

New Patient Intake Form

Please fill this out entirely and bring it with you to your first office visit.

Name _____ Date _____ SSN _____

Address _____ City _____ State _____ Zip _____

Phone (H) _____ (C) _____ Email _____

Date of Birth _____ Age _____ Sex _____ Occupation _____

Employer _____ Hrs per Week _____ Live alone?

How did you hear about us? _____

Emergency Contact _____ Phone _____

Our Clinic or individual health care providers will call patients at times, and we wish to ensure your privacy regarding treatment at our clinic. In the event that we are unable to reach you by phone, **please indicate where it is appropriate to leave messages for you:**

Home message machine With family members At work Never leave messages

Other instructions _____

What are your primary health concerns? List as many as you can, in the order of their importance to you.

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

What are the primary expectations you have for your visit today to our clinic?

- 1) _____
- 2) _____
- 3) _____

Is this your first visit to a Naturopathic Physician? _____ Acupuncturist? _____
Homeopath? _____ if no, which remedies have you taken in the past

General Information:

Height _____ Weight _____ Weight 1 yr ago _____ Max weight _____ When _____

When during the day is your energy and alertness best? _____ Worst? _____

Blood type _____

Primary interests and hobbies _____

Primary form of exercise, if any _____

How often _____

Family History: Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.

- | | | | |
|--------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> HighCholesterol | <input type="checkbox"/> MS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Grave's | <input type="checkbox"/> Lupus (SLE) | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness | |

Please list other significant family medical history not listed above:

Are you currently receiving health care? If yes, where and from whom? Please provide contact information (phone and address) if available. If not, when was the last time you received medical care and why?

Which of the following childhood illnesses have you had?

- Diphtheria
- Measles
- Scarlet Fever
- German Measles
- Mumps
- Rheumatic Fever
- Chickenpox
- Other : _____

Which immunizations have you had. If you don't know if you've had one, place a question mark beside it.

- Diphtheria
- Measles/Mumps/Rubella (MMR)
- Meningitis
- Polio
- Tetanus
- Chickenpox
- Hepatitis A/B/C
- Pertusis
- Flu
- Other: _____

Which diagnostic studies have you had?

- Electrocardiogram (EKG)
- X-Ray
- Bone Density Scan (DEXA)
- CT Scan
- Electroencephalogram (EEG)
- Mammogram
- MRI
- Other: _____

Are you aware of having allergies to any of the following? If so, describe your reaction to each one:

Drugs: _____
Foods: _____
Chemicals/Perfumes: _____
Animals: _____

Which medications, *either by prescription or over-the-counter*, are you taking or have you taken in the past 6 months?

- Laxatives
- Pain Relievers
- H2 Blockers/Ulcer Medication
- Antacids
- Cortisone/Predisone
- Appetite Suppressants
- Antidepressants
- Antibiotics
- Tranquilizers
- Thyroid medication
- Cholesterol-lowering medication
- Sleeping medication
- Other: _____

Please list, by name, any prescription medications you currently take, over-the-counter medications, and all vitamins/supplements/herbs you take regularly at this time. Include dosage, if known. *Note: Please bring each of these with you to your first office visit.*

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

(continue on back if necessary)

Assessing the Areas of Your Life

In assessing your health, it is helpful to have some sense of the degree of satisfaction you feel in various areas of your life. Using the scales below, please rate yourself in terms of satisfaction and dissatisfaction. Number 1 means you are very dissatisfied or stressed. Number 10 means you are very satisfied or comfortable.

Friends & Family

0 1 2 3 4 5 6 7 8 9 10

Physical Environment

0 1 2 3 4 5 6 7 8 9 10

Health

0 1 2 3 4 5 6 7 8 9 10

Career

0 1 2 3 4 5 6 7 8 9 10

Relationships/Romance

0 1 2 3 4 5 6 7 8 9 10

Recreation

0 1 2 3 4 5 6 7 8 9 10

Money

0 1 2 3 4 5 6 7 8 9 10

Personal Growth/Spirituality

0 1 2 3 4 5 6 7 8 9 10

Y (Yes) or N (No)	Y or N	Y or N
6-8 hours of sleep nightly		Treated for drug/alcohol dependency?
Sleep Well?		If yes, when?
Awaken Rested?		Drink alcohol?
In a supportive relationship?		Use tobacco? If so,
Contraception? Type?		how many packs daily: ____ How many
Suffered recent (past 3 years) life trauma		How many years: ____
History of abuse		Enjoy your work?
Use recreational drugs?		Take vacations?
Watch TV? Hours daily ____		Drink tea? type? amount?
Read? Hours daily ____		Drink coffee? type? amount?
Eat 3 meals daily?		Drink soda/cola ?
Eat out more than 3 times weekly?		Use products with Nutrasweet?
Go on diets more than twice yearly?		Splenda? Sweet&Low? Other?
		Add sugar/salt to food?

Review of Systems

In this section, circle if you have the symptom currently or if you have experienced it in the past 6 months. Some questions are yes/no, in which case circle to indicate "yes."

Mental/Emotional

Treated for depression
Mood swings
Considered/Attempted suicide
Poor concentration
Depression
Anxiety or nervousness
Tension
Memory problems

Immune

Chronic fatigue syndrome
Swollen glands
Reaction to vaccines
Ongoing infections

Slow wound healing
Colds/flu more than once yearly

Neurological

Seizures
Muscle weakness
Loss of memory
Vertigo/dizziness
Paralysis
Numbness or tingling
Easily stressed
Involuntary shaking or unsteadiness in hands

Endocrine

Hair loss
Brittle nails
Excessive thirst
General fatigue
Fatigue after meals
Heat intolerance
Cold intolerance
Excessive hunger
Seasonal depression

Ears

Impaired hearing
Earaches
Ringing
Itching inside or outside
Frequent popping

Head

Headaches
Migraines
Head injury
Jaw pain/TMJ

Nose and Sinuses

Frequent head colds
Stuffiness
Sinus pain
Nose bleeds

Eyes

Spots in vision
Blurriness
Color blindness
Double vision
Cataracts
Eye pain/strain
Uncomfortable tearing or dryness
Glaucoma

Mouth and Throat

Frequent sore throat
Teeth grinding
Gum bleeding/pain/disease
Dental cavities

Copious saliva
Sore tongue/lips
Hoarseness
Jaw clicks

Neck

Lumps
Goiter/enlargement in front of throat
Pain or stiffness

Skin

Rashes
Acne, boils
Color changes
Lumps
Eczema
Hives
Generalized itching
Night sweats

Urinary

Frequent infections
Unable to hold urine
Kidney stones
Splitting of stream
Pain with urination
Frequency at night; If so, how often do you wake to urinate each night __

Respiratory

Cough
Spitting of blood
Asthma
Pneumonia
Emphysema
Pain on breathing
Shortness of breath at night
Shortness of breath daily
Shortness of breath lying down
Lung congestion/sputum
Wheezing
Bronchitis
Pleurisy
Difficulty breathing

Difficult taking a full deep breath

Cardiovascular

Heart disease
High blood pressure
Low blood pressure
Blood clots
Phlebitis
Rheumatic fever
Ankle swelling
Angina/chest pain
Heart murmurs
Fainting
Heart palpitations/fluttering

Intestinal

Trouble swallowing
Change in thirst
Change in appetite
Nausea/vomiting
Burning pain in stomach
Jaundice
Gallbladder disease
Liver disease
Hemorrhoids
Heartburn
Abdominal pain or cramps
Excessive belching or excess gas

Stool

Constipation
Diarrhea
Black stools
Blood in stools
Bowel movement (BM) daily
How often are BMs: _____

Musculoskeletal

Joint pain or stiffness
Broken bones
Muscle spasms or cramps
Arthritis
Weakness
Sciatica

Blood/Peripheral Vascular

Easy bleeding/bruising
Deep leg pain
Varicose veins
Anemia
Cold hands
Cold feet

Male Reproduction (questions apply to lifetime, not just last 6 months)

Hernias
Prostate disease
Are you sexually active?
Impotence
Premature ejaculation
Use condoms
Testicular masses or pain
Discharge or sores on penis
Chlamydia
Gonorrhea
Condyloma/genital warts
Genital herpes
Syphilis

Female Reproduction (questions apply to lifetime, not just last 6 months)

Age at first menses (period)
Age of last menses (if menopausal)
Usual length of cycle (blood flow to next blood flow) _____
Irregular Cycles
Painful Menses
Heavy flow
Light flow
Bleeding/spotting between periods
Clotting
Discharge
PMS
Menopausal symptoms
Endometriosis
Ovarian cysts
Date of last annual exam/Pap _____

Sexually active
Pain during intercourse
Use of birth control; if so, what type
Difficulty conceiving
Cervical dysplasia
Sexual difficulties
Gonorrhea
Genital herpes
Chlamydia
Condyloma/genital warts
Syphilis
Regular self breast exams
Breast pain/tenderness
Breast lumps
Nipple discharge
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____

Are there any other health concerns that you have which have not been covered in this questionnaire?

Signature

Date