrition issues would you like to discuss on your first visit?

_____

List below the 3 main physical complaints you have in order of their importance: (Use back if needed)

	Problem	**When did it start?**
1.	_____	_____
2.	_____	_____
3.	_____	_____

List all prescribed Medications or Supplements you are currently taking and what for:

	Medication or Supplement		
1.	_____	for	_____
2.	_____	for	_____
3.	_____	for	_____
4.	_____	for	_____
5.	_____	for	_____
6.	_____	for	_____

List any symptoms that you may be experiencing in these general areas:

Nerves, Digestion or Respiratory: _____
Liver, Bones or Heart: _____
Hormones, Blood Sugar or Sex Organs: _____
Skin, Glands or Musculoskeletal: _____
Mental/Emotional or Inflammation: _____
Pain or Immune System: _____
Other: _____

WHAT WE DO AND DO NOT DO AT CHRYSALIS

I FULLY UNDERSTAND that Chrysalis provides only nutritional, herbal, lifestyle and acupuncture support for improving health, that natural medicines support health but do not treat disease, that I am encouraged by the Chrysalis staff to rely on my regular doctors for all ordinary medical care and for any emergency care. I understand the general time and costs involved, I have read the refund policy and I agree I am responsible for and agree to pay for any and all costs incurred at time of in person or phone consultations, and also for any orders I place any time with Chrysalis, and all for visits/orders I put on my credit card(s). I also understand that I may be charged if I do not provide a notice of cancellation to Chrysalis at least 24 hours (business days) in advance of my scheduled appointment.
Signed: _____ Date: ____/____/____

PRIVACY RULES – I FULLY UNDERSTAND that Chrysalis staff will not release or discuss my records or medical condition without my written consent, except as needed to conduct normal office business (check-out etc), with our staff, and with my treating physicians. I may give verbal consent for family/friends accompanying me.

Signed: _____ Date: ____/____/____