MCKENZIE INTEGRATIVE MEDICINE, LLC
KEYENA (ANGELA) MCKENZIE, ND, MIDWIFE
MCKENZIEINTEGRATIVEMEDICINE.COM
608.258.2525

New Client Intake Form - Adult

Date Form Completed:_____

Preferred Name_____ Legal Name_____

Mailing Address/City/State/Zip_____

Telephone (cell)_____ (home)_____ Email_____

Date of Birth_____ Age_____ Gender Identity _____ Sexual Orientation_____

Live with (check all that apply): ___ By Myself ___ Partner/Spouse ___ Children ___ Parents ___ Friends

Occupation/s_____Hours/week_____

Emergency Contact _____ Relationship_____ Phone_____

How did you hear about McKenzie Integrative Medicine?

Are you currently accessing health care (body and/or mental health care) of any kind? Y N
If yes, what type and with whom?

Do you have unmet needs for healthcare in the community? If so, what are they?

What are your most important health concerns? List in order of concern or severity:

1) _____ 2)_____ 3) _____

Supplements/Herbs/Homeopathics Regularly Taken/Including Dosages:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medications/Including Dosages - current as well as those taken LONG TERM in past (note if current or past):

_____ _____
_____ _____
_____ _____

Food/Drug/Environmental Allergies and Sensitivities:

_____ _____ _____
_____ _____ _____

Injuries/Surgeries/Hospitalizations (include Date/s and Reason/s for Surgery):

_____ _____ _____
_____ _____ _____

Immunizations/Vaccines, Include Approximate Dates if Remembered:

___Measles ___Diphtheria ___Chickenpox ___ Flu
___Mumps ___Pertussis ___ Polio ___Hepatitis A
___Rubella ___Tetanus ___HPV/Gardisil ___Hepatitis B
___others (please list – include travel and military vaccines)_____

Symptoms/Medical History **X = symptoms you have now** **P = past**

___ Vision Problems, Describe:
___ Ear/Hearing Problems, Describe:
___ Head Injuries
___ Sinus Infections
___ Nosebleeds
___ Tooth decay/loss
___ Gum disease/abscess
___ Throat Pain, Frequent
___ Lump in throat
___ Thyroid Disorder, Type_____
___ Facial Pain
___ Acne, moderate to severe
___ Acne Rosacea
___ Hair loss
___ Headaches, Frequent or Severe
___ Memory problems
___ Vertigo/Dizziness
___ Numbness/Crawling Sensations
___ Shooting/Burning/Electric pains
___ Sweats/Fevers
___ Fatigue/Exhaustion
___ Sleep problems, Describe:
___ Nightmares
___ PTSD
___ Depression
___ Anxiety
___ Mental Illness, Type_____
___ Unusual Fears
___ Neck Pain
___ Back Pain, Location_____
___ Joint Pain, Location/s_____
___ Muscle Pain, Location/s_____
___ Pain, Other, Location_____
___ Fracture/s, Location _____
___ Skin Problems, Type/s_____

___Cough, Chronic
___ Asthma/Wheezing
___ Respiratory Infections, Frequent
___ Tuberculosis
___ Heart Problems
___ Cholesterol, High/Low
___ Blood Pressure High/Low
___ Bleeding Disorder, Type _____
___ Easy Bruising
___ Hepatitis, Type ____
___ Immune disorder, Type _____
___ Appetite, Low or Excessive
___ Nausea/Vomiting
___ Eating Disorder, Type_____
___ Jaundice
___ Stomach/Belly Aches
___ Gas, Excessive
___ Constipation
___ Diarrhea
___ Blood in Stool
___ Hemorrhoids
___ Incontinence of Stool
___ Blood in Urine
___ Incontinence of Urine
___ Urinary Tract Infections, Frequent
___ Kidney Disease
___ Diabetes, Type_____
___ Blood Sugar Regulation Problems
___ Food Allergies/Sensitivities
___ Allergies, Other, Type_____
___ Cancer, Type _____
___ Lyme/Tick-Borne Disease, Type _____
___ Addiction/s, Type/s _____Current ___Recovering
___ Alcoholism ____Current ____Recovering

Other, Please Describe: _____

Women's Health:

Last Menstrual Period, Date:
Age at Onset of Menses:
Age at Menopause:
___ Menses Absent/Irregular/Too Frequent
___ Menses Heavy
___ Menses Painful
___ Premenstrual Symptoms, Describe:
___ Uterine Infections
___ Uterine Fibroids
___ Endometriosis
___ Fertility Challenges
___ Miscarriage, Repeated
___ Yeast Infections, Frequent
___ Unusual Vaginal Discharge
___ STD History, Type/s:
___ Breasts, Painful, Location:_____
___ Breast Cancer, Type:_____
___ Ovarian Cancer
___ Endometrial Cancer
___ Cervical Cancer
___ Painful Sex
___ Libido, Too Low or Too High (for You)
___ Problems with Orgasm
Pregnancies, Total ____
Pregnancies, # of Live Births___ Wks Gestation_____
Pregnancies, # Miscarried ___ Wks Gestation_____
Pregnancies, Stillborn, Wks Gestation _____
Pregnancies, # Terminated ___
Birth Control/STD Prevention, Types Used:
Sexually Active with (circle): Men/Women/Neither/All

Other: _____

Men's Health:

___ Prostate Enlargement
___ Prostate Cancer
___ Urinary Changes
___ Difficulty Starting/Stopping Urine Flow
___ Forked Urine Stream
___ Blood in Urine
___ Fertility Challenges
___ Semen Analysis Tests Abnormal
___ Vasectomy, Date:
___ Libido, Too Low orToo High (for You)
___ Problems with Orgasm
___ Erectile Difficulties
___ Painful Sex
___ Unusual Urethral Discharge
___ STD History, Type/s:
___ Birth Control/STD prevention, Types Used:
Sexually Active with (circle): Men/Women/Neither/All

Other: _____

Biological Family History and Close Social Contacts:

___Family history not known (adopted or other reason)

	Parent	Parent	Siblings	Partner/ Spouse	Kids
Age (if living)					
Health					
Age at death					
Cancer					
Diabetes					
Heart disease					
Birth anomalies					
Mental illness					
Hypertension					
Arthritis					
Thyroid disorders					
Stroke/s					

	Parent	Parent	Siblings	Partner/ Spouse	Kids
Sickle Cell Anemia					
Kidney disease					
Alcoholism					
Drug Abuse					
Tuberculosis					
Syphilis					
Smallpox					
Asthma					
Eczema					
Other					

Describe your typical daily diet including beverages _____

_____

_____

Are you/have you been a tobacco user? Y N **Circle Types Used:** Chew Pipes Cigars Cigarettes
How many packs/day? **For how many years do you or have you used tobacco?**

Were you exposed to any of the following in your childhood years? Circle or Underline: Tobacco users in the house / Paper mills in the community / Other industrial manufacturing potentially affecting air or water quality / Agricultural sprays applied directly by family members or adjacent to aerial/airplane application / Superfund or Toxic waste dumping in region

Do you/have you experience/d or witness/ed abuse or violence in your home/community/workplace (including areas of global conflict) now or in the past? ____No ____Yes ____ Currently ____ Previously

Shade or otherwise mark the following according to your CURRENT level of satisfaction and fulfillment. Leave blank any fields you'd prefer to not answer:

Social/Sense of Community Belonging 0% |_____|_____|_____|____|_____|_____|_____|_____|_____|_____| 100%

Physical Well-Being/Comfort in Body 0% |_____|_____|_____|____|_____|_____|_____|_____|_____|_____| 100%

Intellectual/Stimulation of Thought 0% |_____|_____|_____|____|_____|_____|_____|_____|_____|_____| 100%

Spiritual Fulfillment/Inner Peace/Awe 0% |_____|_____|_____|____|_____|_____|_____|_____|_____|_____| 100%

Emotional Well-Being 0% |_____|_____|_____|____|_____|_____|_____|_____|_____|_____| 100%

Work/Volunteer/Community Service 0% |_____|_____|_____|____|_____|_____|_____|_____|_____|_____| 100%

Financial Comfort/Ease 0% |_____|_____|_____|____|_____|_____|_____|_____|_____|_____| 100%

Recreational Engagement 0% |_____|_____|_____|____|_____|_____|_____|_____|_____|_____| 100%

Fun/Joy 0% |_____|_____|_____|____|_____|_____|_____|_____|_____|_____| 100%

Where are you currently on the following scale? Introverted_____|_____Extroverted
Where would you feel more satisfied/replenished? Introverted_____|_____Extroverted

MCKENZIE INTEGRATIVE MEDICINE, LLC
KEYENA (ANGELA) MCKENZIE, ND, LM, CPM
NATUROPATHIC PHYSICIAN & MIDWIFE
608.258.2525

Payment Options/Late Cancellation & No Show Agreement

Please Read the Following and Sign:

PAYMENT OPTIONS:

- In order to secure and hold an appointment time, the client's credit card number will be entered into our secure billing system. No charges will be made to this card unless there is a late cancellation (see cancellation policy below) or client does not show for the scheduled appointment. The card on file can also be used for drop shipments or special orders as approved by the client.

- Payment for services is due in full at the time of service.

- Accepted forms of payment include cash, check, HSA card, credit/debit card (excluding American Express).

- In order to secure an appointment time, a credit card number is kept on file in our secure billing system. This card may be charged in the event of a late cancellation and/or no show appointment (see cancellation policies and associated fees below) or if any billable items are to be sent to the client.

- Dr McKenzie does not contract with HMOs, PPOs, Medicare, Medicaid or other insurance companies to provide discounted services.

CANCELLATION POLICY:

- In order to allow all clients to schedule in a timely manner, a minimum of 48 business hours (two full business days) is required to cancel or change an appointment time to avoid being charged the full fee for the scheduled appointment. Please **call the clinic**, McKenzie Integrative Medicine, **at 608-258-2525 to make any changes.**

_____ (initial) I understand payment is due in full at the time of service.

_____ (initial) I agree to give 48 business hours (two full business days) notice of cancellation or appointment time change to allow others who may be waiting to schedule an appointment the opportunity to do so.

_____ (initial) I am aware that fees for the full office visit will be charged to my card on file in the event of late cancellation or not showing up for a scheduled appointment. I agree to pay any and all late cancellation or no show fees. Fees charged will be dependent on the the type of appointment and time allocation scheduled.

_____ (initial) I am aware that if I must cancel with less than 48 business hours notice or cannot show up for a scheduled appointment, I can avoid late cancellation/no show fees if I reschedule with Dr McKenzie and show up for that rescheduled appointment. If I no-show or late cancel for the rescheduled appointment, I understand that my card on file will be charged full fees for not only the rescheduled appointment but also the initial appointment.

Signature _____ Date_____