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ADULT INTAKE

Full Legal Name: LAST _____, FIRST_____ M.I.____
Name I Prefer to Go By _____ Occupation _____
Today's Date (1st Appt.) ____/____/____ AGE____ Date of Birth____/____/____ Gender____

CONTACT INFORMATION

Street Address _____ City_____
State_____ Zip Code_____ E-Mail_____
Day Phone_____ Eve Phone_____ Cell_____
( )Single ( )Married ( )Partnered Name of partner/spouse: _____
Emergency Contact_____ Phone_____ Relationship_____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic? _____
_____
What do you know about the naturopathic medical approach? _____
_____
What *three* expectations do you have from *this* visit? _____
_____
What *long-term* expectations do you have?_____
_____
What expectations do you have of me personally as your health care provider? _____
_____
_____
What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.
0% 0 1 2 3 4 5 6 7 8 9 10 100%
What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? _____
_____
What behaviors or lifestyle habits do you currently engage in regularly that you believe do not support your health? _____
_____
_____
What potential obstacles do you forsee in addressing the factors that may need to change in order to enhance your health? _____
_____
_____
Who do you know that could sincerely and consistently support you with the beneficial changes you could make? _____
_____
_____

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Your Primary Care Doctor_____ Phone_____
Date last seen and Reason_____
Other Healthcare Provider_____ Phone_____
Date last seen and Reason_____
Other Healthcare Provider_____ Phone_____
Date last seen and Reason_____

What are your most important health problems? List as many as you can in order of importance.
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
Do you have any known contagious diseases at this time? Yes / No
If yes, what? _____

FAMILY HISTORY
Do you have a family history of any of the following (please circle)?

High Blood Pressure	Diabetes	Cancer	Tuberculosis	Asthma/Eczema
Heart Disease	Kidney disease	Epilepsy	Arthritis	Hay fever/hives
Heart murmur	Glaucoma	Stroke	Mental Illness	Anemia

Is your father still living? Yes; his age ____ No; age at time of death ____ Cause of death_____
_____
Is your mother still living? Yes; her age ____ No; age at time of death ____ Cause of death_____
_____
Any other relevant family history? _____
_____
What is your family heritage? _____

CHILDHOOD ILLNESSES
Please circle whether you have/had any of the following as a child:

Chicken pox	Diptheria	German measles	Measles
Rheumatic fever	Mumps	Scarlet fever	Other _____

HOSPITALIZATIONS/SURGERY/IMAGING
What hospitalizations, surgeries, x-rays, CAT scans, MRI's, EEGs, EKGs have you had?
_____ Year _____ _____ Year _____
_____ Year _____ _____ Year _____
_____ Year _____ _____ Year _____

ALLERGIES
Are you hypersensitive or allergic to:
Any drugs? _____
Any foods? _____
Any environmental agents or chemicals? _____
_____

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CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives	Pain Relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping pills	Thyroid medication
Birth Control Pills	Hormone Replacement		

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

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

GENERAL

Height: _____Weight: _____ Weight one year ago:_____
Maximum Weight: _____ When: _____
When during the day is your energy the best? _____ Worst? _____
Main interests and hobbies: _____
Exercise: Y / N If so, what kind and how often: _____
Watch TV: Y / N If so, how many hours? ____Read: Y / N If so, how many hours? _____
Do you have a religious or spiritual practice? Y / N If so, what kind? _____

TYPICAL FOOD INTAKE

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To drink: _____

FOR THE FOLLOWING, PLEASE CIRCLE:
Y = Yes N = No P = Problem in the Past

GENERAL

Do you sleep well?	Y N
Average 6-8 hours?	Y N
Awake rested?	Y N
Have a supportive relationship?	Y N
Have a history of abuse?	Y N P
Experienced a major trauma?	Y N P
Use recreational drugs?	Y N P
Treated for drug dependence?	Y N P
Use alcoholic beverages?	Y N P
Use tobacco?	Y N P
If in the past, how many years? _____	
How many packs per day? _____	
Do you enjoy your work?	Y N
Take vacations?	Y N
Spend time outside?	Y N
Eat three meals a day?	Y N
Do you go on diets often?	Y N P

ENDOCRINE

Hypothyroid?	Y N P
Hypoglycemia?	Y N P
Excessive thirst?	Y N P
Fatigue?	Y N P
Heat or cold intolerance?	Y N P
Hyperthyroid?	Y N P
Diabetes?	Y N P
Excessive hunger?	Y N P
Seasonal depression?	Y N P
Difficulty exercising?	Y N P

RESPIRATORY

Cough?	Y N P
Sputum?	Y N P
Asthma?	Y N P
Wheezing?	Y N P
Bronchitis?	Y N P

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GENERAL CONTINUED

Do you eat out often?	Y	N	P
Do you drink coffee?	Y	N	P
Drink soda?	Y	N	P
Do you eat refined sugar?	Y	N	P
Do you add salt to your food?	Y	N	P

HEAD

Headaches?	Y	N	P
Migraines?	Y	N	P
Head injury?	Y	N	P
Jaw or TMJ problems?	Y	N	P

EARS

Impaired hearing?	Y	N	P
Ringing in ears?	Y	N	P
Dizziness?	Y	N	P
Ear aches?	Y	N	P

EYES

Impaired vision?	Y	N	P
Cataracts?	Y	N	P
Glaucoma?	Y	N	P
Spots in vision	Y	N	P
Color blindness?	Y	N	P
Tearing or dryness?	Y	N	P
Eye pain or strain?	Y	N	P
Double vision?	Y	N	P

NOSE AND SINUS

Frequent colds?	Y	N	P
Stuffiness?	Y	N	P
Sinus problems?	Y	N	P
Nose bleeds?	Y	N	P
Hayfever?	Y	N	P
Loss of smell?	Y	N	P

MOUTH AND THROAT

Frequent sore throat?	Y	N	P
Copious saliva?	Y	N	P
Sore tongue or lips?	Y	N	P
Hoarseness?	Y	N	P
Jaw clicks?	Y	N	P
Teeth grinding?	Y	N	P
Gum problems?	Y	N	P
Dental cavities?	Y	N	P

NECK

Lumps in neck?	Y	N	P
Goiter?	Y	N	P
Difficulty swallowing?	Y	N	P
Pain or stiffness in neck?	Y	N	P

RESPIRATORY CONTINUED

Coughing up blood?	Y	N	P
Pneumonia?	Y	N	P
Pleurisy?	Y	N	P
Difficulty breathing?	Y	N	P
Shortness of breath?	Y	N	P
" " when lying?	Y	N	P
Pain on breathing?	Y	N	P
Emphysema?	Y	N	P
Tuberculosis?	Y	N	P

IMMUNE

Reactions to immunizations?	Y	N	P
Chronically swollen glands?	Y	N	P
Slow wound healing?	Y	N	P
Chronic fatigue syndrome?	Y	N	P
Chronic infections?	Y	N	P
Night sweats?	Y	N	P

CARDIOVASCULAR

Heart disease?	Y	N	P
Angina?	Y	N	P
High/Low blood pressure?	Y	N	P
Heart murmus?	Y	N	P
Blood clots?	Y	N	P
Fainting?	Y	N	P
Phlebitis?	Y	N	P
Palpitations/fluttering heart?	Y	N	P
Chest pain?	Y	N	P
Rheumatic fever?	Y	N	P
Swelling in ankles?	Y	N	P

GASTROINTESTINAL

Trouble swallowing?	Y	N	P
Change in thirst?	Y	N	P
Change in appetite?	Y	N	P
Nausea/vomiting?	Y	N	P
Ulcer?	Y	N	P
Jaundice?	Y	N	P
Gall bladder disease?	Y	N	P
Liver disease?	Y	N	P
Hemorrhoids?	Y	N	P
Pancreatitis?	Y	N	P
Heartburn?	Y	N	P
Abdominal pain or cramps?	Y	N	P
Belching or passing gas?	Y	N	P
Constipation?	Y	N	P
Bowel movments: how often? _____			
Is this a change? _____			
Black stools?	Y	N	P
Blood in stools?	Y	N	P
Anorexia/Bulimia	Y	N	P

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SKIN
- Rashes? Y N P
- Acne/boils? Y N P
- Change in skin color? Y N P
- Lumps or bumps on skin? Y N P
- Eczema or hives? Y N P
- Itching? Y N P
- Perpetual hair loss? Y N P

URINARY
- Increased freq. Of urination? Y N P
- Inability to hold urine? Y N P
- Pain on urination? Y N P
- Frequency at night? Y N P
- Frequent UTIs? Y N P
- Kidney stones? Y N P

MUSCULOSKELETAL
- Joint pain or stiffness? Y N P
- Arthritis? Y N P
- Broken bones? Y N P
- Weakness? Y N P
- Muscle spasms or cramps? Y N P
- Sciatica? Y N P

BLOOD
- Anemia? Y N P
- Easy bleeding or bruising? Y N P
- Cold hands/feet? Y N P
- Deep leg pain? Y N P
- Thrombophlebitis? Y N P
- Varicose veins? Y N P

MALE REPRODUCTIVE
- Are you sexually avitve? Y N P
- Sexual orientation: _____
- Birth control? Type: _____
- Discharge or sores? Y N P
- Chlamydia? Y N P
- Gonorrhea? Y N P
- Genital warts? Y N P
- Herpes? Y N P
- Syphilis? Y N P
- Hernias? Y N P
- Testicular masses? Y N P
- Testicular pain? Y N P
- Prostate disease? Y N P
- Impotence? Y N P
- Premature ejaculation? Y N P

FEMALE REPRODUCTIVE
- Age of first menses: _____
- Age of last menses (if menopausal): ____
- Length of cycle: _____ days
- Duration of menses: _____ days
- Are your cycles regular? Y N P
- Painful menses? Y N P
- Heavy or excessive flow? Y N P
- PMS? Y N P
- Symptoms: _____
  _____
- Bleeding between cycles? Y N P
- Clotting? Y N P
- Endometriosis? Y N P
- Ovarian cysts? Y N P
- Vaginal odor? Y N P
- Vaginal discharge? Y N P
- Date of last pap smear: _____
- Abnormal PAP? Y N P
- Cervical dysplasia? Y N P
- Are you sexually active? Y N P
- Sexual orientation: _____
- Birth control? Type: _____
- Pain during intercourse? Y N P
- Gonorrhea? Y N P
- Herpes? Y N P
- Chlamydia? Y N P
- Genital warts? Y N P
- Syphilis? Y N P
- Difficulty conceiving? Y N P
- Number of pregnancies: _____
- Number of live births: _____
- Number of miscarriages: _____
- Number of abortions: _____
- Do you do self breast exams? Y N P
- Breast pain/tenderness? Y N P
- Breast lumps? Y N P
- Nipple discharge? Y N P
- Menopausal symptoms? Y N P

MENTAL/EMOTIONAL
- Treated for emotional prob? Y N P
- Depression? Y N P
- Anxiety or nervousness? Y N P
- Poor concentration? Y N P
- Do you have mood swings? Y N P
- Considered suicide? Y N P
- Tension? Y N P
- Memory problems? Y N P

How did you hear about me? ( )From a Friend ( )Yellow Pages ( )Website ( )Insurance Company
( )Practitioner/Other Referral ( )Flyer/Business Card ( )Other_____

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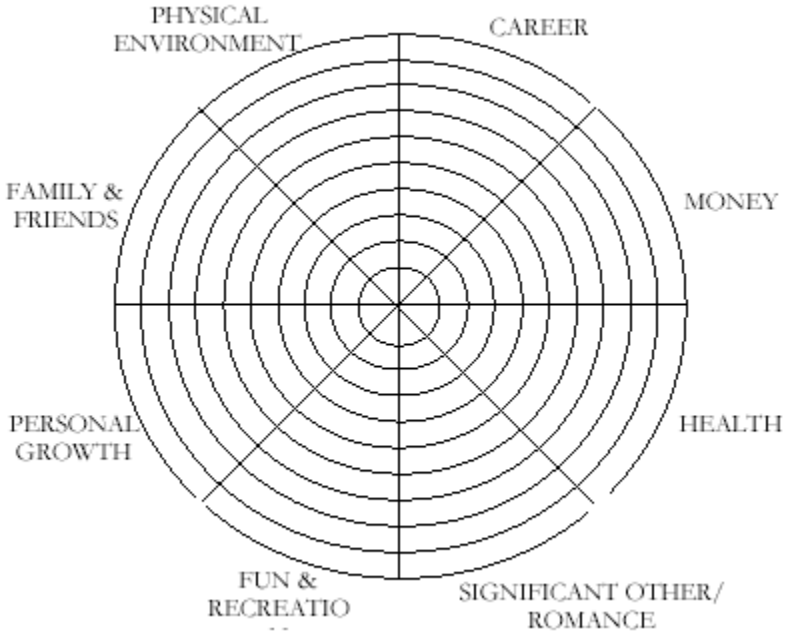
WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you. For example, if you are 60% satisfied in your career, shade the first six levels of the career slice. Do the same for each area, starting from the center point radiating outward.



Thank you for your time and effort. I look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so at the bottom of this page.