noha, llc
new & old health alternatives
720-629-4211 ♦ www.noha.co

PATIENT INTAKE FORM

Date of First Appointment_____

Full Name	DOB
Email	Address
Phone	
May I contact you by ☐Email ☐Call ☐Text	May I leave a message? *Please Initial* _____
Emergency Contact Phone Number Relationship May I contact them? *Please Initial* _____	**Physician Contact** Phone Number City May I contact them? *Please Initial* _____
Main Reason(s) For Seeking Treatment?	
Have you received diagnosis for this condition?	☐Yes ☐No

Known Allergies

☐ metal/latex	☐ chemicals/drugs	☐ foods/nuts/oils	☐ seasonal

Medications/Herbs	Reason	Approximate Dose	How Long or Age?

Major Illnesses, Injuries, Hospitalizations, Surgeries	Dates or Age

Dietary & Lifestyle Habits

Do you have any cravings?	☐Yes	☐No	☐Bitter ☐Bland ☐Salty ☐Sweet ☐Bland
Do you drink alcohol?	☐Yes	☐No	☐Quit When?
Do you smoke/chew tobacco?	☐Yes	☐No	☐Quit When?
Do you do recreational drugs?	☐Yes	☐No	☐Quit When?

Neuropsychological

☐Numbness	☐Tingling	☐Paralysis	☐Poor Memory
☐Seizures	☐Dizziness	☐Vertigo	☐Loss of Balance
☐Concussion	☐Palpatations	☐Mood Swings	☐Depression
Other/Please Explain			

I affirm that all information is true and complete to the best of my knowledge.

PATIENT SIGNATURE_____DATE_____

Patient Name_____ Service Date_____