Cypress Natural Medicine Confidential Patient Intake Form www.CNMvirtualhealth.com

Patient Name ________________________________ Email address ________________________________

DOB ____/____/________ Gender ____ Blood Type ____ Date ____/____/________

In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The ***Health Care Consumer (HCC) - Health Care Provider (HCP)*** *relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.*

Zyto Computerized Visits (In Office or Virtual) / Naturopathic Visits
$300 Initial, including assessment and treatment plan
$150 Follow Up, moderate
$300 Follow Up, complex

Osteopathic Visits (Dr. Logan)
$300 Initial, Adult
$200 Initial, Child
$175 Follow Up

Craniosacral Visits (Dr. Skinner)
$300 Initial, Adult
$200 Initial, Child
$150 Follow Up, Adult
$125 Follow Up, Child

Acupuncture Visits
$200 Initial
$110 Follow Up

Hand Cradle Purchase for Zyto Computerized Virtual Visits (Home Visits)
$150 (One-Time Fee)

****Please note that we require a credit card in order to reserve your initial appointment time. This credit card will only be charged upon missing your appointment, failure to cancel or change your appointment without at least 48 hours notice, or at the completion of your initial appointment.**

Address	Phone	
	Home	
	Work	
	Cell	

Emergency Contact (Address and Phone)

	Home	
	Work	
	Cell	

Chief Complaints (please list in order of importance to you)

	Onset	Duration

Please list all of the medications you are taking. Include over the counter medications, herbs & vitamins.

Medication Name	*Dose*	*Last taken*	*Medication Name*	*Dose*	*Last taken*

Surgical History

Surgery or Procedure	Date of Procedure	Name of Provider Performing Procedure

Trauma History

Event	Date	Description

Relevant family history

Please list and describe allergic reactions you have had to food, medications or insect stings.

Check if you are you allergic to ❑Shellfish ___________ ❑IV Contrast Dye __________ ❑Penicillins ___________

Please list other Food, Medication or Insect Allergies	Describe your reaction

Have you traveled, in the past 1 year? ❑Yes ❑No

Travel destinations OUTSIDE the United States	Dates spent at this destination

Travel destinations INSIDE the United States	Dates spent at this destination

Vaccination History Have you ever had any of the following vaccinations?

Vaccine		Date of last vaccination
Influenza	❑Yes ❑No	
Pneumonia	❑Yes ❑No	
Tetanus	❑Yes ❑No	
BCG	❑Yes ❑No	
Varicella	❑Yes ❑No	
HPV (Gardasil)	❑Yes ❑No	

Please list your occupations. Include the length of time you performed in that role, and describe your work responsibilities in that occupation. (Include military experience.)

Occupation	Start Date	Stop Date	Responsibilities

Exercise History

Do you exercise? ❑Yes ❑No If yes, describe how long and how often you exercise on average each week

Please describe your hobbies.

Patient Name ______________________________ DOB ____/____/________ Date ____/____/________

Past Medical History Please check all that apply.

Condition	Yes	Past	Condition	Yes	Past
Adrenal Dysfunction	❑Yes	❑Past	Irregular Heart Rhythym	Yes	Past
Alzheimer	❑Yes	❑Past	Kyphosis	Yes	Past
Amyotrophic Lateral Sclerosis	❑Yes	❑Past	Liver Dysfunction	Yes	Past
Anorexia or Bulemia	❑Yes	❑Past	Kidney Failure, or Dysfunction	Yes	Past
Anxiety	❑Yes	❑Past	Malignancy If yes, describe below	Yes	Past
Arteriovenous Malformations	Yes	Past			
Arthritis	Yes	Past			
Asthma	❑Yes	❑Past	Mania	Yes	Past
Autoimmune Disease	❑Yes	❑Past	Muscular Dystrophy	Yes	Past
Bipolar Disorder	❑Yes	❑Past	Myocardial Infarction (Heart Attack)	Yes	Past
Bleeding Disorder	❑Yes	❑Past	Narcolepsy	Yes	Past
Cataracts	❑Yes	❑Past	Obstructive Sleep Apnea	Yes	Past
Cerebrovascular Accident	❑Yes	❑Past	Organ Transplant If yes, describe	Yes	Past
Chemotherapy (if yes, state when)	❑Yes	❑Past			
			Osteoporosis	Yes	Past
Claudication	❑Yes	❑Past	Pancreatitis	Yes	Past
Clotting Disorder	❑Yes	❑Past	Periodic Limb Movement Disorder	Yes	Past
Congenital Heart Defects	❑Yes	❑Past	Peripheral Artery Disease	Yes	Past
Coronary Artery Disease	❑Yes	❑Past	Personality Disorder	Yes	Past
COPD	❑Yes	❑Past	Pituitary Dysfunction	Yes	Past
Cystic Fibrosis	❑Yes	❑Past	Polycystic Ovarian Syndrome	Yes	Past
Depression	❑Yes	❑Past	Pulmonary Artery Hypertension	Yes	Past
Diabetes	❑Yes	❑Past	Pulmonary fibrosis	Yes	Past
Dialysis	❑Yes	❑Past	Radiation Therapy If yes, explain	Yes	Past
Eclampsia or Pre-eclampsia	❑Yes	❑Past			
Endocarditis	❑Yes	❑Past	Recurrent Infections	Yes	Past
Endometriosis	❑Yes	❑Past	Restless Leg Syndrome	Yes	Past
End Stage Renal Disease	❑Yes	❑Past	Sarcoidosis	Yes	Past
Erectile Dysfunction	❑Yes	❑Past	Schizophrenia	Yes	Past
Esophageal Dysfunction	❑Yes	❑Past	Scleroderma	Yes	Past
Fibromyalgia	❑Yes	❑Past	Scoliosis	Yes	Past
Gallstones	❑Yes	❑Past	Seizure Disorder	Yes	Past
Gastritis or Ulcers	❑Yes	❑Past	Sickle Cell	Yes	Past
GERD (reflux)	❑Yes	❑Past	Sjogren	Yes	Past
Glaucoma	❑Yes	❑Past	Skin Disorders (Psoriasis, Acne)	Yes	Past
Heart or Valve Defects	❑Yes	❑Past	Thalassemia	Yes	Past
Hemochromatosis	❑Yes	❑Past	Thrombocytopenia	Yes	Past
Hemorrhoids	❑Yes	❑Past	Thrombophilia	Yes	Past
Hepatitis	❑Yes	❑Past	Transfusions	Yes	Past
HIV or AIDS	❑Yes	❑Past	Tuberculosis	Yes	Past
Hypertension	❑Yes	❑Past	If yes, have you been treated?	Yes	Past
Hypotension	❑Yes	❑Past	Urinary retention or urgency	Yes	Past
Hypothyroidism	❑Yes	❑Past	Vasculitis	Yes	Past
IBS	❑Yes	❑Past	Visual defects	Yes	Past
			Vocal cord dysfunction/paralysis	Yes	Past

Review of Systems Have you experienced any of the following symptoms?

Symptom	Yes	Past
Constitutional		
Weight Loss or Gain	❑Yes	❑Past
Appetite changes (increased or decreased)	❑Yes	❑Past
Fatigue, profound and impairs daily function	❑Yes	❑Past
Fever	❑Yes	❑Past
Shakes/sweats from lack of alcohol or drug	❑Yes	❑Past
Eyes		
Eye pain or drainage	❑Yes	❑Past
Visual changes	❑Yes	❑Past
Dry, irritated eyes	❑Yes	❑Past
ENT/Mout		
Ear pain or drainage	❑Yes	❑Past
Frequent sinus infections	❑Yes	❑Past
Hearing changes or loss	❑Yes	❑Past
Nosebleeds	❑Yes	❑Past
Dizziness	❑Yes	❑Past
Respiratory		
Blood in your sputum	❑Yes	❑Past
Chest tightness	❑Yes	❑Past
Cough lasting >1 month, productive or not	❑Yes	❑Past
Shortness of breath	❑Yes	❑Past
Wheezing	❑Yes	❑Past
Chest pain with inhalation or coughing	❑Yes	❑Past
Cardiovascular		
Chest pain or heaviness	❑Yes	❑Past
Palpitations	❑Yes	❑Past
Fainting or near fainting spells	❑Yes	❑Past
Swelling of feet or legs	❑Yes	❑Past
Shortness of breath lying flat in bed	❑Yes	❑Past
Gastrointestinal		
Abdominal pain	❑Yes	❑Past
Blood in your stool	❑Yes	❑Past
Constipation	❑Yes	❑Past
Diarrhea or Food Intolerance	❑Yes	❑Past
Heartburn or Indigestion	❑Yes	❑Past
Vomiting or nausea lasting for >1 day	❑Yes	❑Past
Swallowing difficulty	❑Yes	❑Past
Psyc		
Anxiety without clear explanation	❑Yes	❑Past
Sadness lasting for days or weeks	❑Yes	❑Past
Hearing voices	❑Yes	❑Past
Thoughts of hurting yourself	Yes	Past

Symptom	Yes	Past
Genitourinary		
Blood in your urine	Yes	Past
Menstrual changes	Yes	Past
Urinating that is painful or difficult	Yes	Past
Erection problems	Yes	Past
Vaginal discharge or bleed	Yes	Past
Musculoskeletal		
Broken bones	Yes	Past
Joint pain or swelling	Yes	Past
Muscle aches	Yes	Past
Muscle weakness	Yes	Past
Back pain	Yes	Past
Skin/Breasts		
Masses or lumps	Yes	Past
Nipple discharge	Yes	Past
Rashes or nonhealing ulcers	Yes	Past
Neurologic		
Seizures	Yes	Past
Coughing or choking with swallowing	Yes	Past
Excessive daytime sleepiness	Yes	Past
Extremity pain or burning sensations	Yes	Past
Hallucinations	Yes	Past
Numbness or tingling	Yes	Past
Difficulty falling asleep, staying asleep	Yes	Past
Endocrinologic		
Hair loss	Yes	Past
Frequent urination	Yes	Past
Increased thirst	Yes	Past
Heat or cold intolerance	Yes	Past
Heme/Lymph		
Bleeding from gums or nose	Yes	Past
Unexplained bruising	Yes	Past
Night Sweats	Yes	Past
Swollen, painful lymph nodes	Yes	Past
Allergy/Immune		
Watery eyes	Yes	Past
Runny nose	Yes	Past
Food intolerance	Yes	Past
Frequent skin sores	Yes	Past

Female Patients Only

	Response	Descriptions
Have you ever been pregnant	❑Yes ❑No	
# of pregnancies		
# Live Births		
# Miscarriages, Abortions		
Your age at onset of menstruation		
Your age at onset of menopause	❑NA	
Have you ever taken birth control pills, or used patches or implants? If yes, how long	❑Yes ❑No	
Have you ever used hormone replacement therapy? If yes, how long	❑Yes ❑No	
Did you ever have an IUD (Intrauterine Device) implanted?	❑Yes ❑No	
If you had an IUD, was it removed? If yes, when	❑Yes ❑No	

Referral Information – We would appreciate learning how you heard about us? Check one, please

❑Another physician, nurse practitioner or physician assistant?
If so, please specify who:
❑Family member or friend who is a patient of this clinic
❑Family member or friend who is NOT a patient of this clinic
❑Sign outside office
Google
BioSET
NAET
❑ Phone book
❑ Internet
☐ Other, *please specify*

Additional Information that you feel may be helpful for your health care provider to know.

Signature

Date

Credit Card

CVV

Expiration Date