



*Dr. Kristi Tamplings*  
Personalized Functional Medicine

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### New Patient Intake Form

Date \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender \_\_\_\_\_  
Last First Middle Initial

Address \_\_\_\_\_  
Street City State Zip Code

Telephone: Home/Work \_\_\_\_\_ Cell \_\_\_\_\_

Is it okay to send you text message reminders of your appointments? YES \_\_\_\_\_ NO \_\_\_\_\_

Email (s): \_\_\_\_\_

Are you interested in receiving informational emails containing health related recommendations, events, presentations, special offers and more? YES \_\_\_\_\_ NO \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by:

1. Internet
2. Social Media
3. Friends and/or Family Members
4. Professional Colleague
5. Other \_\_\_\_\_

Emergency contact \_\_\_\_\_  
Name Telephone

#### MAIN REASON FOR THIS APPOINTMENT: MEDICAL CONDITIONS & SYMPTOMS

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**DID ANYTHING TRIGGER YOUR CURRENT MEDICAL CONDITIONS/SYMPTOMS? (if known)**

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**PAST MEDICAL CONDITION THAT RESOLVED (include dates):**

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**MAJOR ACCIDENTS**

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**TRAUMA OR CHRONIC STRESS (EMOTIONAL AND PHYSICAL)**

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**HOSPITALIZATIONS AND SURGERIES:**

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**DENTAL PROBLEM HISTORY (surgeries, root canals, cavities, infections)**

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**PRESCRIPTION AND OVER THE COUNTER MEDICATIONS (Name/Dose)**

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**ALLERGIES AND SENSITIVITIES**

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**ENVIRONMENTAL, HOME AND/OR OCCUPATIONAL EXPOSURES**

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**WOMEN:**

First Day of Last Menstrual Period \_\_\_\_\_ Last Women's Pelvic (Pap) Exam \_\_\_\_\_

Last Breast Imaging (mammogram, ultrasound, MRI, thermography) \_\_\_\_\_

Last Doctor's Appointment/For What Reason \_\_\_\_\_

Last Complete Physical Exam and/or Labs \_\_\_\_\_

Married (years) \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Children (#) \_\_\_\_\_ Ages \_\_\_\_\_

Pregnancies \_\_\_\_\_ Deliveries \_\_\_\_\_ Complications \_\_\_\_\_




**MEALS**

**Please list your typical meals for each day during the week. Provide as much information as possible. Please include all beverages. If you are following a specific diet protocol, list here: \_\_\_\_\_ i.e. Paleo Diet, Ketogenic Diet, Whole 30, Vegan/Vegetarian, Gluten Free, Dairy Free, Weight Watchers, etc.**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Snack							
Lunch							
Snack							

Dinner							
Dessert							

# FAMILY MEDICAL HISTORY

Please give age, illnesses, diseases or other medical symptoms. If deceased, list cause, and approximate age and year of death.

## MOTHER:

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## FATHER

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## BROTHERS AND SISTERS

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## GRANDPARENTS: MOTHER'S SIDE

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## GRANDPARENTS: FATHER'S SIDE

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## YOUR CHILDREN

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## PAYMENT AND PATIENT INFORMATION

Please read, initial and sign

Dr. Kristi Tompkins, ND of El Dorado Naturopathic Medicine will do her best to provide you with comprehensive and therapeutic health recommendations that are individualized to your specific health care needs and preferences. The following information is listed to provide you with the financial, medical records and insurance information.

**Payment:** Appointments are paid for at the time of service. We accept credit cards (VISA, MC, AMEX, DISC), cash, money orders and checks. A \$25 fee will be charged for returned checks. Dr. Tompkins does not issue refunds.

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INITIAL

**Appointments:** Dr Tompkins requires a **24 hr notice** if you need to change or cancel your appointment. We are understanding with unforeseen emergencies or changes and therefore willing to be flexible and reschedule appointments as needed. However, if missed appointments are consistently occurring without sufficient notification, a missed appointment fee of \$50 will be billed to the patient.

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INITIAL

**Medical Records:** El Dorado Naturopathic Medicine maintains HIPAA compliant Electronic Medical Records of your medical chart. Patients are given a printed copy of their treatment plans upon completion of the doctor visit or within 24-48 hours if more research into your medical conditions is needed. If you would like a copy of your medical records, we can provide you with a copy upon your signing an authorization form and returning it to us. Please allow up to 10 business days for us to process the request.

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INITIAL

**Health Insurance:** El Dorado Naturopathic Medicine does not directly bill health insurance organizations or Medicare or Medi-Cal. California Licensed Naturopathic Doctors currently are not required or eligible to be credentialed with such organizations. You are welcome to submit your Appointment Sales Receipt to your health insurance organization for possible reimbursement. Please let Dr. Tompkins know and she can include with the corresponding ICD-10 and CPT codes on your Sales Receipt.

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INITIAL

### Patient

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

### Dr. Kristi Tompkins

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*