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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.

_____

_____

_____

_____

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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