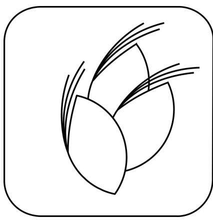


Trinity Natural Medicine & Acupuncture
6505 218TH ST SW, STE 15
MOUNTLAKE TERRACE, Washington, US - 98043-2135

New Patient Intake Form (Minors Under 18)

Trinity Natural Medicine & Acupuncture

How did you hear about us? *

☐ Family / Friend ☐ Doctor / professional referral ☐ Facebook ☐ Instagram
☐ Google ☐ Yelp ☐ Other

If someone referred you, whom can we thank (name)? ____________________

--PATIENT INFORMATION--

First Name: * ____________________

Last Name: * ____________________

Birth Gender: *
☐ Female ☐ Male ☐ Other
☐ Decline to specify

What gender do you identify as?
☐ Female ☐ Male ☐ Other
☐ Decline to specify

Previous Name (If applicable): ____________________

Preferred Name/Nickname: ____________________

Birthday: * ____________________

Mailing Address: * ____________________

Apt/Unit/Suite #: ____________________

City/State/Zip: * ____________________

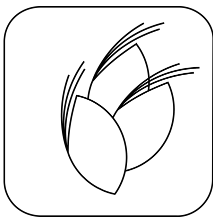
Email: * ____________________

Preferred Phone #: * ____________________

Preferred phone # is my
☐ Home ☐ Cell ☐ Work

Is it okay to leave confidential voicemails at this number? *
☐ Yes ☐ No

Social Security #: ____________________



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Race *

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White / Caucasian
- ☐ Decline to answer

Ethnicity *

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Decline to answer

--EMERGENCY CONTACT--

Parent/Guardian/Emergency Contact Name: * ____________________

Parent/Guardian/Emergency Contact #: * ____________________

Relationship to Patient: ____________________

--INSURANCE INFORMATION--

Health insurance company name: ____________________

Member ID: ____________________

Policy Holder's name (if other than patient): ____________________

Policy Holder's date of birth (if other than patient): ____________________

Policy Holder's relationship to patient: ____________________

--SOCIAL HISTORY--

Relationship Status ☐ Single ☐ In a relationship ☐ Other

Do you have a part-time job? ☐ Yes ☐ No

Do you play sports or participate in physical activities? Which ones? ____________________

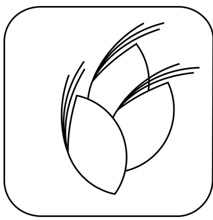
Do you smoke? ☐ Current ☐ Past ☐ Never

Do you drink alcohol? ☐ Current ☐ Past ☐ Never

Do you use recreational drugs? ☐ Current ☐ Past ☐ Never

--MEDICAL HISTORY--

Height: * ____________________



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Weight: *

What is the purpose of your visit today? *

List all allergies and allergic responses (i.e. pollen - sneezing): *

Past surgeries & hospitalizations:

Current supplements:

Current medications and doses: *

Do you currently have or have a history of the following medical conditions (check all that apply):

- ☐ Adrenal Disorder
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis / Joint Disorder
- ☐ Asthma
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Digestive Problem
- ☐ Heart Disease
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other

Please list any significant FAMILY health history of diseases or conditions:

PATIENT SIGNATURE *

Date *