PATIENT INTAKE FORM

DATE________________________

Name_____________________________Age____Date of Birth_____________ Male___Female____
Address___________________________Phone (H)___________________(W)___________________
___________________________Social Security #_____________________________________
Employer__________________________Insurance Co.______________________________________
Policy Holder______________________________________
Emergency Contact________________ Policy #____
Relationship_______________________
Phone____________________________ How did you hear about clinic_______________________
What other health care are you presently receiving?____

*Please note that naturopathic, holistic and preventive health care are only possible when the physician has a complete picture of the patient physically, mentally & emotionally.
Please complete this questionnaire as thoroughly as possible. Thank you.

In your opinion, what are your most important health concerns; list in order of significance:
1)_____________________________________ 4)_____________________________________
2)_____________________________________ 5)_____________________________________
3)_____________________________________ 6)_____________________________________

HEALTH HISTORY:
Health as a child? Good____ Fair____ Poor____
Childhood illnesses: Scarlet Fever____ German Measles___ Measles____ Pertussis____
Rheumatic Fever____ Chicken Pox____ Diptheria____ Mumps____

List any hospitalizations and year: ____
____

Serious Illnesses/Injuries, date & cause ____
Current Vaccinations, date & adverse reactions if any ______________________________________

MEDICATIONS: List all current medications, supplements, and ointments. Be sure include both prescription and non-prescription items. Indicate dosage.
____ ____
____ ____
____ ____

ALLERGIES: List any allergies you have to drugs, food, animals or airbornes.
____ ____
____ ____
____ ____

HABBITS:

Alcohol (type, frequency, amount) ____
Do you use recreational drugs? ____
Do you smoke cigarettes? _______ How many? _____ per day. How many years? ___________
Are you satisfied with your diet as it is now _______ Do you eat 3 meals daily? _____________
Do you crave ______ starches ______ sweets ______ salt ______ fats?
Do you sleep well? ______ Wake rested? _____ Average hours of sleep per night? __________
Do you: enjoy your work? _____ spend time outside? _____ exercise regularly? ___________
Type of exercise ____________________________________

FAMILY HISTORY: Check those applicable.

	Father	Mother	Brother	Sister	Spouse	Child	Other
Age (if living)	_______	_______	_______	_______	________	______	______
Age (at death)	_______	_______	_______	_______	________	______	______
Cause of death	_______	_______	_______	_______	________	______	______
Health G=good P=poor	_______	_______	_______	_______	________	______	______
Cancer	_______	_______	_______	_______	________	______	______
Diabetes	_______	_______	_______	_______	________	______	______
Heart Disease	_______	_______	_______	_______	________	______	______
High Blood Pressure	_______	_______	_______	_______	________	______	______
Stroke	_______	_______	_______	_______	________	______	______
Epilepsy	_______	_______	_______	_______	________	______	______
Mental Illness’	_______	_______	_______	_______	________	______	______
Asthma, Hayfever, Hives	_______	_______	_______	_______	________	______	______
Anemia	_______	_______	_______	_______	________	______	______
Kidney Disease	_______	_______	_______	_______	________	______	______
Glaucoma	_______	_______	_______	_______	________	______	______
Tuberculosis	_______	_______	_______	_______	________	______	______
Other	_______	_______	_______	_______	________	______	______

GENERAL INFO:

Weight _______ Weight 1 year ago _______ Maximum weight _______ When _______
Height _______ Night Sweats: ___yes ___never had ___past condition
Fatigue: ___yes ___never had ___past condition

Date of last physical ____

REVIEW OF SYSTEM: Y=yes, a condition now N=never had P=past condition

SKIN

Rashes	Y	P	N
Inflammation	Y	P	N
Infection	Y	P	N
Growth	Y	P	N
Changes in hair or nails	Y	P	N

HEAD

Headache	Y	P	N
Head injury	Y	P	N

EYES

Impaired vision	Y	P	N
Eye pain	Y	P	N
Tearing	Y	P	N
Dryness	Y	P	N
Double vision	Y	P	N

EARS

Impaired hearing	Y	P	N
Ringing	Y	P	N
Earache	Y	P	N
Itching	Y	P	N
Dizziness	Y	P	N

MOUTH & THROAT

Sore throat	Y	P	N
Sore tongue	Y	P	N
Sores in mouth	Y	P	N
Sores on lips	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Dental problem	Y	P	N

NOSE & SINUSES

Frequent colds	Y	P	N
Nose bleeds	Y	P	N
Stuffiness	Y	P	N
Sinus problem	Y	P	N
Post nasal drip	Y	P	N

NECK

Swollen glands	Y	P	N
Pain/stiffness	Y	P	N

RESPIRATORY

Cough	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N
Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N
Shortness of breath	Y	P	N
“lying down	Y	P	N
“at night	Y	P	N
Positive TB test ever	Y	P	N

HEART

Heart disease	Y	P	N
High blood pressure	Y	P	N
Rheumatic fever	Y	P	N
Chest pain	Y	P	N
Swelling ankles	Y	P	N
Palpations	Y	P	N
Fluttering	Y	P	N

DIGESTION

Trouble swallowing	Y	P	N
Heartburn	Y	P	N
Stomach pain	Y	P	N
Thirst change	Y	P	N
Appetite change	Y	P	N
Nausea	Y	P	N
Vomitting	Y	P	N
Bowels move:	daily	more	less
Loose stools	Y	P	N
Blood in stools	Y	P	N
Belching/gas	Y	P	N
Liver/gallbladder disease	Y	P	N
Hemorrhoids	Y	P	N

URINARY

Pain on urination	Y	P	N
Increase frequency	Y	P	N
Frequency at night	Y	P	N
Inability to hold urine	Y	P	N
Bladder infections	Y	P	N

BLOOD

Anemia	Y	P	N
Easy bruising	Y	P	N

NEUROLOGIC

Fainting	Y	P	N
Seizures	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness	Y	P	N
Tingling	Y	P	N
Loss of memory	Y	P	N

EMOTIONAL

Depression	Y	P	N
Mood swings	Y	P	N
Anxiety or nervousness	Y	P	N
Tension	Y	P	N

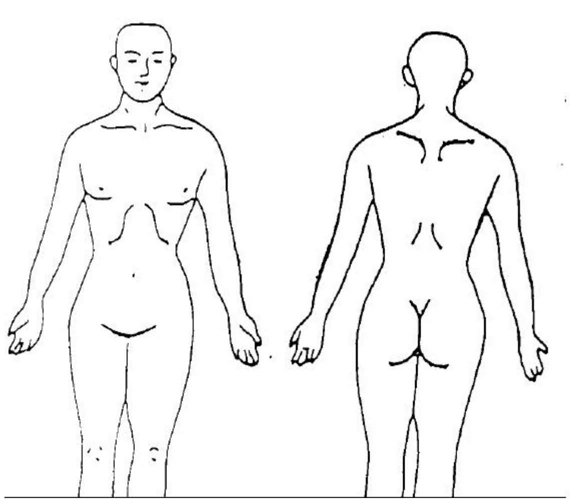
ENDOCRINE

Thyroid problem	Y	P	N
Heat or cold intolerance	Y	P	N
Hypoglycemia	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
Easy weight gain	Y	P	N

MUSCULOSKELETAL

Joint pain	Y	P	N
Joint stiffness	Y	P	N
Broken bones	Y	P	N
Muscle spasm/ cramps	Y	P	N
Weakness	Y	P	N

Indicate on diagram below any problem areas:



CIRCULATION

Deep leg pain	Y	P	N
Cold hand/foot	Y	P	N

MALE REPRODUCTION

Hernias	Y	P	N
Testicular masses	Y	P	N
Sexually active	Y	P	N
Sexual difficulties	Y	P	N
Prostate problems	Y	P	N
Venereal disease	Y	P	N
Discharge of sores	Y	P	N
Difficulty starting urination	Y	P	N
Difficulty stopping urination	Y	P	N
Vascetomy	Y	P	N

Birth control:
Type____________________

FEMALE REPRODUCTION

Age menses began________________
Number of days menstrual flow________
Lenght of complete cycle___________

Bleeding btw. periods	Y	P	N
Regular cycles	Y	P	N
Pain with intercource	Y	P	N
Menstrual cramps	Y	P	N
Vaginal discharge	Y	P	N
Excessive flow	Y	P	N
PMS	Y	P	N

Date last pap smear________________

Abnormal pap results	Y	P	N

Date of last period__________________
No. of pregnancies_________________
No. of live births___________________
No. of miscarriages_________________
Birth control:
Type______________________

Difficulty conceiving	Y	P	N
Menopausal symptoms	Y	P	N
Sexually active	Y	P	N
Sexual difficulties	Y	P	N
Venereal disease	Y	P	N