Dr. Jessica Corbeille, ND, CES
Elevated Natural Health
12000 15th Ave NE Suite C
Seattle, WA 98125
P: 206.566.7225 | F: 206.363.1390

# 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

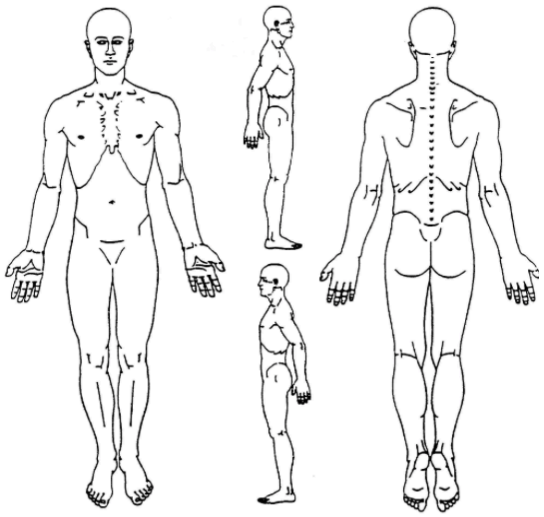
**When was your last:**

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

Dr. Jessica Corbeille, ND, CES
Elevated Natural Health
12000 15th Ave NE Suite C
Seattle, WA 98125
P: 206.566.7225 | F: 206.363.1390

**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. _____
5. _____
6. _____
7. _____
8. _____

**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

Dr. Jessica Corbeille, ND, CES
Elevated Natural Health
12000 15th Ave NE Suite C
Seattle, WA 98125
P: 206.566.7225 | F: 206.363.1390

**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: _____

Any recent new or exceptional 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

**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 |

Dr. Jessica Corbeille, ND, CES
Elevated Natural Health
12000 15th Ave NE Suite C
Seattle, WA 98125
P: 206.566.7225 | F: 206.363.1390

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 | Stress |
| Lack of coordination | Numbness | PTSD | Weakness |
| Concussion | Irritability | Anxiety | Tremor |
| Poor memory | | | |

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. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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

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

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

Signature: _____ Date: _____