

PATIENT INTAKE FORM

Today's Date _____

Name _____ Birthday _____ Age _____ Sex _____

Address _____ Phone-Home _____ Day or Eve? _____

City/State/Zip _____ Phone-Work _____ Day or Eve? _____

Occupation _____ Can we leave messages for you at Work?__ Home?__

Employer Name and Address _____

What other Health Care are you presently receiving? _____

Primary Health Care Provider _____ Phone _____

Permission to consult with primary provider? Please initial if yes. __ Yes _____ __ No

Person to contact in case of emergency _____ Phone _____

How did you hear about our clinic? _____



A NOTE TO OUR PATIENTS: Naturopathic, holistic, and preventive health care are only possible when the physician has a complete profile of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible.

PRESENT HEALTH CONCERNS: In your opinion, what are your most important health concerns in order of significance? Indicate the problem that motivated you to come in today.

- 1) _____
2) _____
3) _____
4) _____
5) _____

Name _____

MEDICATIONS: Please list all medications you are presently taking, including prescription and non-prescription items. Also include dosages for each item.

HERBS/SUPPLEMENTS: Please list all herbs, vitamins, and homeopathy you are presently using including dosages for each item.

ALLERGIES: List any and all allergies you have:

Drugs: _____

Foods: _____

Airborne: _____

Other: _____

What happens when you have an allergy attack? _____

HEALTH HISTORY:

General health as a child? Good Fair Poor

Childhood illnesses - check if you have had any of these:

Scarlet Fever German Measles Measles Pertussis

Rheumatic Fever Chicken Pox Diphtheria Mumps

Other serious illness as a child. Which illness? _____

Other illnesses as an adult or child - check if you had one of these:

Bronchitis Hepatitis Pancreatitis Tropical Dz

Diverticulosis Liver Dz Polio HIV

Emphysema Malaria Typhoid Fever Mononucleosis

Other _____

List all hospitalizations, surgeries, serious illnesses and injuries (adult and childhood), and the year they occurred.

Please check any of the following tests and immunizations you have had. Also list the year when the last one was done.

Test	Year	Test	Year
<input type="checkbox"/> Physical Exam	_____	<input type="checkbox"/> Tetanus Shot	_____
<input type="checkbox"/> Chest X-Ray	_____	<input type="checkbox"/> Blood Tests	_____
<input type="checkbox"/> EKG/ECG	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Blood Transfusion	_____	<input type="checkbox"/> Measles/Mumps	_____
<input type="checkbox"/> Biopsy: Where? When?	_____	<input type="checkbox"/> Hepatitis A/B	_____
_____	_____	<input type="checkbox"/> Flu	_____
<input type="checkbox"/> CT Scan/MRI	_____	<input type="checkbox"/> TB Test	_____
<input type="checkbox"/> Treadmill test	_____	Other immunizations _____	
<input type="checkbox"/> HIB	_____		

Name _____

HABITS:

Sleep well? Y N Wake rested? Y N Regular sleep pattern? Y N
How many hours of sleep? _____ How many needed? _____
Exercise regularly? Y N What type, how long is the exercise session, and how often? _____

How many meals do you have daily? _____ Snacks? _____
How many hours can you go without eating and still feel good? _____
Enjoy your work? Y N Spend time outside? Y N How much? _____
How do you relieve stress? _____

Do you crave starches? Y N Sweets? Y N Salt? Y N Fats? Y N
Do you use: **How much?** **Age started?** **Age stopped?**

 Alcohol: _____
 Coffee: _____
 Cigarettes: _____
 Drugs: _____

Do you wear seatbelts? all the time sometimes never
When do you not wear seatbelts? _____

FAMILY HISTORY:

Married Seperated Divorced Single Widowed Life Partner
Please list #, age and sex of siblings, parents & children (if deceased, list age at death and cause)

Have you or any of your close relatives (*parents, grandparents, aunts, uncles, siblings and children*) ever had any of the following? Please check off the categories that apply to you, and write in the relation of the family member that may fit into any of the following categories.

Example: Allergies brother, sister, aunt

You	Relative	You	Relative
<u> </u> Addictions _____		<u> </u> Gynecological Problems _____	
<u> </u> Alcoholism _____		<u> </u> Intestinal Problems _____	
<u> </u> Allergies _____		<u> </u> Heart Disease _____	
<u> </u> Anemia _____		<u> </u> Hypertension _____	
<u> </u> Arthritis _____		<u> </u> Kidney Disease _____	
<u> </u> Asthma/Hives _____		<u> </u> Liver Problems _____	
<u> </u> Bladder Problems _____		<u> </u> Lung Problems _____	
<u> </u> Cancer _____		<u> </u> Migraines _____	
<u> </u> Depression/Suicide _____		<u> </u> Psoriasis _____	
<u> </u> Diabetes _____		<u> </u> Stroke _____	
<u> </u> Eating Disorders _____		<u> </u> Syphilis _____	
<u> </u> Eczema _____		<u> </u> Thyroid Disorders _____	
<u> </u> Epilepsy _____		<u> </u> Tuberculosis _____	
<u> </u> Genetic Diseases _____		<u> </u> Ulcers _____	
<u> </u> Glaucoma _____		<u> </u> Bleeding Disorders _____	
<u> </u> Gout _____		<u> </u> Other _____	

Name _____

REVIEW OF SYSTEMS

Please circle: **Y** if it is a condition you have **now**.

P if it is a condition you have *ever* had in the **past**.

N if it is a condition you have **never** had.

If you had this condition in the past, and presently have it, circle both **Y and P**.

General

Weight _____
Weight 1 year ago _____
Maximum weight _____
Min. adult weight _____
Height _____
Night sweats Y P N
Fatigue Y P N

Skin

Rashes/Inflammation Y P N
Infection Y P N
Growths Y P N
Acne Y P N
Dry skin Y P N
Eczema Y P N
Psoriasis Y P N
Change in hair/nails Y P N
Wounds heal slowly Y P N
Skin Cancer Y P N

Eyes

Impaired vision Y P N
Eye pain Y P N
Poor night vision Y P N
Tearing or dryness Y P N
Double vision Y P N
Dyslexia Y P N
Cataracts Y P N
Glaucoma Y P N
Infections Y P N

Ears

Impaired hearing Y P N
Ringing Y P N
Earache/itch Y P N
Ear infection Y P N

Nose and Sinuses

Nose bleeds Y P N
Nasal congestion Y P N
Sinus problems Y P N
Post nasal drip Y P N

Respiratory

Cough Y P N
Blood in sputum Y P N
Wheezing/Asthma Y P N
Difficulty breathing Y P N
Pain on breathing Y P N
Shortness of breath: Y P N
" lying down Y P N
" at night Y P N
Positive TB test Y P N
Pneumonia Y P N

Heart

Heart disease Y P N
High blood pressure Y P N
Rheumatic fever Y P N
Chest Pain/Tightness Y P N
Swelling in ankles Y P N
Palpitations/Fluttering Y P N
Low blood pressure Y P N
Irregular heartbeat/Murmur Y P N

Digestion

Difficulty swallowing Y P N
Heartburn Y P N
Stomach pain Y P N
Change in thirst Y P N
Change in appetite Y P N
Nausea Y P N
Vomiting Y P N
Bowels move daily more less
Loose stools Y P N
Is this a change? Y P N
Blood in stools Y P N
Belching or gas Y P N
Liver/Gall Bladder disease Y P N
Hemorrhoids Y P N
Hiatal Hernia Y P N
Constipation Y P N
Ulcer Y P N
Black or Tan stools Y P N
Need to eat frequently Y P N
Fatigue after eating Y P N

Name _____

Mouth and Throat

Frequent sore throat Y P N
Sore tongue Y P N
Sores on mouth/lips Y P N
Gum problems Y P N
Hoarseness Y P N
Dental problems Y P N
TMJ problems Y P N
Grinding of teeth Y P N

Neck

Swollen glands Y P N
Pain or stiffness Y P N

Urinary

Pain on urination Y P N
Increase frequency Y P N
Frequency at night Y P N
Inability to hold urine Y P N
Bladder infections Y P N
Kidney stones Y P N
Incontinence Y P N
Change in urine appearance Y P N

Musculoskeletal

Joint pain or stiffness Y P N
Broken bones Y P N
Muscle cramps Y P N
Weakness Y P N
Joint swelling Y P N
Back pain Y P N

Immune System

Chronic cold/flu Y P N
Cancer or pre-cancerous lesions Y P N

Men

Sexual Orientation
men ___ women ___ both ___
Hernia Y P N
Vasectomy Y P N
Fertility problems Y P N
Testicular/scrotal pain Y P N
STD's Y P N
Prostate problems Y P N
Genital lumps/swelling Y P N
Penile discharge Y P N
Change in sex drive Y P N
Impotence Y P N

Blood

Anemia Y P N
Easy bleeding or bruising Y P N

Circulation

Deep leg pain Y P N
Cold hands/feet Y P N
Varicose veins Y P N
Sleep propped with pillows Y P N

Neurologic

Fainting/Blackouts Y P N
Seizures Y P N
Paralysis Y P N
Muscle weakness Y P N
Numbness or tingling Y P N
Loss of memory/Forgetful Y P N
Tremors Y P N
Dizziness Y P N
Poor balance/Clumsiness Y P N
Poor concentration Y P N
Nerve damage/Frostbite Y P N
Insomnia Y P N
Childhood hyperactivity Y P N

Endocrine

Thyroid Problems Y P N
Intolerance to hot/cold Y P N
Hypoglycemia Y P N
Excessive thirst Y P N
Excessive hunger Y P N
Easy weight gain Y P N
Easy weight loss Y P N

Emotional

Depression Y P N
Mood swings Y P N
Anxiety/Nervousness Y P N
Eating disorder Y P N

Breasts/Chest/Armpit (men and women)

Examine regularly Y P N
Lumps Y P N
Pain or tenderness Y P N
Armpit lumps Y P N
Nipple discharge Y P N

Women

Sexual orientation
men ___ women ___ both ___
Hernia Y P N
PMS Y P N
Hot flashes Y P N
Vaginal dryness Y P N
Pain with intercourse Y P N
Urethral/vaginal discharge Y P N
Change in sex drive Y P N
Sexual difficulties Y P N
Fertility problems Y P N

Name _____

FOR WOMEN ONLY

Age at first period. _____ Age at last period. _____

	Within the last year	In the past
How long do you flow?	_____	_____
Is your flow light, medium, or heavy?	_____	_____
Do you have cramping with periods?	_____	_____
Do you spot between periods?	_____	_____
Are your periods regular?	_____	_____
Do your periods change with stress?	_____	_____
Length of cycle? (<i>example: 27 days</i>)	_____	_____

When did you last have:

_____ complete pelvic exam _____ mammogram Do you examine your breasts? Yes/No
_____ pap smear _____ pelvis ultrasound If yes, how often do you examine them?
_____ breast exam monthly sometimes rarely

Did your mother ever take DES? __Y __N

Have you ever been pregnant? _____ If yes, how many times? _____ Please list by date:
Deliveries _____ Miscarriages/Abortions _____
Were there any problems with any pregnancy, delivery, miscarriage or abortion? _____

Have you had any babies under 6 pounds or over 9 pounds? _____ If yes, how many? _____
Did you breast feed? __Y __N How long each child?(*list dates*) _____

Have you ever had any of the following?

_____ Abnormal pap smears	_____ Uterine fibroids
_____ Breast implants	_____ Pelvic Inflammatory Disease (PID)
_____ Cautery/ cryosurgery/ laser surgery or conization of the cervix	_____ Urinary tract (bladder/kidney) infection
_____ Colposcopy	_____ Vaginal infection
_____ Sexually Transmitted Diseases (STD)	_____ D and C
_____ Cervicitis	_____ Hysterectomy
_____ Endometriosis	_____ Laparoscopy
_____ Ovarian cysts	_____ Tubal ligation
_____ Breast cysts	_____ Cancer (ovarian, uterine, cervical or breast)
	_____ Abnormal bleeding

Do you use birth control now? _____ What type? _____
If no, is it because you: _____

Please list the methods you have used in the past, brands, dates used and reasons for stopping:

Have you ever used Hormone Replacement Therapy? (*either estrogen or progesterone*) __Y __N
IF yes, list types, dose and length of time. _____