

## New Patient Intake Form

Please fill out this questionnaire as thoroughly as possible. Print all information clearly and mark anything you don't understand with a question mark. All information contained in these pages is completely confidential.

### Personal Information

Today's Date \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Phone - Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Mobile (\_\_\_\_) \_\_\_\_\_  
Preferred \_\_\_ Home \_\_\_ Work \_\_\_ Mobile Is it OK to leave messages? \_\_\_ Yes \_\_\_ No  
Address \_\_\_\_\_ Apt # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Email address \_\_\_\_\_  
Are you interested in receiving email notifications of classes and lectures? \_\_\_ Yes \_\_\_ No

If the patient is under the age of 18:

Name of mother \_\_\_\_\_ Phone number \_\_\_\_\_  
Name of father \_\_\_\_\_ Phone number \_\_\_\_\_

Who may we thank for your referral? \_\_\_\_\_  
Have you been to a Doctor of Naturopathic Medicine before? \_\_\_ If so, when? \_\_\_\_\_  
Under what circumstances? \_\_\_\_\_  
When did you last receive medical care? \_\_\_\_\_  
Where? \_\_\_\_\_ Why? \_\_\_\_\_

What is your most important reason for making this appointment? \_\_\_\_\_  
\_\_\_\_\_

Please list other medical concerns, in order of importance: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Emergency Contact

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone Number Day (\_\_\_\_) \_\_\_\_\_ Evening (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_  
\_\_\_\_\_

### Health History

Please list any known allergies (environmental, drug, food): \_\_\_\_\_

Do you take any of the following over-the-counter medications? Please check any that apply:

\_\_\_ Aspirin    \_\_\_ Ibuprofen or acetaminophen    \_\_\_ Antihistamine    \_\_\_ Sleeping pills  
\_\_\_ Laxatives    \_\_\_ Appetite depressants    \_\_\_ Antacid    \_\_\_ Medicine to stay awake

Please list any pharmaceutical and/or natural medications (including vitamins) that you are taking or have taken in the last year:

Medication	Dosage	Dates	Reason for taking

If any of the following apply to you, please indicate dates:

Hospitalization _____	Endoscopy _____
Surgery _____	Colonoscopy _____
X-ray _____	Mammogram _____
MRI _____	CT scan _____
Rectal exam _____	Bone Scan _____
Electrocardiogram _____	Other _____

For the following conditions and symptoms, please indicate any that apply to you by marking "C" for current or "P" for past:

<input type="checkbox"/> Skin rash	<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Easy bleeding or bruising	<input type="checkbox"/> Weakness	<input type="checkbox"/> Heart palpitations
<input type="checkbox"/> Varicose veins or hemorrhoids	<input type="checkbox"/> Dizziness or fainting	<input type="checkbox"/> Atherosclerosis
<input type="checkbox"/> Bone or joint disease	<input type="checkbox"/> Numbness / tingling / paralysis	<input type="checkbox"/> Gastrointestinal disorder
<input type="checkbox"/> Mood swings	<input type="checkbox"/> Neurological disease	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Anxiety or nervousness	<input type="checkbox"/> Seizures	<input type="checkbox"/> Gastritis or ulcers
<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Excessive thirst / hunger
<input type="checkbox"/> Feel unsafe at home	<input type="checkbox"/> Headaches	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Head injury	<input type="checkbox"/> Eating disorder
<input type="checkbox"/> Frequent antibiotic use	<input type="checkbox"/> Dental problems	<input type="checkbox"/> Parasites
<input type="checkbox"/> Frequent colds or flu	<input type="checkbox"/> Cold sores	<input type="checkbox"/> Liver disease
<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Gallbladder disease
<input type="checkbox"/> Lyme disease	<input type="checkbox"/> Impaired hearing / vision	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Problems with urination
<input type="checkbox"/> Vaccinations	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Sexual difficulties

When and where are your symptoms worse?

<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening	<input type="checkbox"/> At home	<input type="checkbox"/> At work	<input type="checkbox"/> Upon waking
<input type="checkbox"/> Other _____			<input type="checkbox"/> Overnight	<input type="checkbox"/> No pattern	

## Family History

If you or anyone in your immediate family has or had any of the following conditions, please indicate who was affected (self, mother, father, sister, brother, child):

Cancer _____	Diabetes _____
Heart Disease _____	Asthma, hay fever, rashes _____
Stroke _____	Osteoporosis _____
High blood pressure _____	Depression _____
Alcoholism or substance abuse _____	Autoimmune disease _____
Attempted suicide _____	Other _____

## For Men Only

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Please check all that apply to you:

- |  |   |
|--|---|
| <input type="checkbox"/> Prostate exam _____ / _____ / _____ | <input type="checkbox"/> Abnormal discharge from penis  |
| <input type="checkbox"/> Regular self testicular exam        | <input type="checkbox"/> Pain or lump in scrotum        |
| <input type="checkbox"/> Impaired fertility                  | <input type="checkbox"/> Prostate problem               |
| <input type="checkbox"/> Sexual abuse                        | <input type="checkbox"/> Sexually transmitted infection |

## For Women Only

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Last menses \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last pap smear \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Age menses began \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_  
Number of live births \_\_\_\_\_

If you are still having periods:

Average number of days of bleeding \_\_\_\_\_  
Average number of days in cycle \_\_\_\_\_  
Bleeding is  Regular  Irregular  
 Light  Medium  Heavy  
Symptoms  Bleeding b/n periods  Mood swings  
 PMS  Painful menses  Breast tenderness

If you are no longer having periods:

Hot flashes  Vaginal dryness  
 Dry skin  Changes in memory  
 Spotting  Changes in libido  
 Facial hair  Changes in mood  
 Hair loss  Hormone replacement therapy  
 Incontinence  Urinary tract infections

Please check all that apply to you:

- |  |
|--|
| <input type="checkbox"/> Hysterectomy _____ / _____ / _____  |
| <input type="checkbox"/> Abnormal pap smear  |
| <input type="checkbox"/> Breast pain / lump / nipple discharge   |
| <input type="checkbox"/> Sexual difficulties   |
| <input type="checkbox"/> Frequent vaginitis / chronic yeast infections   |
| <input type="checkbox"/> Abnormal vaginal discharge  |
| <input type="checkbox"/> Endometriosis   |
| <input type="checkbox"/> Polycystic ovary syndrome   |
| <input type="checkbox"/> Sexually transmitted infection  |
| <input type="checkbox"/> Pelvic inflammatory disease   |
| <input type="checkbox"/> Uterine fibroids  |
| <input type="checkbox"/> Impaired fertility  |
| <input type="checkbox"/> Sexual abuse  |
| <input type="checkbox"/> Regular self breast exam  |
| <input type="checkbox"/> Sexually active   |
| <input type="checkbox"/> Use methods to prevent pregnancy and/or sexually transmitted infections:<br>Current _____<br>Past _____ |

## Lifestyle History

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Please check any that apply to you and fill in corresponding details:

- |  |   |
|--|---|
| <input type="checkbox"/> Exercise _____ hours per week                           | Height _____  |
| Activities _____   | Weight _____  |
| <input type="checkbox"/> Watch TV _____ hours per week                           | Weight one year ago _____   |
| <input type="checkbox"/> Tobacco use _____ packs per day                         | Maximum weight _____  |
| <input type="checkbox"/> Alcohol use _____ drinks per week                       | When? _____   |
| <input type="checkbox"/> Recreational drug use                                   | Sleep _____ hours per night   |
| <input type="checkbox"/> Mercury amalgam fillings                                | Is this enough? <input type="checkbox"/> Yes <input type="checkbox"/> No                                    |
| <input type="checkbox"/> Employed outside the home                               | Meals per day _____   |
| Occupation _____   | Bowel movements per day _____   |
| Hours per week _____   | Dietary restrictions _____  |
| Employer _____   | _____   |
| Do you enjoy your work? <input type="checkbox"/> Yes <input type="checkbox"/> No | Level of stress <input type="checkbox"/> Low <input type="checkbox"/> Average <input type="checkbox"/> High |
| <input type="checkbox"/> Toxic exposure _____                                    |   |
| <input type="checkbox"/> Major life change in last year _____                    |   |