RR Patient Intake

Roots & Rivers® Naturopathic Medical Center

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Confidential Patient/Client Information. Feel free to skip anything that is not applicable to you. For those in WA state, you are considered a patient. Those out of state, are called clients.

Today's Date

Patient Name

First Name:

Last Name:

Date of Birth

Phone

Address

Line 1:

City:

Line 1:

Country:

State:

Zip Code:

Gender

- Male
- Female
- Other

Please specify any other consideration of inclusion (e.g. preferred pronouns, Gender Expression, Gender Identity, Assigned Sex at Birth, Race, Ethnicity, and anything else)

How did you hear about us?

Name and telephone number of Primary Care physician:

Emergency Contact, their relationship to you, their phone number

Agreement(Read Only)

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Clinic Policy requires payment at time of services.

☐ **I hereby agree to the document above.**

Patient Intake Form

List your health concerns in order of importance

1.
2.
3.
4.
5.

Allergies & Food Intolerance

Carroll Food Intolerance:

Allergies:

Food Sensitivities:

Dietary Considerations (Kosher, vegan, vegetarian, etc?):

Medications & Supplements (Open Answer)

Medications

-

Supplements:

-

Blood type (if known)

Personal Medical History

List All Surgeries & Hospitalizations, including date occurred.

1.
2.
3.
4.
5.

Family Medical History

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

X-Rays:

MRI/Cat Scans:

Ultrasounds:

Accidents:

Last Dental Visit:

SARS-COV 2 (set of symptoms are called COVID-19). If vaccinated, please list dates and product name. If had Illness, please estimate dates.

Did you have the following disease, get immunized or neither?

-	Disease	Immunized	Neither
Measles	☐	☐	☐
Chicken Pox	☐	☐	☐
Haemophilus (Hib)	☐	☐	☐
Rubella	☐	☐	☐
Tetanus	☐	☐	☐
Whooping Cough	☐	☐	☐
Mumps	☐	☐	☐
Hepatitis B	☐	☐	☐

Any vaccination reactions:

Definition of a Fever is below:

Temperature location	Average Normal Temperature	Fever
Rectal, temporal, Ear (about 0.5° higher than oral)	99.1 °F	100.4° F or higher
Oral (mouth)	98.6°F	100° F or higher
Axillary/armpit/forehead scan (about 1° lower than oral)	97.6 °F	99° F or higher

When was your last cold, flu, or fever? What temperature did you achieve?

List yes, no, or past regarding use of the following:

-	Yes	No	Past
Antacids	☐	☐	☐
Steroids	☐	☐	☐
Analgesics/NSAIDS	☐	☐	☐
Laxatives	☐	☐	☐

-	Yes	No	Past

List yes, no, or past regarding use of the following. If applicable list how much, often and long used:

-	Yes	No	Past	How much?	How often?	How long?
Tobacco	☐	☐	☐			
Nicotine	☐	☐	☐			
Chew	☐	☐	☐			
Smoking	☐	☐	☐			
Vaping	☐	☐	☐			
Coffee	☐	☐	☐			
Caffeine	☐	☐	☐			
Soda pop	☐	☐	☐			
Alcohol	☐	☐	☐			
Any alcohol addiction	☐	☐	☐			
Any alcohol treatment	☐	☐	☐			
Recreational drugs	☐	☐	☐			
Any drug addictions	☐	☐	☐			
Any drug treatment	☐	☐	☐			
Eating disorder	☐	☐	☐			
Any eating disorder treatment	☐	☐	☐			

Review of Systems

Height (in.)

Weight

Weight one year ago:

Maximum weight and when:

Minimum weight as adult & when:

Ideal Weight:

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

Good Energy:

Please select one

- Y
- N
- P

Fatigue:

Please select one

- Y
- N
- P

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?

Please select one

- Y
- N

DIET: List what you have eaten in the last 24 hours or a sample of your meals. Note eating times.

Please check any that apply for you currently or in the past 2 weeks:

Endocrine/Hormone

Please select all that apply

- ☐ Feeling unusually cold in the extremities
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Abnormal Hair Growth
- ☐ Abnormal Hair Loss
- ☐ Loss of hair at the lateral ends of eyebrows
- ☐ Dry Skin
- ☐ Excessive Urination (polyuria)
- ☐ Excessive Thirst (Polydypsia)
- ☐ Excessive appetite (polyphagia)
- ☐ Recent Viral Infection
- ☐ Abnormal Weight Loss
- ☐ Abnormal Weight Gain

Comments

Skin

Please select all that apply

- ☐ Rash
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Dry
- ☐ Cancer
- ☐ Lesions
- ☐ Wounds
- ☐ Color Change
- ☐ Lump
- ☐ Itchy
- ☐ Warts
- ☐ Moles
- ☐ Perspiration
- ☐ Change in hair
- ☐ Change in nails

Comments

Head

Please select all that apply

- [ ] Headache
- [ ] Dandruff
- [ ] Oily hair
- [ ] Dry hair
- [ ] Migraine
- [ ] Head injury
- [ ] Hair loss

Comments

Nose

Please select all that apply

- [ ] Frequent colds
- [ ] Congestion
- [ ] Polyps
- [ ] Loss of smell
- [ ] Runny nose
- [ ] Nosebleeds
- [ ] Post nasal drip
- [ ] Seasonal allergies
- [ ] Sinus pain

Comments

Eyes

Please select all that apply

- [ ] Dry
- [ ] Watery
- [ ] Double vision
- [ ] Glaucoma
- [ ] Blurry vision
- [ ] Cataracts
- [ ] Styes
- [ ] Strain
- [ ] Itchiness
- [ ] Pain

- [ ] Discharge
- [ ] Dark under eyelid
- [ ] Vision loss

Comments

Mouth/Throat

Please select all that apply

- [ ] Canker sores
- [ ] Soreness in mouth
- [ ] Soreness in throat
- [ ] Dentures
- [ ] Hoarse voice
- [ ] Cold sores
- [ ] Gum disease
- [ ] Cavities
- [ ] Dry mouth

Comments

Ears

Please select all that apply

- [ ] Pain
- [ ] Fullness
- [ ] Loss of hearing
- [ ] Discharge
- [ ] History of Ear Infections?

Comments

Neck

Please select all that apply

- [ ] Stiffness
- [ ] Decreased range of motion
- [ ] Swollen glands
- [ ] Tension

Comments

Musculoskeletal

Please select all that apply

- ☐ Weakness
- ☐ Stiffness
- ☐ Misalignment
- ☐ Trauma/Injury
- ☐ Arthritis
- ☐ Leg cramps
- ☐ Pain
- ☐ Joint swelling
- ☐ Sciatica
- ☐ Decreased range of motion
- ☐ Carpel tunnel
- ☐ Other impingements

Comments

Nervous System/Neurological

Please select all that apply

- ☐ Paralysis
- ☐ Tingling
- ☐ Numbness
- ☐ Seizures
- ☐ Muscle weakness
- ☐ Dizziness
- ☐ Vertigo
- ☐ Difficulty with balance
- ☐ Memory loss
- ☐ Fainting
- ☐ Tremors

Comments

Mental/Emotional

Please select all that apply

- ☐ Depression
- ☐ Suicidal thoughts

- [ ] Anxiety
- [ ] Post traumatic stress disorder (PTSD)
- [ ] Addiction
- [ ] Hallucinations
- [ ] Angry
- [ ] Irritable
- [ ] High-strung
- [ ] Tense
- [ ] Fear
- [ ] Panic
- [ ] Psych hospitalization
- [ ] Hearing voices
- [ ] Mood swings
- [ ] Changes in mood from your normal
- [ ] Mood Disturbance

Comments

Respiratory

Please select all that apply

- [ ] Cough
- [ ] Shortness of breath w/ exertion
- [ ] Shortness of breath sitting
- [ ] Shortness of breath lying down
- [ ] Wheezing
- [ ] Coughing blood
- [ ] Tuberculosis (TB)
- [ ] Bronchitis
- [ ] Pneumonia
- [ ] Asthma
- [ ] Painful breathing
- [ ] Difficult/labored breathing

Comments

Cardiovascular

Please select all that apply

- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Arrhythmias
- [ ] Edema (swelling of ankles, feet, wrists)

- [ ] Shortness of breath
- [ ] Fatigue
- [ ] Rheumatic fever
- [ ] Murmurs
- [ ] Palpitations
- [ ] Chest pain
- [ ] Syncope/fainting

Comments

Urinary Tract

Please select all that apply

- [ ] Incontinence
- [ ] Frequent infections
- [ ] Urgency
- [ ] Urinary frequency
- [ ] Pain or burning w/ urination
- [ ] Kidney stones
- [ ] Discharge
- [ ] Blood

Comments

Gastrointestinal

Please select all that apply

- [ ] Heartburn
- [ ] Indigestion
- [ ] Bloating
- [ ] Nausea
- [ ] Bowel movement frequency
- [ ] Recent bowel movement change
- [ ] Diarrhea
- [ ] Constipation
- [ ] Vomiting
- [ ] Change in appetite
- [ ] Pancreatitis
- [ ] Abdominal pain
- [ ] Gas
- [ ] Blood in stool
- [ ] Hemorrhoids
- [ ] Gallbladder disease

- [ ] Liver disease
- [ ] Ulcers
- [ ] Smelly burps
- [ ] Blood in vomitus

Comments

Male

Please select all that apply

- [ ] Testicular pain
- [ ] Testicular swelling
- [ ] Hernia
- [ ] Discharge
- [ ] Impotency
- [ ] Sexually active
- [ ] Prostate symptoms

Sexually transmitted disease (S.T.D.)

Sexual orientation

Comments

Please check any that apply for you currently or in the past 3 months:

Female

Please select all that apply

- [ ] Heavy menstrual bleeding
- [ ] Menstrual pain
- [ ] Menstrual cramping
- [ ] PMS
- [ ] Food cravings
- [ ] Discharge
- [ ] Dry vagina
- [ ] Sexually active

- [ ] Pain with intercourse
- [ ] Healthy libido
- [ ] Vaginitis
- [ ] Nipple discharge
- [ ] Abnormal hair growth (e.g. chin or nipple)

Sexual orientation

Age period began:

Age menopause began

How often period occurs:

How long period lasts:

Times Pregnant:

How many births:

Miscarriages:

Abortions:

Please list any birth control used and ages used:

Last Pap Smear:

Any abnormal pap smears? If yes, when were they abnormal?

Sexually transmitted disease (S.T.D.)

Use of hormones? If yes, what type of hormones used?

Mammography? If yes, what were results?

Bone density test? If yes, what were results?

Breast Pain/lumps/skin changes:

Comments

Exercise

How often do you exercise?

What type of exercise?

For how long?

Hobbies:

Comments

Please check any that apply for you currently or in the past 2 weeks:

Sleep

Please select all that apply

- ☐ Nighmares
- ☐ Wake refreshed
- ☐ Must nap during the day
- ☐ Sleep walk
- ☐ Grind teeth
- ☐ Snore

How long do you sleep per night?

If you wake up frequently, what is the reason?

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?

List anything you have that you were not born with and what it is made of (e.g. implants, surgical hardware, fillers, amalgams, etc.)

Have you ever had any unusual insect or animal bites, scratches, tick borne infections including lyme disease, significant exposure to mold with adverse health consequences?

Social Life

Your Employer:

Your Occupation:

Enjoy job:

Please select one

- Y
- N
- P

Hours worked per week:

Highest Level of Education:

Active spiritual practice:

Please select one

- Y
- N
- P

Marital Status

Name of Spouse/Partner (or parent for a minor child)

Quality of significant relationship:

History of sexual, mental/emotional, physical abuse:

Please select one

- Y

- N
- P

What is your greatest health concern:

Please tell me about any financial concerns/considerations.

How does it limit you the most:

On a scale of 0 to 10, how willing are you to make valuable changes?

Please select one

- 0 -not willing
- 1
- 2 - somewhat not willing
- 3
- 4
- 5 - moderately willing
- 6
- 7
- 8 - willing
- 9
- 10 - completely willing

Additional Information

Please list any additional information/topics which you believe is important we address during your office visit: