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ADULT NATUROPATHIC INTAKE FORM

Name: First_____Last_____
Address: _____
City_____State._____ZipCode_____
Phone: home_____Mobile_____Bus_____
Email:_____
Occuption:_____
Emergency Contact_____Phone_____
Birthdate: (day/month/year)_____
Height_____Weight_____1 year ago_____

Willingness to make dietary changes (0-5): _____

Willingness to take nutritional supplements (0-5): _____

Willingness to make changes in lifestyle habits (0-5): _____

Overall health rating (0-10): _____

Present Health Concerns and Symptoms

1)_____
2)_____
3)_____
4)_____
5)_____

Allergies: (medications, food, environmental)_____
_____
Medical Conditions:
_____
_____
_____
Prescription Medications _____

_____
_____
_____
_____

Over the Counter Products (Tylenol, ASA, Antacids, etc.)

_____

_____

Supplements, Vitamins/Minerals, Herbal Remedies, Homeopathics

_____

_____

Surgeries, Hospitalizations, Illnesses

_____

_____

_____

Dental (amalgam filings and/or root canals)

_____

_____

_____

Recent Lab Tests and Imaging (x-rays, MRI)

_____

_____

_____

Family Health History

_____

_____

_____

Foods You Avoid

_____

_____

Foods You Crave

_____

_____

Fluid Intake (water, coffee/tea, juice, carbonated beverages)

_____

Bowel Movements (frequency)

_____

Do you have your gallbladder?_____Appendix?_____

LIFESTYLE HABITS

Interests and Hobbies_____

Exercise (type, # times/week)_____

_____

Alcohol Intake (type, amount/wk, type)_____
Tobacco Use? _____ Amount/day_____years of use_____
Recreational Drug Use?_____(amount, type)_____
Energy: rate from 1 (low) to 10 (high) Morning_____Midday_____Evening_____
Stress: rate from 1 (low) to 10 (high)_____
Recent Stressful Events_____

Tools to Reduce and Balance Stress_____
Sleep: # of hrs/night_____easy to fall asleep?_____wake midsleep?_____

FEMALE:

Length of Menstrual Cycle (ie 28 days) Duration of Menses (ie 5 days)

_____
Menstrual Flow or PMS Symptoms? (Heavy or light flow, clotting, mid cycle bleeding, pain, bloating, headaches, breast tenderness, mood changes, cravings_____

_____
Menopause/Perimenopausal symptoms? (hot flashes, poor memory, mood changes, low libido, painful intercourse, vaginal dryness _____

_____

Are you sexually active?_____low libido?_____Type of Contraception_____

Toxic Exposure (Mercury Fillings and Removal, Occupational Exposure, Pesticides/Fertilizers)

_____
_____

Patients' Full Name_____

Date of Consent:_____