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._____

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 disease		
Gastric Upset		
Gout		
Headaches/Migraines		
Heart Attack/Angina		
Heart Infection		
Heart Disease		
Hepatitis/Liver Disease		
Herpes I/II		
High Cholesterol/Triglycerides		
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	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 test-ing	Yes	No		

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 individual ingredients/ dosages in supplements, may use separate page if needed)	Dosage	How often	Reason	Date Began

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 mark through time the impactful events you have experienced in your life.