Robyn Kutka, ND LLC

New Patient Information Form

Welcome! I look forward to helping you accomplish your health goals. Please take a moment to fill out this intake form.

Legal Name	Preferred Name (if different)	Date of Birth
Email	Preferred Phone	Alternate Phone
Address	City, State:	Zip
Emergency Contact and Phone		Relationship

Is it okay to leave a message at the phone number(s) above? _____

How did you hear about us? _____

Referral from another physician or a friend? Health Fair, Internet Search, Insurance Website? If this was a referral let us know, so that we may thank them!

Your Personal Insurance Information

Primary Insurance Co	Member ID	Group No	Customer Service Phone No
Secondary Insurance Co	Member ID	Group No	Customer Service Phone No

Insurance Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above-listed companies and assign directly to the provider, Robyn Kutka ND LLC, payment of all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges for all services provided, whether or not paid by insurance. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due.

I hereby authorize the provider to release any medical or other information necessary to secure the payment of benefits. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____

What are your long term personal goals for our work together?

Ongoing Concerns (prioritized)

Concern	Started when?	How often?	How severe?
Headaches	*June 2010*	*4 per week*	*mild/mod/severe*

You may list more later on the Health Systems Check-list

Tell us about your prior medical history

Hospitalizations or Surgeries and Dates	Allergies to Medications	Type of Reaction

Illness	Past	Now	Family	Who?
Asthma	O	O	O	
Cancer	O	O	O	
Diabetes	O	O	O	
Digestive Concerns	O	O	O	
Heart Disease	O	O	O	
Hepatitis	O	O	O	
High Blood Pressure	O	O	O	
Lung Disease	O	O	O	
Seizures	O	O	O	
Thyroid Condition	O	O	O	
?	O	O	O	
?	O	O	O	
?	O	O	O	

Other Important Information?

What medications are you currently taking? (Both prescriptions and OTC)

Medication and Dose	Reason	Started?	Prescribed By
Prozac 20mg 2x/day	*Feeling Down*	*11/2008*	*Alan James, MD*

If you would like, we can provide you with a longer medication and supplement form

Supplement, Brand and Dose	Reason	Started?	Recommended By
Super Vitamin C (Thorne) 500mg / day	*Immune Support*	*11/2008*	*Self*

Other Healthcare Providers?

What prior experiences have you had with healthcare in general?

What prior experiences have you had with alternative therapies?

Additional Prior Medical History that you would like to share:

Tell us about how you eat

Sodas, oz/day _____
Coffee, oz/day _____
Water, oz/day _____
Alcohol #/day _____

Food Cravings _____
Snack Foods _____

Typical Breakfast _____
_____

Typical Lunch _____
_____

Typical Dinner _____
_____

Food Sensitivity _____
Food Restrictions _____
Food Ethics ☐ Vegan ☐Vegetarian ☐Kosher ☐Other:

Do you eat?
☐ In the car ☐ Watching TV ☐ Standing
☐ With others ☐ On the go ☐ In a hurry
☐ After 11pm ☐ In your sleep ☐ On waking

How often do you eat out? Where?

Tobacco Use? ☐ Never ☐ Age ____ to ____. ___ packs per day

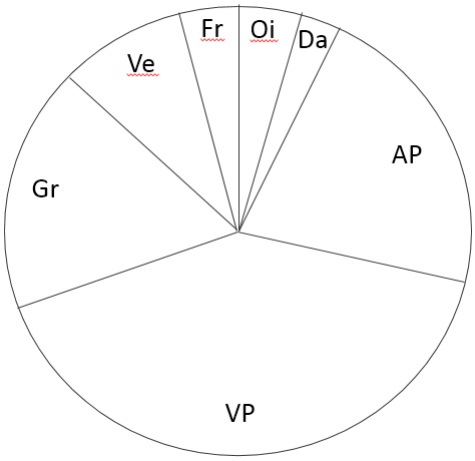
Bowel movements per day _____ ☐ Constipated?
Any Bowel Concerns?

Diet Chart

Create a pie chart below that roughly describes the distribution of the food you eat on a daily or weekly basis (whichever is easiest for you). Use the following as a guideline

☐ Vegetable Protein (VP) ☐ Animal Protein (AP) ☐ Dairy (Da) ☐ Grains (Gr)
☐ Oils and Fats (Oi) ☐ Vegetables (Ve) ☐ Fruits (Fr)

For example, your chart may look like this:



Tell us about your home life

With whom do you live? (including family, pets, roommates)?

Name	Age	Relationship	Name	Age	Relationship

What is your occupation?

What are the major stressors in your life?

How is your sleep? When do you go to sleep and wake up?

What do you do to relax? What are your hobbies?

What types of physical activity do you do?

Do you have a religious or spiritual affiliation? _____ What type?

Initial Health Systems Check-list

As a New Patient, please check any items that have concerned you in the last **YEAR**. We will use this sheet to track progress over future visits.

GENERAL:	☐ NO COMPLAINTS	☐ WEIGHT LOSS	☐ FATIGUE	☐ MOOD CHANGES	☐ HARDER TIME EXERCISING
	☐ STRESS	☐ WEIGHT GAIN	☐ INSOMNIA	☐ CHANGES IN STRENGTH	☐ OTHER _____
HEAD/EAR:	☐ NO COMPLAINTS	☐ DIZZINESS	☐ HEAD TRAUMA	☐ CHANGES IN HEARING	☐ OTHER _____
	☐ MENTAL FOG	☐ HEADACHES	☐ RINGING IN EARS	☐ BLEEDING FROM EARS	
EYES:	☐ NO COMPLAINTS	☐ DOUBLE VISION	☐ EYE PAIN	☐ BLURING OF VISION	☐ OTHER _____
	☐ CHANGES IN VISION	☐ EXCESSIVE TEARING	☐ BLIND SPOTS	☐ CORRECTIVE LENSES	
NOSE/MOUTH:	☐ NO COMPLAINTS	☐ FREQUENT BLEEDING	☐ BLEEDING GUMSN	☐ COLD/CANCRE SORES	☐ TOOTH PAIN
	☐ CONGESTION	☐ NASAL DISCHARGE	☐ NASAL OBSTRUCTIO	☐ USE OF DENTURES	☐ OTHER _____
NECK/THROAT:	☐ NO COMPLAINTS	☐ NECK PAIN	☐ LUMPS/BUMPS	☐ DIFFICULTY SWALLOWING	
	☐ NECK STIFFNESS	☐ NECK TENDERNESS	☐ SORE THROAT	☐ OTHER _____	
BREAST:	☐ NO COMPLAINTS	☐ TENDERNESS	☐ PAIN	☐ OTHER _____	
	☐ LUMPS	☐ SWELLING	☐ NIPPLE DISCHARGE		
CHEST/LUNG:	☐ NO COMPLAINTS	☐ COUGH	☐ SPITTING UP BLOOD	☐ PAIN WITH BREATING	
	☐ WHEEZING	☐ SHORT OF BREATH	☐ MANY INFECTIONS	☐ OTHER _____	
CARDIOVASCULAR:	☐ NO COMPLAINTS	☐ HIGH CHOLESTEROL	☐ LEG SWELLING	☐ HIGH BLOOD PRESSURE	☐ OTHER _____
	☐ CHEST PAIN	☐ IRREGULAR BEAT	☐ COLD HANDS/FEET	☐ LOSS OF CONSCIOUSNESS	☐ SHORT OF BREATH W/ LAYING
ABDOMEN/DIGESTION:	☐ NO COMPLAINTS	☐ ABDOMINAL PAIN	☐ DIARRHEA	☐ HEART BURN	☐ BOWEL MOVEMENTS/DAY
	☐ NAUSEA/VOMITING	☐ CHANGE IN APPETITE	☐ CONSTIPATION	☐ BLOOD IN STOOL	☐ OTHER _____
URINATION:	☐ NO COMPLAINTS	☐ FREQUENCY	☐ URGENCY	☐ FREQUENT INFECTIONS	
	☐ PAINFUL URINATION	☐ INCONTINENCE	☐ DRIBBLING	☐ INCOMPLETE EMPTYING	
WOMENS HEALTH:	☐ NO COMPLAINTS	☐ PAIN WITH MENSES	☐ PELVIC PAIN	☐ DIFFICULTY CONCEIVING	☐ CYCLE LENGTH: DAYS
	☐ CHANGE IN MENSES	☐ VAGINAL DISCHARGE	☐ CRAMPING	☐ SPOTTING	☐ OTHER _____
MUSCULOSKELETAL:	☐ NO COMPLAINTS	☐ MUSCLE SORENESS	☐ MUSCLE TENSION	☐ NUMBNESS/TINGLING	☐ OTHER _____
	☐ MUSCLE CRAMPS	☐ MUSCLE WEAKNESS	☐ JOINT PAIN	☐ LIMITED RANGE OF MOTION	
NEUROLOGICAL:	☐ NO COMPLAINTS	☐ SEIZURES	☐ CHANGE IN SLEEP	☐ LOSS OF COORDINATION	☐ DEPRESSION
	☐ TREMOR	☐ MENTAL CHANGES	☐ MEMORY CHANGES	☐ COGNITIVE IMPAIRMENT	☐ OTHER _____
SKIN/HAIR:	☐ NO COMPLAINTS	☐ EASY BRUISING	☐ RASH	☐ TEXTURE CHANGES	☐ CHANGES IN NAILS
	☐ DRYNESS	☐ SLOW HEALING	☐ COLOR CHANGES	☐ THINNING HAIR	☐ OTHER _____

Additional Health Systems Concerns: