East Valley Naturopaths

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Patient Intake Form

Name:_____ ____/____/____
(Last) ***(First)*** ***(Your Date of birth)***

List in Order of importance what your problems are:

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

Last time you had blood work done and with what physician: _____

_____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when died:						
Reason for death:						
Cancer type:						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Please Note IF, When & Why You Have Had Each of the Following:

X-Rays: _____ MRI/Cat Scans: _____
Ultrasounds: _____ Accidents: _____
TB Test: _____ Mammogram: _____
HIV: _____ Last Dental Visit: _____
Last Eye Exam: _____

Did you have the following **D**isease (**D**), VACCINES **(V),** or **N**either (**N**):

Measles: D V N **Chicken Pox**: D V N **Mumps**: D V N **Rubella**: D V N

Tetanus: D V N **Whooping Cough**: D V N **Hemophilus (Hib)**: D V N **Hepatits B**: D V N

German Measles: D V N **COVID:**_____ **Any vaccination reactions:** _____

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Antacids: Y N P **Steroids**: Y N P **Tobacco:** Y N P **Number of years**: _____

Analgesics: Y N P **Laxatives**: Y N P **Coffee**: Y N P **Cups per day if Yes/Past**: _____

Soda Pop: Y N P **Ounces per day if Yes/Past**: _____

Alcohol: Y N P **How often & how much if Yes/Past**: _____

Any Alcohol Addiction: Y N P **Any Alcohol Treatment**: Y N P

Recreational Drugs: Y N P **Any Drug Addictions**: Y N P

Any Drug Treatment: Y N P

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and include dosage if known:

_____

_____

_____

Review of Systems:

Present Weight: _____ **Weight one year ago**: _____ **Height**: _____

Maximum weight and when: _____ **Minimum weight as adult & when**: _____

Ideal Weight: _____ **GENDER**: M F **Identifying as**:_____

Good Energy: Y N

Fatigue: Y N

If you have fatigue, when in morning, afternoon, evening is it the worst? _____

If you have fatigue, can you do what you need to during the day? Y N

REGARDING THE NEXT LONG SECTION: Please circle (**Y)** if you have the problem **NOW**, (**N)** if you've **NEVER** had the problem, (**P)** if you had the problem in the **PAST**.

SKIN				
Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
Cancer:	Y N P		**Perspiration:**	Y N P
HEAD				
Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
Oil/dry hair:	Y N P		**Hair loss:**	Y N P

NOSE					
Frequent Colds:	Y N P			**Nosebleeds:**	Y N P
Congestion:	Y N P			**Post Nasal Drip:**	Y N P
Polyps:	Y N P			**Seasonal Allergies:**	Y N P
EYES					
Dry/Watery:	Y N P			**Blurry Vision:**	Y N P
Double Vision	Y N P			**Cataracts:**	Y N P
Glaucoma:	Y N P			**Styes:**	Y N P
Strain:	Y N P			**Discharge:**	Y N P
Itchy:	Y N P			**Dark under Eyelid:**	Y N P
MOUTH/THROAT					
Canker sores:	Y N P			**Cold sores:**	Y N P
Sore Throat:	Y N P			**Gum disease:**	Y N P
Dentures:	Y N P			**Cavities:**	Y N P
Loss of taste:	Y N P			**Hoarseness:**	Y N P
NECK					
Stiffness:	Y N P			**Swollen Glands:**	Y N P
Full movement:	Y N P			**Tension:**	Y N P
RESPIRATORY					
Cough:	Y N P			**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P			**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P			**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P			**Asthma:**	Y N P
Wheezing:	Y N P			**Painful breathing:**	Y N P
CARDIOVASCULAR					
High Blood Pressure:	Y N P			**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P			**Murmurs:**	Y N P
Arrhythmias:	Y N P			**Palpitations:**	Y N P
Edema:	Y N P			**Chest Pain:**	Y N P
GASTROINTESTINAL					
Heartburn:	Y N P			**Bowel Movement Freq:**	
Indigestion:	Y N P			**Recent BM Change:**	Y N P
Bloating:	Y N P			**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P			**Hemorrhoids:**	Y N P
Vomiting:	Y N P			**Gall Bladder Disease**	Y N P
Change in Appetite:	Y N P			**Liver Disease:**	Y N P
Pancreatitis:	Y N P			**Ulcer**	Y N P

URINARY TRACT

Incontinence:	Y N P	**Pain w/ Urination**	Y N P
Frequent Infections:	Y N P	**Kidney Stones**	Y N P
Urgency:	Y N P	**Discharge/Blood:**	Y N P

MALE GENITALIA

Testicular pain/swelling:	Y N P	**Sexually Active:**	Y N P
Hernia:	Y N P	**S.T.D.:**	Y N P
Discharge:	Y N P	**Prostate Disease/Symptoms:**	Y N P
Impotency:	Y N P	**Sexual Orientation:**	Hetero Homo Bi

FEMALE GENITALIA

Age Period Began:		**How Often Period Occurs:**	
How long period lasts:		**Heavy menstrual bleeding:**	Y N P
Menstrual cramping:	Y N P	**Menstrual Pain:**	Y N P
PMS:	Y N P	**Food cravings:**	Y N P
Times Pregnant:		**How many births:**	
Miscarriages:		**Abortions:**	
Last Pap Smear:		**Diagnosis:**	
Any abnormal paps:	Y N P	**When was abnormal:**	
Menopausal since what age:		**Use of hormones:**	Y N P
Type of hormones used:		**Healthy libido:**	Y N P
Dry vagina:	Y N P	**Sexually Active:**	Y N P
Pain w/ Intercourse:	Y N P	**Vaginitis:**	Y N P
S.T.D.:	Y N P	**Mammography:**	Y N P
Dexa Scan:	Y N P	**If Yes, what were results:**	
Sexual Orientation:	Hetero Homo Bi	**Birth Control type and ages used:**	

MUSCULOSKELETAL

Weakness:	Y N P	**Arthritis:**	Y N P
Stiffness:	Y N P	**Leg Cramps:**	Y N P
Tremors:	Y N P	**Pain:**	Y N P

NERVOUS

Paralysis:	Y N P	**Sciatica:**	Y N P
Tingling/numbness:	Y N P	**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P	**Fainting:**	Y N P

Mental/Emotional

Depression:	Y N P	**Anger/irritability:**	Y N P
Suicidal:	Y N P	**High-strung/tense:**	Y N P
Anxiety:	Y N P	**Fear/Panic**	Y N P

Exercise

How often do you exercise? _____ **What type of exercise**? _____

For how long? _____ **Hobbies**: _____

_____

Sleep

How long per night? _____ **If you wake up frequently, what is the reason**? _____

Nightmares: Y N P **Wake Refreshed**: Y N P **Must nap during the day**: Y N P

Sleep walk: Y N P **Grind teeth**: Y N P **Snore**: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

_____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

_____

Social Life

Enjoy job: Y N P **Hours worked per week**: _____ **Highest Level of Education**: _____

Active spiritual practice: Y N P **Quality of significant relationship**: _____

History of sexual, mental/emotional, physical abuse: Y N **P** **If so, at what age and by whom**: _____

What is your greatest health concern: _____

How does it limit you the most: _____

How committed are you towards making valuable changes: ☐ Little ☐ Moderately ☐ Very

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

_____

Allergies

List all known Allergies (food, drugs, environment): _____

_____

_____