

# 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

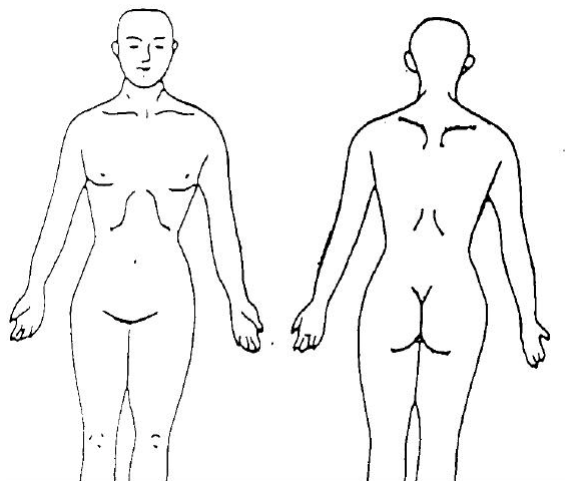
**ENDOCRINE**

Thyroid problem	Y	P	N
Heat or cold flow			
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
Vasectomy	Y	P	N
Birth control:			
Type	_____		

**FEMALE REPRODUCTION**

Age menses began	_____		
Number of days menstrual	_____		
Length of complete cycle	_____		
Bleeding btw. periods	Y	P	N
Regular cycles	Y	P	N
Pain with intercourse	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