

New Patient Intake Form

Welcome! Holistic health care and preventive medicine are only possible when the doctor has a complete understanding of your health history. Please fill out this questionnaire as thoroughly as possible. Print all information clearly and mark anything you don't understand with a question mark. All information contained in these pages is completely confidential.

Personal Information

Name _____ Today's Date: ___/___/___
___ Female ___ Male Age _____ Date of birth ___/___/___
Phone: Home (____) _____ Work (____) _____ Mobile (____) _____
Preferred ___ Home ___ Work ___ Mobile Is it OK to leave messages? ___ Yes ___ No
Address _____ Apt # _____
City _____ State _____ Zip Code _____
Email address _____
Are you interested in receiving email notifications of classes and lectures? ___ Yes ___ No

If the patient is under the age of 18:

Name of mother _____ Phone number _____
Name of father _____ Phone number _____

Who may we thank for your referral? _____
Have you been to a Doctor of Naturopathic Medicine before? ___ If so, when? _____
Under what circumstances? _____
When did you last receive medical care? _____
Where? _____ Why? _____

What is your most important reason for making this appointment? _____

Please list other medical concerns, in order of importance: _____

Emergency Contact

Name _____
Relationship _____
Phone Number Day (____) _____ Evening (____) _____
Address _____ Apt # _____

Health History

Please list any known allergies (environmental, drug, food): _____

Do you take any of the following over-the-counter medications? Please check any that apply:

___ Aspirin ___ Ibuprofen or acetaminophen ___ Antihistamine ___ Sleeping pills
___ Laxatives ___ Appetite depressants ___ Antacid ___ Medicine to stay awake

Please list any pharmaceutical and natural medications (including vitamins) that you are taking or have taken in the last year:

Medication	Dosage	Dates	Reason for taking

If any of the following apply to you, please indicate dates:

Hospitalization _____	Endoscopy _____
Surgery _____	Colonoscopy _____
X-ray _____	Mammogram _____
MRI _____	CT scan _____
Rectal exam _____	Bone Scan _____
Electrocardiogram _____	Other _____

For the following conditions and symptoms, please indicate any that apply to you by marking "C" for current or "P" for past:

<input type="checkbox"/> Skin rash	<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Easy bleeding or bruising	<input type="checkbox"/> Weakness	<input type="checkbox"/> Heart palpitations
<input type="checkbox"/> Varicose veins or hemorrhoids	<input type="checkbox"/> Dizziness or fainting	<input type="checkbox"/> Atherosclerosis
<input type="checkbox"/> Bone or joint disease	<input type="checkbox"/> Numbness / tingling / paralysis	<input type="checkbox"/> Gastrointestinal disorder
<input type="checkbox"/> Mood swings	<input type="checkbox"/> Neurological disease	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Anxiety or nervousness	<input type="checkbox"/> Seizures	<input type="checkbox"/> Gastritis or ulcers
<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Excessive thirst / hunger
<input type="checkbox"/> Feel unsafe at home	<input type="checkbox"/> Headaches	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Head injury	<input type="checkbox"/> Eating disorder
<input type="checkbox"/> Frequent antibiotic use	<input type="checkbox"/> Dental problems	<input type="checkbox"/> Parasites
<input type="checkbox"/> Frequent colds or flu	<input type="checkbox"/> Cold sores	<input type="checkbox"/> Liver disease
<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Gallbladder disease
<input type="checkbox"/> Lyme disease	<input type="checkbox"/> Impaired hearing / vision	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Problems with urination
<input type="checkbox"/> Vaccinations	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Sexual difficulties

When and where are your symptoms worse? At home At work Upon waking
 Morning Afternoon Evening Overnight No pattern Other

Family History

If you or anyone in your immediate family has or had any of the following conditions, please indicate who was affected (self, mother, father, sister, brother, child):

Cancer _____	Diabetes _____
Heart Disease _____	Asthma, hay fever, rashes _____
Stroke _____	Osteoporosis _____
High blood pressure _____	Depression _____
Alcoholism or substance abuse _____	Autoimmune disease _____
Attempted suicide _____	Other _____

For Men Only

Please check all that apply to you:

- Prostate exam _____ / _____ / _____
 Regular self testicular exam
 Impaired fertility
 Sexual abuse

- Abnormal discharge from penis
 Pain or lump in scrotum
 Prostate problem
 Sexually transmitted infection

For Women Only

- Last menses _____ / _____ / _____
Last pap smear _____ / _____ / _____
Age menses began _____
Number of pregnancies _____
Number of live births _____

If you are still having periods:

- Average number of days of bleeding _____
Average number of days in cycle _____
Bleeding is Regular Irregular
 Light Medium Heavy
Symptoms Bleeding b/n periods Mood swings
 PMS Painful menses Breast tenderness

If you are no longer having periods:

- Hot flashes Vaginal dryness
 Dry skin Changes in memory
 Spotting Changes in libido
 Facial hair Changes in mood
 Hair loss Hormone replacement therapy
 Incontinence Urinary tract infections

Please check all that apply to you:

- Hysterectomy _____ / _____ / _____
 Abnormal pap smear
 Breast pain / lump / nipple discharge
 Sexual difficulties
 Frequent vaginitis / chronic yeast infections
 Abnormal vaginal discharge
 Endometriosis
 Polycystic ovary syndrome
 Sexually transmitted infection
 Pelvic inflammatory disease
 Uterine fibroids
 Impaired fertility
 Sexual abuse
 Regular self breast exam
 Sexually active
 Use methods to prevent pregnancy and/or sexually transmitted infections:
Current _____
Past _____

Lifestyle History

Please check any that apply to you and fill in corresponding details:

- Exercise _____ hours per week
Activities _____
 Watch TV _____ hours per week
 Tobacco use _____ packs per day
 Alcohol use _____ drinks per week
 Recreational drug use
 Mercury amalgam fillings
 Employed outside the home
Occupation _____
Hours per week _____
Employer _____
Do you enjoy your work? Yes No
Level of stress Low Average High
 Toxic exposure _____
 Major life change in last year _____
- Height _____
Weight _____
Weight one year ago _____
Maximum weight _____
When? _____
Sleep _____ hours per night
Is this enough? Yes No
Meals per day _____
Bowel movements per day _____
Dietary restrictions _____

The above information is true to the best of my knowledge.

Signature (Parent or guardian if patient is under 18 years old)

_____/_____/_____
Date