FULL LEGAL NAME: _____ DATE: _____

New Patient Naturopathic Intake Form

Preferred name:_____ Date of birth: _____ Age: _____ Sex: Male / Female
Number of children: _____ Please circle, if applicable: pregnant trying to conceive lactating

Reasons for office visit (please list additional on back):

1.
2.
3.
4.
5.

Commitment towards making valuable changes 1-10 (10 being most): 1 2 3 4 5 6 7 8 9 10

Primary care physician: _____ Facility: _____ Date last seen: _____
Date of most recent lab tests: _____ Abnormal findings: _____

Past Medical History

Current Weight: _____ Weight one year ago: _____ Ideal weight: _____ Current Height: _____

DATE	PREVIOUS DIAGNOSIS	OUTCOME/TREATMENT

DATE	SURGERY, EVENT, HOSPITALIZATION	OUTCOME

Please list date of most recent:

Dental exam: _____ Mammogram: _____ Pap smear: _____
Chest x-ray: _____ Colonoscopy: _____ Eye exam: _____

FULL LEGAL NAME: _____ DATE: _____

Review of Systems

Please circle to indicate Yes (Y), No (N) or Past (P). If Yes (Y), please circle the concerns you have.

Y N P	Skin: rash, hives, eczema, psoriasis, warts, cancer, abnormal moles, itching, acne, bumps on backs of arms or other skin concerns
Y N P	Head: migraines, headaches, concussion/brain injury or other head concern
Y N P	Neuro: brain fog, dizziness, numbness, tingling, burning, tremor, cognitive decline, seizures, paralysis or other neuro concern
Y N P	Nose: nose bleeds, polyps, congestion, problems smelling or other nose concern
Y N P	Eyes: dryness, itching, vision changes, watery, pain, redness or other eye concern
Y N P	Ears: infections, ringing, hearing changes, or other ear concerns
Y N P	Mouth/throat/neck: cavities, gum disease, dentures, sores, neck stiffness, goiter, sore throat, swollen glands, difficulty swallowing
Y N P	Cardiovascular: chest pain, murmurs, palpitations, heart attack, edema, hypertension, arrhythmias, low blood pressure
Y N P	Respiratory: asthma, shortness of breath, pneumonia, wheezing, bronchitis, cough, emphysema or other respiratory concerns
Y N P	Musculoskeletal: weakness, stiffness, tension, pain, cramps or other musculoskeletal concerns
Y N P	Male: STI, discharge, pain, hernia, prostate disease, erectile dysfunction, low libido, frequent nighttime urination or other male concerns
Y N P	Urinary: incontinence, urgency, kidney stones, blood in urine, frequent infections, pain with urination or other urinary concerns
Y N P	Immune: autoimmunity, frequent infections, allergies, or other immune concerns
Y N P	Gastrointestinal: abdominal pain, nausea/vomiting, bloating, gas, belching, diarrhea, constipation, heartburn, hemorrhoids, change in appetite or other GI concerns
Y N P	Mental/emotional: depression, anxiety, eating disorder, suicidal, fear/panic, irritability, bipolar, obsessive, psych hospitalization or other mental/emotional concerns
Y N P	Female: irregular periods, abnormal pap, PMS, STI, vaginitis, discharge, odor, heavy bleeding menstrual cramping, pain with intercourse, low libido, or other female concerns To be completed by females only: 1st day of LMP: _____ Age of First Menses: _____ Age of Menopause: _____ # of pregnancies: _____ # of live births: _____ # of miscarriages/abortions: _____

Have you ever used the following?

Antacids: YES / NO

Analgesics/pain relievers (prolonged use): YES / NO

Laxatives: YES / NO

Steroids: YES / NO

Birth Control: YES / NO

FULL LEGAL NAME: _____ DATE: _____

Family History

Family Member	Age / Age of Death	Health Conditions, Reason of Death
Mother		
Father		
Maternal grandparents		
Paternal grandparents		
Siblings: ___ Number		
Children ___ Number		

Social History

Occupation: _____ Job satisfaction 1-10 (10 being most): _____

Are you spiritually active? YES / NO

Marital Status: single partner married separated divorced widowed

Satisfaction with relationship 1-10 (10 being most): _____

Sleep: Average bed time: _____ Average wake time: _____ Sleep satisfaction 1-10 (10 being most): _____

I struggle with: falling asleep staying asleep night terrors snoring grinding teeth unrested

Energy: Rate your average energy 1-10 (10 being most): 1 2 3 4 5 6 7 8 9 10

Energy level is affected by: _____

Exercise: Activity type: _____

Frequency of activity: _____ days/week

Duration of activity: _____ minutes

Intensity: low moderate vigorous

Other hobbies you enjoy:

_____

_____

Water intake: _____ oz/day Water source: tap well distilled reverse osmosis filtered

Do you consume caffeine? YES / NO If yes, how much and how often? _____

Do you consume alcohol? YES / NO If yes, how much and how often? _____

Do you use tobacco? YES / NO If yes, how much and how often? _____

Do you use recreational drugs? YES / NO If yes, how much and how often? _____

Any history of substance abuse? YES / NO - If YES, please specify: _____

Some of our medicines are extracted in alcohol. Are you opposed to taking these medicines? YES / NO

Diet: Number of meals per day: _____ Number of snacks per day: _____

Are you avoiding any foods for any reason? YES / NO

If yes, describe which foods you are avoiding and the reason:

_____

_____

Please describe your typical diet:

_____

_____

FULL LEGAL NAME: _____ DATE: _____

CURRENT MEDICATIONS AND SUPPLEMENTS LIST

Name of Pharmacy: _____ Location (please be specific):_____

Pharmacy Phone Number: _____ Pharmacy Fax Number: _____

Drug Allergies (please list name of drug and reaction):
Food Allergies (please list food and reaction):

OVER THE COUNTER PRODUCT	DOSING & FREQUENCY	DATE STARTED	PURPOSE

PRESCRIPTION PRODUCT	DOSING & FREQUENCY	DATE STARTED	PURPOSE

SUPPLEMENT	DOSING & FREQUENCY	DATE STARTED	PURPOSE