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New Patient Intake Form

Name: ____ Date of Birth: _______________________ Gender (circle): M / F

Address: ____ City: _____________________ State: ________ Zip: _________

Telephone(s): _____________________________________ (work/cell) ________________________________ (work/cell)

Email address: ____

Occupation/Employer: _____________________________ Hrs/wk: ________ Do you commute: YES / NO

Status (circle): Single Married Separated Divorced Partnered Widowed

Living with (circle): Spouse Partner Friend(s) Children Alone Other family

Race (circle): Asian African Amer/Black American African Caucasian Native American

Pacific Islander Native Hawaiian Hispanic Other

Emergency Contact:

Contact name: _____________________________________ Relationship: ____________________________

Telephone (cell/home/work): ___________________________ (cell/home/work): ______________________

How did you hear about us? ____

Have you ever seen a Naturopathic Doctor (ND) before: YES / NO

Are you seeking primary care at this clinic? YES / NO Do you have other doctors you see on a regular basis? YES / NO

If so, list here: ____ ____

____ ____

____ ____

Current Health Status:

How do you rate your overall health? Poor Fair Good Great Excellent

General Information:

Height: _________ Weight: _________ Sleep habits: I sleep (circle) WELL / NOT WELL and for _________ hours per night

Energy level (1 = no energy; 10 = plenty of energy): 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When was your last:

	Date			Date
Blood test			(Males) Prostate exam	
Physical exam			(Females) Pap smear	
Dental exam			(Females) Breast exam	
Eye exam			Colonoscopy	

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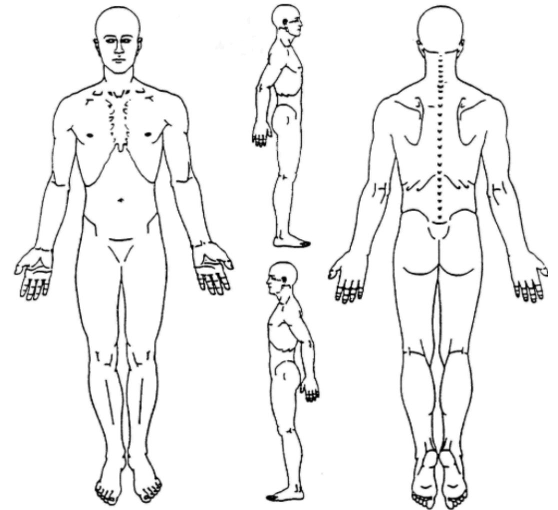
Chief Concerns and Time of Onset:

1. ____
2. ____
3. ____
4. ____
5. ____



Where do you have pain?
Indicate on the diagram to the right.

How intense is your pain?
1 = low level of pain; 10 = extremely high level of pain

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Past Medical History

Current diagnosis and time of onset:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

Surgical History:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

Allergies:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

Past Exposures:

1. ____
2. ____
3. ____
4. ____

Scars:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

Other:

Have you taken several antibiotics as a child or adult? YES / NO If yes, for what? ____________________
Do you have amalgam (silver/black) fillings? YES / NO Do you have any gold or silver crowns? YES / NO

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Family Medical History:

	Age	Health Problems/Diagnoses	Age at Death	Cause of Death
Mother				
Father				
Brother/Sister				
Brother/Sister				
Other (specify) ________________				

Emotional and Social Health History:

Stress level: ___________________ Happiness level: ________________________ New/Recent Stressors: ___________________

Where in your body do you hold your stress?: ____

Stress-reduction activities: ____

Current quality of life: ____

Exercise habits: Type(s): ____ Frequency: _____________________________

Other hobbies: Type(s): ____ Frequency: _____________________________

Alcohol: ______drinks/week Tobacco: YES / NO If yes, how much: ______ Marijuana: YES / NO NO If yes, how much: ________

Review of Systems:

General:

Fever	Fatigue	Night sweats	Chills
Hot flashes	Increased appetite	Decreased appetite	Insomnia
Change in energy	Weight gain	Weight loss	Bleeding

Musculoskeletal:

Joint pain	Low back pain	Rotator cuff injury	Arthritis/osteoarthritis
Joint swelling	mid back pain	Muscle tear	Osteoporosis
Joint redness	Neck pain	Sprain/strain	Osteopenia

Head, Eyes, Ears, Nose Mouth:

Headaches	Cataracts	TMJ pain/clicking	Tooth pain
Migraines	Glaucoma	Decreased hearing	Nose bleeds
Dizziness	Floaters	Snoring	Sore throat
Eye Pain	Ringing in ears (tinnitus)	Sinus issues (sinusitis)	Postnasal drip
Blurry vision	Ear aches	Change in vision	Vertigo

Respiratory Tract:

Coughing	Decreased stamina	Postnasal drip	Pneumonia
Wheezing	Runny nose	Difficulty breathing	COPD
Asthma	Allergies	Shortness of breath	

Cardiovascular:

Chest pain	Cold hands/feet	Palpitations	Irregular heartbeat
High blood pressure	Fainting	Low blood pressure	Blood clots
Dizziness	Swelling of feet/hands	Shortness of breath	Diabetes

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Skin and Hair:

Hair loss	Dry skin	Wrinkles	Dandruff
Rash	Oily skin	Spider veins	New moles/spots/lesions
Eczema	Acne	Ulcers	Itching
Psoriasis	Rosacea	Abnormal hair growth	

Gastrointestinal:

Nausea	Gas/bloating	Hemorrhoids	Black stool
Vomiting	Abdominal pain	Parasites	Yellow stool
Diarrhea	Heartburn/reflux	Blood in stool	Gastric ulcers
Constipation	Indigestion	Bad breath	Hernia

Genitourinary:

Pain with urination	Loss of control	Genital sores	Impotence
Difficulty urinating	Incontinence	Genital rash	Kidney stones
Frequent urination	Frequency at night	Discharge	Urgency
Discolored urine	Blood in urine		

Neurological/Psychological:

Lack of balance	Twitches	Depression	Poor Memory
Lack of coordination	Numbness	PTSD	Weakness
Concussion	Irritability	Anxiety/stress	Tremor

Gynecology and Pregnancy:

Irregular periods	Fertility problems	# of pregnancies __________
Painful periods	PMS	# of births ____________
Mid-cycle spotting	Vaginal sores	# of miscarriages ___________
Heavy flow/clots	Pregnancy (currently)	#of abortions ___________
Vaginal discharge	Abnormal pap, date(s) _____________	Age of first menses _________

Medications and Supplements:

Current Medications (prescription and over the counter) – include dose, frequency, and why you are taking:

1. ______________________________ 4. ______________________________
2. ______________________________ 5. ______________________________
3. ______________________________ 6. ______________________________

Current Supplements – include dose, frequency, and why you are taking:

1. ______________________________ 5. ______________________________
2. ______________________________ 6. ______________________________
3. ______________________________ 7. ______________________________
4. ______________________________ 8. ______________________________

Is there anything else we should know about you that was not previously covered on this form? ________________________________

____

I certify the above information to be true to the best of my knowledge:

Signature: ____ Date: ______________________