Treating the Root Cause

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Patient Intake Form

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

Name: ______________________________ Date: ______ DOB: ________ Age: _____

Address:____

Contact Phone: ____________________ Email: ____________________________________

Gender: _________ Height: _______ Weight: ______ Max Weight: ________ When? _____________

Parent/Legal Guardian Name (if underage): ____

Please List in order of importance your chief complaints:

1. ____
2. ____
3. ____
4. ____
5. ____

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	Dosage	How often	Reason	Date Began

Medical Coordination:
Current GP: ________________________________Duration with GP_________ Last Visit ________

Are you currently being treated by other practitioners? Please list (use back of page if necessary)

Name:
1. ____________________________ Treatment:_____________________ Began:______________

2. ____________________________ Treatment:_____________________ Began:______________

3. ____________________________ Treatment:_____________________ Began:______________

4. ____________________________ Treatment:_____________________ Began:______________

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

Relation	Age (current or age when passed)	Deceased (✓) (if deceased, state cause of death)	Health problems (alcoholism, allergy, arthritis, asthma, dermatological, diabetes,cancer, cardiovascular, epilepsy, gastrointestinal, genetic, kidney, neurological, psychological, respiratory, etc.)
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			
Aunt/Uncle			
Aunt/ Uncle			
Children			
Children			

Have you had adverse reactions to any vaccine, medication or medical procedure? ☐Yes ☐No
If yes, please explain:

Date of Last Menstrual Period (if female):

Please list any known allergies/hypersensitivities:

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		
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)		
Epilepsy, Convulsions, Seizures		
Eye Symptoms		
Fibroids (if female)		
Gallstone/Gallbladder dis-ease		
Gastric Upset		
Gout		
Headaches/Migraines		
Heart Attack/Angina		
Heart Infection		
Heart Disease		
Hepatitis/Liver Disease		
Herpes I/II		
High Cholesterol/Triglyc-erides		
High Blood Pressure		
HIV/AIDS		
Irritable Bowel Syndrome		
Kidney Problems		
Libido/Sexual Dysfunction		

Measles		
Meningitis		
Menstrual Disorders		
Mononucleosis		
Mouth Problems		
Mumps		
Musculoskeletal Pain		
Nightmares		
Pertussis (Whooping Cough)		
Pleurisy		
Pneumonia		
Prostatitis (if male)		
Psoriasis		
Psychiatric Disorder		
Rheumatic Fever		
Rubella		
Scarlet Fever		
Sexually Transmitted Infection		
Sinusitis		
Sleep Apnea		
Strep Throat		
Stroke		
Thyroid Imbalance		
Tonsillitis		
Ulcerative Colitis		
Other (please describe)		

Screening Tests

Please indicate which of the following you receive.

Lab Test	Circle one	Date of last test (approximate)	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 (CBC)	Yes No		
Electrocardiogram (ECG)	Yes No		
Eye Examination	Yes No		
Liver Function Tests	Yes No		
Kidney Function Tests	Yes No		
Respiratory: PFT's/ Spirometry	Yes No		
X-Ray	Yes No		
Ultrasound	Yes No		
Endocrine/Hormone testing	Yes No		

Have you had any minor or major conditions or procedures, after which, you feel you have never really recovered? If yes, please explain (use back if necessary):

____

____

Are you or have you ever been a tobacco user? _____________

How many alcoholic drinks do you consume weekly? __________

Do you use recreational drugs? If so, how often? ____________

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. ____ ____________

Occupation: ______________________ Hours per week: ____________

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. ____ ____________

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

Is there anything else you feel is important to mention at this time?
____
____
____
____

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 work your way to the present day. Include significant times of your life that made an impact on you.