Initial Intake Form

DATE _____

NAME: _____ AGE: _____ BIRTHDATE: _____ SEX: _____

ADDRESS: _____CITY: _____STATE: _____ZIP: _____

PHONE: (home) (_____)_____(work) (_____)_____ OCCUPATION:_____

PARENT OR GUARDIAN (for minor patient): _____

NAME OF EMERGENCY CONTACT: _____ PHONE: (_____)_____

A note to our patients: This is a confidential record of your medical history and will not be released except when you have authorize us to do so. Thank you.

PRESENT HEALTH CONCERNS: (Please list most important ones first and indicate when you first noticed the problem)

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

What other healthcare professionals are you seeing and their specialty:_____

_____

What diagnoses were you given?_____

_____

WHAT GOALS DO YOU HAVE FOR YOUR VISIT AT THE CLINIC TODAY?

Primary Goal: _____

Other Goals: _____

HAVE YOU EVER CONSULTED A NATUROPATH BEFORE? YES NO (Circle one)

HAVE YOU EVER CONSULTED AN ACUPUNCTURIST BEFORE? YES NO (Circle one)

DO YOU HAVE ANY QUESTIONS ABOUT NATUROPATHIC MEDICINE OR ACUPUNCTURE BEFORE WE GET STARTED?

_____

_____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING, WITH DOSAGES: (Please include prescription and non-prescription drugs. For example, allergy medications, aspirin, Tylenol, Advil, laxatives, oral contraceptives, hormones etc.)

1)_____ 4) _____

2)_____ 5) _____

3)_____ 6)_____

7)_____ 8)_____

LIST VITAMINS, MINERALS, HERBS, HOMEOPATHIC REMEDIES PRESENTLY TAKING, WITH DOSAGES:

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

7)_____ 8)_____

PLEASE LIST ANY KNOWN ALLERGIES TO THE FOLLOWING: (explain the reactions)

DRUGS: _____

_____

FOODS: _____

_____

ENVIRONMENTAL (grasses, pollens, animal dander, etc.) _____

_____

PERSONAL HABITS:

Do you: (Please check box and circle day or week, as appropriate)

- ❑ Use tobacco _____packs per day/week How many years?_____ Date Quit:_____
- ❑ Drink coffee _____cups per day/week
- ❑ Drink black tea _____cups per day/week
- ❑ Drink alcohol _____glasses per day/week
- ❑ Drink sodas _____glasses per day/week
- ❑ Drink water _____glasses per day/week
- ❑ Use artificial sweeteners _____packets per day/week
- ❑ Use margarine _____pats per day/week
- ❑ Use recreational drugs explain use_____

How many times a week do you eat in a restaurant? Breakfast_____ Lunch_____ Dinner_____

What types of restaurants?_____

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

_____

PAST HISTORY:
Hospitalizations: (Please indicate reasons/dates) _____

Serious Illnesses and Injuries: _____

CHILDHOOD:
How was your health as a child? (circle one) excellent good fair poor
Were there any complications with your delivery? Explain._____

Were you breast fed? _____ How long? _____

Did you have any serious emotional, mental or physical traumas as a child? Please explain._____

_____

_____

_____

Do you have siblings? (Indicate age and sex)_____

IMMUNIZATIONS: (Check those that apply)

- ❑ Measles When?_____
- ❑ Mumps When?_____
- ❑ Rubella When?_____
- ❑ Small pox When?_____
- ❑ Influenza When?_____
- ❑ Tetanus When?_____
- ❑ Diphtheria When?_____
- ❑ Hepatitis B When?_____
- ❑ Other _____

BLOOD TYPE:
What is your blood type? (Circle one) A B AB O don't know

FOR WOMEN:
Age at onset of menstruation? _____ Any period of time without a menstrual cycle, if so how long? _____

Any use of oral contraceptives? If so how long?_____

Number of children:_____Ages of children:_____

Number of miscarriages, c-sections and/or abortions. Explain: _____

_____

Age at onset of menopause? _____ Any hormone replacement therapy, if so how long? _____

Date of last Pap Smear: _____ Results Were: (circle one) Normal Abnormal Don't know

Date of last mammogram: _____ Results: (explain)_____

SOCIAL HISTORY:
Please circle those that apply: Single Married Significant Other Separated Divorced Widowed
Do you have children? _____ If so, how many? _____ Please list their ages: _____

TEST HISTORY:
Please check box and indicate date of last procedure. Circle any tests that were abnormal and explain in space provide below.

Test	Date	Test	Date	Test	Date
❑ Chest X-ray		❑ Cholesterol		❑ PSA	
❑ Spine X-ray		❑ Chemistry Panel		❑ Complete Physical Exam	
❑ Blood Tests		❑ Pap Smear		❑ DEXA	
❑ EKG		❑ Mammogram		❑ Others (Please list)	
❑ MRI		❑ Sigmoidoscopy			
❑ CAT Scan		❑ Colonoscopy			
❑ Cardiac Stress Test		❑ Rectal exam			

FAMILY HISTORY:
Please check the "yes" box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "RELATION" column when appropriate.

	YES	RELATION	COMMENTS		YES	RELATION	COMMENTS
Alcoholism				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Diabetes				Stroke			
Eczema				Tuberculosis			
Epilepsy				Other			

OTHER QUESTIONS

What are your favorite foods? _____
Do you crave sweets?_____ Any particular time of the day? _____
Do you salt your food at the table? _____
What foods do you really dislike? _____
Would you like to increase or decrease your weight? If so, by how much?_____
When did you last have a significant weight change (more than 10 pounds)? _____
What exercise do you do and how often? _____
How many hours of sleep do you get each night? _____Do you wake rested?_____
Are you presently sexually active? _____Any difficulties?_____
Method of birth control?_____
Rate your current stress level from 1-10 (10= most stress)_____How much does this affect you? _____
What are the major stress factors in your life now?_____
Please rate your current emotional health? (please circle) Excellent Good Fair Poor Unstable Crisis
Are you currently in psychotherapy?_____ Do you have a good support network?_____
Does your home environment have a supportive effect on your health?_____
How many hours of relaxation (not including sleep) do you give yourself during the work week?_____
During the weekends?_____
How many vacations do you take per year?_____

What are your favorite recreational activities? _____
When was your last eye exam? _____Do you wear contacts? _____Hard or Soft?_____
Do you have any visual impairments, if so, what are they?_____
Do you drink purified or bottle water? _____If so, what brand do you use?_____
Do you have amalgam (silver fillings)?_____How many? _____Any other dental problems?_____
Do you make an effort to eat organic foods? _____If so, what percentage of your diet?_____
Are you on a restricted diet do to religious or other beliefs? Please explain. _____
_____
Are you considering any elective surgery or medical procedure in the near future?_____
Are you or have you ever been exposed to any toxic chemicals?_____
If yes, which ones?_____

HEALTH AND LIFESTYLE OVERVIEW

1. Please tell me what is bothering you. If this involves a specific health condition or illness, please tell me about it in as much detail as possible. List the very first time that you noticed the condition and describe carefully any factor that you think may have played a role in its onset and progression. Please attach a sheet if more space is required.)

2. Is your health currently getting better, worse, or staying the same. How do you know?

3. What have you tried to do to improve your state of health (ex. other doctors, treatments, etc.)?

4. Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.
   a.
   b.
   c.
   d.
   e.

1. Please list any other health concerns/conditions, even if you think they may not be important.

2. Why did you choose this clinic?

3. For our time together to be a true win for you, what do you want to take place over the course of your care here?

4. How long do you feel this will take?

5. Do you think the pain and/or symptoms that you are experiencing could be purposeful? That is, could they be your body's wisdom saying, " I need some help…let's change some things here!" Please share your thoughts.

6. Do you feel your pain and/or illness is a reflection of a short-term superficial circumstance or longer term potentially deeper-seated challenges? Please share your thoughts.

7. What areas of your lifestyle are likely involved with your condition and you would like to improve: (prioritize #1.2,3 etc)

___my level of anxiety
___My pace of living
___Not enough quiet time and rest
___My diet and nutrition program
___My exercise program
___Other.Explain_____

___Not enough time spent in nature
___My creative expression
___My feelings around career
___My social and family life
___My communication skills

8. Please list any self-destructive lifestyle habits (example: smoking, lack of exercise, addictions, etc.)

9. What might it cost you if you don't significantly improve your lifestyle and underlying contributing factors to compromised health? (For example, vitality, longevity, joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

10. What is your present level of commitment to change the underlying causes of problem(s) which relate to your lifestyle? (Rate from 1-10 with 10 being 100% committed)

11. List your 3 highest priorities in life which come to mind and speak to your heart. Where does your health and vitality factor in?
    a)

    b)

    c)

1. What obstacles could prevent you from changing those lifestyle factors undermining your health?

2. What might stop you from following the therapeutic protocols that I may prescribe for you?

3. Who would be willing to support you in your health goals?

4. Please list your special interests and passions:

DIET SURVEY
Please list everything you eat and drink for 2-3 days

Day	Breakfast	Snack	Lunch	Snack	Dinner	Snack
1						
2						
3						

CHECK ALL THAT APPLY:

LIFESTYLE				
❑ Alcohol	❑ Marijuana	❑ Stress	❑ Regular exercise	
❑ Tobacco	❑ Drugs	❑ Occupational Hazards	❑ Type:_____	❑ Frequency:_____
			❑ Type:_____	❑ Frequency:_____
GENERAL SYMPTOMS				
❑ Poor appetite	❑ Poor sleep	❑ Heavy sensation in body	❑ Chills	❑ Bleeds easily
❑ Big appetite	❑ Heavy sleep	❑ Cold hands or feet	❑ Night sweats	❑ Bruises easily
❑ Strongly like cold drinks	❑ Dream-disturbed sleep	❑ Poor circulation	❑ Sweats easily	❑ Peculiar taste in mouth
❑ Strongly like hot drinks	❑ Fatigue	❑ Shortness of breath	❑ Muscle cramps	(explain)_____
❑ Recent weight loss/gain	❑ Lack of strength	❑ Fever	❑ Vertigo or dizziness	_____
HEAD, EYES, EARS, NOSE & THROAT				
❑ Glasses	❑ Glaucoma	❑ Sores on lips or in mouth	❑ Swollen glands	❑ Headaches
❑ Eye strain	❑ Cataracts	❑ Dry mouth	❑ Lump in throat	❑ Migraines
❑ Eye pain	❑ Teeth problems	❑ Excessive saliva	❑ Enlarged thyroid	❑ Concussions
❑ Itchy or burning eyes	❑ Grind teeth	❑ Sinus problems	❑ Nosebleeds	❑ Other head and neck
❑ See spots in visual field	❑ TMJ	❑ Excessive phlegm	❑ Ringing in ears	problems (explain)
❑ Poor vision	❑ Facial pain	❑ Color of	❑ Poor hearing	_____
❑ Blurred vision	❑ Gum problems	phlegm_____	❑ Earaches	_____
❑ Night blindness	❑ Hoarseness	❑ Recurrent sore throat		_____
RESPIRATORY				
❑ Shortness of breath on exertion	❑ Difficulty breathing when laying down	❑ Cough	❑ Color of phlegm_____	
❑ Shortness of breath without exertion	❑ Asthma	❑ Coughing blood	❑ History of Tuberculosis	
	❑ Wheezing	❑ Pneumonia		
		❑ Chronic Bronchitis		
CARDIOVASCULAR				
❑ High blood pressure	❑ Fainting	❑ Difficulty breathing	❑ Irregular heartbeat	❑ Swelling
❑ Low blood pressure	❑ Chest pain	❑ Cyanosis	❑ Murmurs	❑ Intermittent severe pain
		❑ Heart palpitations	❑ Arrythmias	in calf when walking
GASTROINTESTINAL				
❑ Nausea	❑ Diarrhea	❑ Intestinal pain	❑ Bowel movements	
❑ Vomiting	❑ Constipation	❑ Intestinal cramping	❑ Frequency:_____	
❑ Acid regurgitation	❑ Laxative use	❑ Itchy anus	❑ Color:_____	
❑ Gas	❑ Black stools	❑ Burning anus	❑ Texture:_____	
❑ Hiccups	❑ Bloody stools	❑ Rectal pain	❑ Odor:_____	
❑ Bloating	❑ Mucus in stools	❑ Hemorrhoids	❑ Undigested food (Y orN)	
❑ Bad breath	❑ Abdominal pain	❑ Anal fissures		
MUSCULOSKELETAL				
❑ Neck pain/tightness	❑ Low back pain/tightness	❑ Hip pain	❑ Arthritis	❑ Muscle weakness
❑ Shoulder pain/tightness	❑ Joint pain	❑ Ankle pain	❑ swelling	❑ Any paralysis
❑ Upper back pain/tightness	❑ Knee pain	❑ Wrist/elbow pain	❑ Limited range of motion	❑ Other (describe)
	❑ Rib pain	❑ Shoulder pain	❑ Limited use	_____
SKIN, HAIR & NAILS				
❑ Rashes	❑ Eczema	❑ Dry skin	❑ Hair loss	❑ Fungal infections
❑ Hives	❑ Psoriasis	❑ Itching	❑ Change in hair /skin /nail	
❑ Ulcerations	❑ Acne	❑ Dandruff	texture	
NEUROPSYCHOLOGICAL				
❑ Seizures	❑ Tics or Tremors	❑ Memory loss	❑ Phobias	❑ Attempted suicide
❑ Numbness or Tingling	❑ Loss of sensation	❑ Easily stressed	❑ Depression	❑ Seeing therapist
❑ Speech problems	❑ Gait problems	❑ Anxiety	❑ Abuse survivor	❑ Other (explain)
❑ Weakness/paralysis	❑ Coordination problems	❑ Irritability	❑ Considered suicide	
GENITOR-URINARY				
❑ Pain on urination	❑ Blood in urine	❑ Venereal disease	❑ Increased libido	❑ Impotence
❑ Frequent urination	❑ Unable to hold urine	❑ Bedwetting	❑ Decreased libido	❑ Premature ejaculation
❑ Urgent urination	❑ Incomplete urination	❑ Wake to urinate	❑ Kidney stones	❑ Nocturnal emissions
GYNECOLOGY				
❑ Length of cycle (from day 1 to day1)_____	❑ Any clots	❑ Painful periods	❑ Depression	❑ Age at menopause_____
	❑ Date of last period_____	❑ PMS explain:	❑ Irritability	❑ Menopausal symptoms
	❑ Spotting	_____	❑ Vaginal discharge.	(explain)_____
❑ Duration of flow_____	❑ Irregular periods	_____	color?_____	_____
	❑ Breast tenderness	_____	❑ Vaginal sores	_____
❑ Color of flow	❑ Abdominal cramps	_____	❑ Vaginal odor	_____
OTHER				
❑ History of anemia	❑ Lymph node enlargement	❑ Breast tenderness/pain		
❑ History of blood transfusion	❑ Lymph node pain	❑ Nipple discharge		