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NEW PATIENT INTAKE FORM

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.

Once completed please fax or email to our office prior to your first visit.

PATIENT INFORMATION

Name (First, Last) ________________________________Middle Initial____ Today's Date ___/___/___

Date of Birth ____/____/___ Age___ Phone: Mobile _________________ Home __________________

Address ____ Apt # ______

City _______________________________________State ____________________Zip Code __________

Email Address ____

Relationship Status (check and circle) ____Married / Partnered ____Single / Widowed ____ Divorced/Separated

Live with ____Spouse ____Partner ____Children ____Alone ____Friend ____Parents ____Roommate

Emergency Contact _______________________________Phone _______________ Relationship __________

How did you hear about us? ____

EMPLOYMENT INFORMATION

Employer ____ Position ________________________________

Address ____ Phone ________________________________

PAYMENT AND CANCELLATION POLICY

I understand that I am financially responsible for all charges and that payment is due in full at time of service.

Last minute cancellations of scheduled appointments are difficult to fill and costly. Therefore, we ask that cancellations be made at least 24 hours to your appointments. Appointments missed or cancelled in less than 24 hours will incur a $50 charge.

I have read the payment and cancellation policy and accept responsibility for payment. Initial _____

CONFIDENTIALITY

You have the right to confidentiality when receiving care. We will not disclose medical information to anyone unless directed to do so in writing by you. If you would like us to be able to leave messages regarding your health care on an answering machine or with another person, please list below and indicate which voice mail we may leave messages on:

Preferred # ______________________

Name & Relationship of person with whom to leave information: ____

PATIENT SIGNATURE ____ DATE ________________

What are your most important health concerns? Please list in order of importance.

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Have you been treated by a Naturopathic Doctor before? ____Yes ____No If so, when? __________________

When did you last receive medical care? _________________ Where? ___________________________________

Why? ____

When was your last blood work? __________________ What was ordered? ______________________________

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

Hospitalization(s)____

Surgeries____

Accidents ____

X-ray____ Mammogram ________________________________

MRI____ CTScan ____________________________________

Electrocardiogram_________________________________ BoneScan/DEXA/Density______________________

Endoscopy____ Colonoscopy ________________________________

Other____

Please list any pharmaceutical and/or natural medications (including vitamins) that you are taking:

Medication or Supplement	Dosage	How Long	Reason For Taking

Allergies

Medications____

Foods ____

Herbs, vitamins, environmental, animals, other ____

____

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

____Aspirin ____Ibuprofen (Advil) or acetaminophen (Tylenol) ____Antihistamine ____Sleeping pills
____Laxatives ____Appetite depressants ____Antacids ___Medicine to stay awake

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
High Blood Pressure	Mental Illness
Stroke	Osteoporosis
Alcoholism	Autoimmune Disease
Liver Disease	Kidney Disease
Hormone/Thyroid Disease	Other

Please check the box that are CURRENT or RECENT problems for you and fill in the blanks where appropriate.

Current Weight ______ Weight 1 year ago _____ Maximum Weight _______ When ______ Height ________

□ Fatigue / tiredness □ Night sweats □ Weight problem □ Appetite changes □ Fever □ Temperature extremes

□ Frequent colds or flu □ Frequent antibiotic use

SKIN

□ Rash □ Infection □ Growths/bumps □ Hair or nail problems □ Itching □ Thinning/sensitive skin □ Acne

□ Oily skin □ Dry skin

HEAD

□ Frequent Headaches □ Migraines □ Head Injury □ Light-headedness □ Hair loss/thinning

EYES

□ Vision problems □ Eye Pain □ Double vision □ Floaters/spots □ Eye redness □ Watery eyes

EARS

□ Hearing loss □ Ringing □ Ear ache □ Dizziness □ Itchy ears □ Hearing aids

NOSE / SINUS

□ Frequent colds □ Nose bleeds □ Sinus problems/discharge □ Hay fever/allergies □ Loss of smell □ Snoring

MOUTH / THROAT

□ Frequent sore throat □ Hoarseness □ Sore tongue □ Mouth sores □ Dental problems □ Phlegm

NECK

□ Swollen Glands □ Enlarged thyroid □ Pain or stiffness □ Trouble swallowing □ Neck pain

RESPIRATORY

□ Cough □ Sputum □ Wheezing □ Shortness of Breath (SOB) □ Lying down (SOB) □ With activity (SOB)

□ Night time (SOB)

HEART

□ Heart disease □ Chest Pain /discomfort □ Angina □ High blood pressure □ Heart Murmurs

□ History Rheumatic fever □ History heart attack □ History stroke / TIA □ Swelling in the ankles

□ Palpitations, fluttering

CIRCULATORY

□ Deep leg pain □ Cold hands/feet □ Leg swelling □ Varicose veins □ Thrombophlebitis □ Thrombosis

BLOOD

□ Anemia □ Easy bleeding or bruising □ Excessive clotting □ Paleness □ Thin brittle nails

DIGESTION

□ Nausea □ Vomiting □ Vomiting blood □ Belching or passing gas □ Abdominal pain □ Jaundice (yellow skin)

□ Liver disease □ Family/personal history colon cancer, polyps

Bowel movements How often? _______________ Is this a change? ____________

□ Blood in stool □ Black/tarry stools

MUSCULOSKELETAL

□ Joint pain or stiffness □ Arthritis □ Broken bones □ Muscle spasms /Weakness □ Osteoporosis

□ Bone or joint disease □ Chronic Pain

NEUROLOGIC

□ Fainting □ Seizures □ Paralysis □ Muscle weakness □ Numbness or tingling □ Loss of memory □ Lyme disease

EMOTIONAL

 Depression Mood Swings Anxiety/nervousness Tension Sleep problems Phobias Suicidal thoughts
 Alcohol / drug dependency

ENDOCRINE

 History of thyroid problems Diabetes Low blood sugar High blood sugar Excessive thirst or hunger

 Weight gain Weight loss Sugar cravings Swelling / edema Abnormal hair growth Difficulty perspiring

 Heat or cold intolerance Rapid aging Loss of muscle mass

FEMALE URINARY/ REPRODUCTION

1st day of last menses _________Last Pat Smear ___________ Age menses began? _______

Average number of days of bleeding? ____ Average length of cycle? ___

 Spotting Excessive flow Are cycles regular? Painful menses Excessive flow Difficulty conceiving

Number of pregnancies ____ Number of live births _____ Number of miscarriages ____

 Sexually active Sexual difficulties Painful intercourse

Birth Control, type Current and past _______________________________

 Poly cystic ovary syndrome Endometriosis Uterine fibroids / polyps Abnormal vaginal discharge PMS

 Breast tenderness Mood swings Irritability Weight Gain Bloating Other: __________

PERI / MENOPAUSE / OTHER
 Hot flashes Dry skin Spotting Facial hair Hair loss Incontinence Vaginal dryness

 Vaginal infections Change in memory Change in libido Change in mood Urinary tract infections

 Weight gain Insomnia Hormone Replacement Therapy when / type:______________

 Hysterectomy, date ______

BREAST
Do you do self-exam Y N
 Lumps Pain or tenderness Nipple discharge Breast Cancer or Family History

MALE URINARY/ REPRODUCTION

 Pain on urination Increased frequency/urgency Dribbling Frequency at night Inability to hold urine

 Blood in Urine Frequent infections Kidney stones Cloudy / foul smelling urine Prostate inflammation

 Last prostate exam _________ Last PSA ________________ Sexually Active Erectile difficulties

 Change in libido Low / abnormal sperm Hernia Genital sores / discharge

ENVIRONMENTAL EXPOSURE

□ Toxic exposure ________________________________ □ Mercury amalgams (fillings in teeth) # _______

LIFESTYLE HISTORY

Exercise ___________ hours per week Types of Exercise ____________________________

Meals per day ___________________ Dietary Restrictions __________________________

Watch TV __________ hours per week

Tobacco use ______________ per day

Alcohol use _________drinks per week

Recreational drug use ______ per week

Work ______________ hours per week Enjoy? Y N

Stress Level __Low __Medium __High

Major life change in last year ____

____

Major injury in last year ____

____

Sleep ___________ hours per night Is this enough? Y N Awaken rested? Y N

Spend time outside? Y N Take vacations? Y N

Please provide any other information not requested above that you feel may be relevant to this evaluation.

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