Treating the Root Cause

Lindsay Samuelson ND, MRN

Harmony in Life Center
5747 Main Street. Sylvania, Ohio 43560
email: DRLINDSAYSAMUELSON@GMAIL.COM
419-250-1110

Patient Intake Form

Please fill out this form to the best of your ability and bring it with you to your first visit.

Name: _____ DOB: _____ Age: _____ Today's Date: _____

Address**:**_____City/State/Zip:_____

Contact Phone: _____ Email: _____

Gender ID: _____ Height: _____ Weight: _____ Max Weight: _____ When? _____

Parent/Legal Guardian Name (if underage): _____

Please List in order of importance your chief complaints:

1. _____

2. _____

3. _____

4._____

Medications, Herbs and Supplements: (include over-the-counter, antibiotics, and other current prescription medications. Any previous medications, herbs and supplements may also be added on a separate sheet. Especially those that may have caused adverse reactions.

Medication/Supplement **(please indicate BRAND NAME supplements, may use separate page if needed)**	Dose	Frequency	Reason	Date Began

Medical Coordination:
Current GP: _____Duration with GP_____ Last Visit _____

Current/Previous other practitioners you have seen for your chief complaints. Use back of page if needed

Name:
1. _____ Treatment:_____ Began:_____

2. _____ Treatment:_____ Began:_____

3. _____ Treatment:_____ Began:_____

4. _____ Treatment:_____ Began:_____

Family History- use back of this page for additional family members

Relative	Age	Deceased If deceased, state cause of death	Health Challenges (i.e. alcoholism, allergy, arthritis, asthma, dermatological, diabetes,cancer, cardiovascular, epilepsy, gastrointestinal, genetic, kidney, neurological, psychological, respiratory)
Mom			
Dad			
Siblings:			
Grandparents			
Aunts and Uncles			
Children			

Health History: Do you or have you ever experienced any of the following conditions?

CONDITION	?	DETAILS
Addiction		
Anemia		
Antibiotic treatment (chronic)		
Arthritis		
Asthma		
Atelectasis/Bronchitis		
Autoimmune Disorders		
Breast Pain/Lumps		
Cancer		
Candida/Fungal over-growth		
Chicken Pox		
Chronic Fatigue Syndrome		
Chronic Diarrhea		
Constipation		
Crohn's Disease		
Croup		
Depression		
Dental Work		
Diabetes		
Diptheria		
Ear Conditions		
Eczema		
Emphysema		
Encephalitis		
Endometriosis (if female)		

Convulsions, Seizures		
Eye Symptoms		
Fibroids (if female)		
Gallbladder Disorders		
Gastric Upset		
Gestational Diabetes		
Gout		
Headaches/Migraines		
Heart Attack/Angina		
Heart Infection		
Heart Disease		
Hepatitis/Liver Disease		
Herpes I/II		
Hyperlipidemia		
High Blood Pressure		
HIV/AIDS		
Irritable Bowel Syndrome		
Kidney Problems		
Libido/Sexuality issues		
Measles		
Meningitis		
Menstrual Disorders		
Mental Disorders		
Mononucleosis		
Mouth Problems		
Mumps		
Musculoskeletal Pain		

Nightmares		
Pertussis		
Pleurisy		
Pneumonia		
Pregnancy Complications		
Prostatitis (if male)		
Psoriasis		
Rheumatic Fever		
Rubella		
Scarlet Fever		
STD's		
Sinusitis		
Sleep Apnea		
Strep Throat		
Stroke		
Thyroid Imbalance		
Tonsillitis		
Ulcerative Colitis		
Other (please describe)		

Diagnosed Illnesses: Please list all diagnosed conditions below:

Condition	Year of Diagnosis	Resolved? Yes /No
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Screening Tests
Please indicate which of the following you have either received or refused

Lab Test	Circle one	Test Date	Results (if abnormal)
PAP test (women)	Yes No		
Breast Exam	Yes No		
Mammogram	Yes No		
DEXA scan	Yes No		
Digital Rectal Exam (men)	Yes No		
Colonoscopy	Yes No		
PSA test (men)	Yes No		
Cholesterol/Lipid Panel	Yes No		
Blood Glucose	Yes No		
Complete Blood Count	Yes No		
Electrocardiogram (ECG)	Yes No		
Eye Examination	Yes No		
Liver Function Tests	Yes No		
Kidney Function Tests	Yes No		
Respiratory Tests	Yes No		
X-Ray	Yes No		
Ultrasound	Yes No		
Endocrine/Hormone	Yes No		

Will you be submitting your own printed copies of the labs? _____
LAB TESTS TO BE SUBMITTED AT INITIAL VISIT:

Or
Do you prefer us to retrieve them through your Promedica or Mercy Medical Records Patient Portal? ($15.00 admin fee)
PATIENT PORTAL WEBSITE ADDRESS: _____
PASSWORD: ($15.00 admin fee)

Are you satisfied in your work?(circle one): YES KIND OF NOT REALLY NO

Marital Status: _____ Children? (Please state ages) :_____ Grandchildren? _____

Are you satisfied with your life circumstances? YES KIND OF NOT REALLY NO

Hobbies:
1. _____
2. _____
3. _____
4. _____

Occupation: _____ Hours per week: _____

How many alcoholic drinks do you consume weekly? _____

Do you use tobacco or recreational drugs? _____

Do you feel you are exposed to unhealthful toxicants in your daily life? _____

Have you had any minor or major conditions or procedures? _____

Of these, are there any which you feel you have never fully recovered? If yes, please explain (use back if necessary):

_____

Have you had adverse reactions to food, medication, plant, animal, vaccine or medical procedure?
☐Yes ☐No

_____

Please state any known allergies/hypersensitivities: _____

Please circle what you consider to be your current stress level (0 none, 10 extremely stressful):

0—-1—-2—-3—-4—-5—-6—-7—-8—-9—-10

How would you describe your general state of health? (please circle one)
excellent —- good —— fair —— poor

Choose 3-5 Symptoms that you would like to see improved. Next to the symptoms indicate how you currently rate the intensity of this problem. (For instance: Sinusitis 6/10):

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

How did you hear about Dr. Samuelson? _____

☐ Check here if you do NOT wish to receive periodic newsletters from Dr. Samuelson or the Ohio Chapter of the American Association of Naturopathic Medicine.

Finally, turn this page counterclockwise and fill out the timeline. Begin with your birthday and mark through time the impactful events you have experienced in your life.

Date of Birth:_____

Current Year: _____