Taylor Made Wellness

Dr. Randon Taylor, NMD

Sugar City, Idaho

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Please return this completed form in person or through a secure, encrypted method only. Do not email this form using unsecured platforms. Submission via unencrypted email is against clinic policy and done at the patient's own risk and responsibility.

New Patient Intake Form

Personal Information

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

Phone (Cell): _____

Email: _____

Emergency Contact (Name/Phone): _____

How did you hear about us? _____

Presenting Concerns

Please briefly describe the main reason(s) for your visit:

_____

_____

Do you attribute your condition to a particular incident? (Include date if applicable):

_____

Health History

Major Illnesses (with approximate dates):

_____

Surgeries / Hospitalizations (with dates):

_____

Accidents / Injuries / Trauma (with dates):

_____

Allergies or Sensitivities (food, environmental, medications):

_____

Current Prescription Medications (dose & duration):

_____

Supplements (dose & duration):

_____

Exercise Routine: _____

Have you been exposed to occupational chemicals? (e.g., pesticides, solvents):

_____

Family History

List any major health conditions in your immediate family:

_____

Review of Systems

(Check all that apply)

Constitutional: [ ] Fever [ ] Weight loss [ ] Fatigue [ ] Night sweats [ ] Poor appetite [ ] None

Cardiovascular: [ ] Chest pain [ ] Palpitations [ ] Irregular heartbeat [ ] Swelling [ ] None

Respiratory: [ ] Cough [ ] Wheezing [ ] Difficulty breathing [ ] Coughing blood [ ] None

Gastrointestinal: [ ] Nausea [ ] Constipation [ ] Diarrhea [ ] Abdominal pain [ ] Reflux [ ] None

Neurological: [ ] Dizziness [ ] Headaches [ ] Tremors [ ] Numbness [ ] Seizures [ ] None

Endocrine: [ ] Hair loss [ ] Dry skin [ ] Cold/Heat intolerance [ ] Excessive thirst [ ] None

Musculoskeletal: [ ] Joint pain [ ] Back pain [ ] Muscle stiffness [ ] None

Genitourinary: [ ] Frequent urination [ ] Painful urination [ ] Testicular pain [ ] None

Skin: [ ] Rashes [ ] Itching [ ] Moles [ ] Skin sores [ ] None

Mental/Emotional: [ ] Anxiety [ ] Depression [ ] Insomnia [ ] Mood swings [ ] None

Emergency Medical Release

In the event of a medical emergency, I authorize Taylor Made Wellness to provide any information necessary to emergency medical personnel for the purpose of diagnosis and treatment. I consent to the release of information if I am incapacitated or unable to communicate.

[ ] I consent to the emergency release of my medical information in urgent or life-threatening situations.

Signature: _____ Date: _____

Authorization to Release Records

I authorize Taylor Made Wellness to request or release my medical records to or from any healthcare provider, clinic, or facility as needed for coordination of care. This may include labs, imaging, treatment notes, and clinical summaries.

I also authorize the release of my medical information to the following person(s), such as spouse, parent, guardian, or other caregiver:

Authorized Individual(s): _____

Relationship: _____

Phone (if applicable): _____

[ ] I authorize the release of my medical records as described above.

Signature: _____ Date: _____

Informed Consent for Care

I understand that the services provided at Taylor Made Wellness may include naturopathic medicine, nutritional counseling, homeopathy, and energy-based therapies such as NAET. These services are considered complementary or alternative by conventional medical standards. I understand that Dr. Randon Taylor is a licensed Naturopathic Medical Doctor in Idaho and is acting as a primary care physician.

I understand that:

- No guarantees have been made regarding outcome.
- I am free to discontinue treatment at any time.
- All medical information provided is confidential unless required by law.
- I have the right to ask questions and receive full explanation of procedures and therapies.

By signing below, I acknowledge that I have been informed of and consent to receive treatment at Taylor Made Wellness.

Patient Name: _____

Signature: _____ Date: _____

HIPAA Privacy Practices Acknowledgment

I acknowledge that I have been offered access to Taylor Made Wellness's Notice of Privacy Practices. I understand that my health information may be used for treatment, payment, and healthcare operations in accordance with HIPAA regulations.

[ ] I have read and understand the above.

Signature: _____ Date: _____

Consent for Communication

I consent to receive communication from Taylor Made Wellness via phone call, voicemail, text message, or email for appointment reminders, updates, or general administrative purposes. I understand that these methods may not be fully secure and accept any associated risks.

[ ] I consent to communication as described above.

Signature: _____ Date: _____

Testimonial & Public Sharing Consent (Optional)

I give permission to Taylor Made Wellness to use my written or verbal testimonials anonymously for professional purposes such as marketing, educational materials, or social media. My full name and identifying details will never be shared without explicit additional consent.

[ ] I consent to the use of my testimonial as described above.

Signature: _____ Date: _____

Fee Schedule and Payment Policy

Fee Schedule

Time Spent	Fee
30minutes	$75
60 minutes	$150
Over 60 minutes	$150 + $2 per additional minute

Payment is due at the time of service.We accept HSA and FSA cards.We do not accept or bill insurance.
A $50 no-show fee applies to missed appointments or cancellations with less than 24 hours' notice.
Thank you for choosing Taylor Made Wellness.We look forward to working with you!