Diana Quinn Inlak'ech, ND
Integrative Empowerment Group PLLC 560 S. Main St., Ann Arbor, MI 48104
Integrative Healthcare Providers 2800 S. State St., Ann Arbor MI 48104

New Patient Intake Form

Personal Information

Date of Birth _____/_____/_____
Name _____ Age _____
Sex (assigned at birth) _____Gender Identify as_____
Preferred Pronouns_____ Preferred Name_____
Address _____Apt. # _____
City _____State _____ Zip _____
Phone (Day) _____ (Evening) _____
(Cell) _____
Is it OK to leave messages? Yes ___ No ___
Email address_____
Preferred contact ___Day phone ___Evening phone ___Cell phone ___Email
May we add your email address to our mailing list to receive infrequent office updates on services? ___Yes ____No
Emergency contact
Name _____
Relationship _____
Daytime Phone _____

Who may I thank for your referral, or, where did you hear about us?

Current Health Conditions

Conditions, symptoms, concerns - in order of priority and approximate date of onset
(1)_____
(2)_____
(3)_____
(4)_____
(5)_____
How do these conditions affect your life?
_____
_____
_____
_____

Social History

Relationship Status_____ Sexual orientation _____ With whom do you live?_____

Medical History

Do you have a Primary Care Physician (PCP)? No ◯ Yes ◯
Dr. _____ Phone_____ Date of last physical exam _____
Have you consulted your PCP about the aforementioned condition(s)? No Yes
Have you consulted another practitioner about the aforementioned condition(s)? No Yes
If so, who? _____
Have you been to a Naturopathic Doctor before? No Yes
Dr. _____
Please state any previous diagnosis, treatment and results (any practitioner):
_____
_____
_____
Please indicate if you have had the following conditions or symptoms by marking “C” for current, “P” for past or “N” for never:

Anemia C ◯ P ◯ N ◯
Anxiety or nervousness Arthritis C ◯ P ◯ N ◯
Asthma C ◯ P ◯ N ◯
Atherosclerosis Autoimmune disease Blood pressure problems Bone diseaseC ◯ P ◯ N ◯
Breathing problems Cancer _____ Chest pain C ◯ P ◯ N ◯
Chronic inflammation Chronic pain C ◯ P ◯ N ◯
Circulatory problems Cold sores C ◯ P ◯ N ◯
Constipation C ◯ P ◯ N ◯
Debilitating fatigue Dental problems Depression C ◯ P ◯ N ◯
Diabetes Type _____ Diarrhea C ◯ P ◯ N ◯
Difficulty breathing C ◯ P ◯ N ◯

Please indicate if you have had the following conditions or symptoms by marking “C” for current, “P” for past or “N” for never:

Difficulty sleeping C ◯ P ◯ N◯
Dizziness or fainting C ◯ P ◯ N◯

Ear infections C ◯ P ◯ N◯
Eating disorder C ◯ P ◯ N◯
Feel unsafe at home C ◯ P ◯ N◯
Frequent antibiotic use C ◯ P ◯ N◯
Frequent colds or flu C ◯ P ◯ N◯
Gallbladder disease C ◯ P ◯ N◯
Gastrointestinal disorder C ◯ P ◯ N◯
Hay fever C ◯ P ◯ N◯
Headaches C ◯ P ◯ N◯
Head injury C ◯ P ◯ N◯
Heartburn C ◯ P ◯ N◯
Heart disease C ◯ P ◯ N◯
Hemorrhoids C ◯ P ◯ N◯
Hypoglycemia C ◯ P ◯ N◯
Irritable Bowel Syndrome C ◯ P ◯ N◯
Kidney disease C ◯ P ◯ N◯
Liver disease C ◯ P ◯ N◯
Loss of appetite C ◯ P ◯ N◯
Lyme disease C ◯ P ◯ N◯
Memory loss C ◯ P ◯ N◯
Mononucleosis C ◯ P ◯ N◯
Mood swings C ◯ P ◯ N◯
Nausea C ◯ P ◯ N◯
Neurological disease C ◯ P ◯ N◯
Numbness / tingling C ◯ P ◯ N◯
Osteoporosis C ◯ P ◯ N◯
Panic attacks C ◯ P ◯ N◯
Parasites C ◯ P ◯ N◯
Physical abuse C ◯ P ◯ N◯
Seizures C ◯ P ◯ N◯
Sinus problems C ◯ P ◯ N◯
Skin problems C ◯ P ◯ N◯
Stroke C ◯ P ◯ N◯
Substance abuse C ◯ P ◯ N◯
Thyroid problems C ◯ P ◯ N◯
Ulcers C ◯ P ◯ N◯
Vaccinations ____Routine Only C ◯ P ◯ N◯

Allergies

Please list any known allergies:
Drug _____
Environmental _____ Food _____ Other _____

Hormonal and Sexual History

Please indicate if you have had the following conditions or symptoms by marking "C" for current, "P" for past or "N" for never:
Abnormal Pap smear C ◯ P ◯ N ◯
Acne C ◯ P ◯ N ◯

Breast pain or lump Changes in sex drive Changes in memory Changes in mood Desire pregnancy Dry skin Endometriosis C ◯ P ◯ N ◯

Facial hair C ◯ P ◯ N ◯
Frequent/chronic yeast infections C ◯ P ◯ N ◯
Hair loss C ◯ P ◯ N ◯
Hormone replacement therapy (What kind? Dosage? How long?) _____

Hot flashes C ◯ P ◯ N ◯

Hysterectomy C ◯ P ◯ N ◯
Impaired fertility C ◯ P ◯ N ◯
Testicular pain C ◯ P ◯ N ◯
Weight changes C ◯ P ◯ N ◯

Are you pregnant now? Yes ◯ No ◯
Age menses began _____ Date of last menstrual period ____ / ____ / _____ Number of pregnancies _____ Number of births _____
Last Pap smear ____ / ____ / _____
Last mammogram ____ / ____ / _____
If you have periods, describe what they are like:
Average number of days in cycle _____ (from one period to the next)
Cycles are Regular ◯ Irregular ◯
Average number of days of bleeding _____
Periods are Light ◯ Medium ◯ Heavy ◯ Painful ◯
PMS No Yes: _____ days per month
Sexual orientation_____
Are you currently sexually active? _____
Are you using contraception? If yes, method _____

Family History

If known, please indicate family history and presence of health conditions with age of onset:
Mother health: _____
If deceased, age and cause of death _____
Father health: _____
If deceased, age and cause of death_____

Alzheimer's disease _____
Alcoholism or substance abuse _____
Allergies or Hay Fever_____
Asthma _____
Attempted or completed suicide_____
Autoimmune disease_____
Cancer (specify kind/location)_____
Depression/Anxiety_____
Diabetes _____
Eczema _____
Heart disease_____
High blood pressure_____
Osteoporosis_____
Stroke _____
Thyroid problems_____
Weight changes_____
Other_____

Medications

Please list any pharmaceutical and natural medications/supplements that you are taking or have taken in the past year, with dosages and reason for taking. Use a separate page if necessary.

_____
_____
_____
_____
_____

The above information is true to the best of my knowledge. I understand that Dr. Quinn does not bill insurance and I agree to pay for services at each visit, unless we have specified a different financial agreement prior to the appointment

_____ ____ / ____ / _____

Signature (Parent or guardian if patient is under 18 years old) Date