True Health Medical Center

New Patient Screening Form

All fields must be completed to be considered for an appointment.

1. ***Patient's Name:*** _____ ***DOB:***_____ ***Sex***: ***M F***
   Parents/Guardians: _____ _____
   Phone: _____
   State/Country: _____ _____
   Email: _____

2. ***Chief complaint/symptom or reason for seeking an appointment (please be specific):***

_____
_____
_____
_____
_____
_____
_____
_____

3. ***Does the patient have a history of any of the following:***

- ☐ Auto-Immune Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Lyme Disease
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Other Chronic Medical Conditions

Please comment on any illnesses marked above:

_____
_____
_____
_____

4. ***Does the patient have any other medical issues, major surgeries, or hospitalizations? If so, please describe:***

_____
_____
_____
_____

5. ***THMC does not provide primary care physician services. Do you have a primary care physician? Y N***

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6. ***What medications and supplements does the patient currently take?***

_____
_____
_____
_____
_____
_____

7. ***If the patient is a minor, who does the patient live with****?* _____
_____
_____

8. ***If parents of the minor are not married, who has legal custody***?_____
_____
_____

9. ***Do both parents have legal medical decision making authority***? _____
_____
_____

10. ***Are both parents supportive of alternative/integrative medical treatments***? _____
_____
_____

11. ***Are both parents willing to attend an initial visit to sign consent forms as required***? _____
_____
_____

12. ***Is the patient willing to come to the office for all follow-up visits (no less than once a year***)? ___
_____
_____
_____

13. ***If patient is a disabled adult, can you provide documentation of guardianship for medical decisions***? _____
_____
_____

14. ***THMC does not accept insurance, therefore do you understand that payment is due at the time of service****?* Y N

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15. ***Do you speak English? Y N If not, will you have an interpreter available for all consultations and phone calls?*** _____

_____

BIOMEDICAL HISTORY

Patient Name: _____

Birth Date: _____

Have you:

[ ] Heard of Biomedical Treatments?

[ ] Seen a Defeat Autism Now! doctor, past or present?

[ ] Tried an alternative diet (gluten/casein free, specific carbohydrate diet, modified Atkins, etc.?)

[ ] Given any supplements (multi-vitamins, minerals, cod liver oil) to your child to improve symptoms?

[ ] Given methyl B12 injections?

[ ] Given anti-virals to help with behaviors?

[ ] Done chelation?

[ ] Done hyperbaric oxygen therapy?

[ ] Yasko Protocol?