ALTERNATIVE MEDICAL HEALTHCARE
Patient Consultation Intake Form

Phone (602) 252-6252 or (866)-221-6636 Fax (602) 252-6253

Date ________________________ Social Security # ___________________________

Name ______________________________________Date of Birth ___/___/___ Age ____
(First) (MI) (Last)

Address _____________________________ City _____________State ___ Zip ________

Home Phone ________________ Work Phone _______________ Cell ________________

Occupation __________________________ Employer ____________________________

Name of Spouse/Partner ____

How did you hear about Alternative Medical Healthcare?
Referred By______________
Web Site________________
Other __________________

Where did you last receive healthcare? ____

Date _______________ Reason? ____

Exercise ____

Sports ____

Allergies ____

Medication allergies ____

List Current Health Problems In Order of Priority	List Surgeries, Hospitalizations, Or Accidents
1. ______________________________	1. ______________________________
2. ______________________________	2. ______________________________
3. ______________________________	3. ______________________________
4. ______________________________	4. ______________________________
5. ______________________________	5. ______________________________

Medical History

Check all that apply	**Self**	**Siblings**	**Mother**	**Father**	**Grandparents**
Allergies					
Anemia					
Arthritis					
Asthma					
Cancer					
Depression					
Diabetes					
Eczema or Hives					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Obesity					
Osteoporosis					
Stroke					
Thyroid Disease					
Substance Abuse					
Alcoholism					
Other					

Current Medications	List Supplement
1. ______	1. ______
1. ______	2. ______
2. ______	3. ______
3. ______	4. ______
4. ______	5. ______
5. ______	6. ______
6. ______	7. ______
7. ______	8. ______

Please fax copies of any recent lab work and/or medical records along with a list of any medications and/or supplements that you are currently taking.

Our initial visit will last 60 minutes. This will allow us time to explore your healthcare needs.

We accept Visa and MasterCard.

Office Cancellation Policy

Please cancel all appointments a minimum of 24 hours prior to the appointment time. This will enable me to offer that time to another patient.

Unfortunately, if 24 hours notice is not given it is necessary that I charge for that appointment.

Thank you for your understanding.

Stephanie Eastman, N.M.D.

Please sign below that you have read and understand our cancellation policy.

Patient ____ Date _______________