



Naturopathic Intake Form

PERSONAL MEDICAL HISTORY

List any surgeries, hospitalizations, imaging (CT, MRI, EEG, EKG, etc.)

Date MM/YY

ALLERGIES

Do you have any allergies to medications?

Yes No

If yes, list medication and reaction

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Do you have any food or environmental allergies or sensitivities (ie, dairy, pollen, etc)?

Yes No unknown.

If yes, list allergy and reaction

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IMMUNIZATION HISTORY

Polio

Pertussis

Hepatitis A

Hepatitis B

HIB

Diphtheria

Chicken pox

Tuberculosis

Flu shot

Date ?

Others

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CHILDHOOD ILLNESS: CIRCLE ANY THAT APPLY

Chicken Pox

Mononucleosis

Rubella

German Measles

Diphtheria

Strep Throat

Tuberculosis

Scarlet Fever

LIST RECENT PREVENTATIVE SCREENING TESTS:

Test (CBC, lipids, etc)

Date

Result

Test (CBC, lipids, etc)	Date	Result
Sigmoidoscopy		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Colonoscopy		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Pap smear		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Mammogram		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Dexascan		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
PSA (prostate)		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Other:		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>



Naturopathic Intake Form
PERSONAL MEDICAL HISTORY
SOCIAL HISTORY

With whom do you live and for how long?

Do you have a religious or spiritual practice? Yes No

If yes, feel free to describe:

Do you have any pets that live in the home with you? Yes No Describe:

How often do you take vacations?

Do you exercise? Yes No

If yes, what type(s): minutes/day & days/week

Are you satisfied with your sex life? Yes No

Is there anything else you would like to share about your social or personal situation?



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PERSONAL MEDICAL HISTORY

Smoke Cigarettes: Never smoked Yes, in the past. Date quit: _____ Years of use: _____
 Yes, currently Packs per day: _____
 Other tobacco use: Pipe/Cigar/Chew/Snuff Years of Use: _____
 Tobacco exposure: Second-hand smoke Years of exposure: _____
 Do you drink alcohol? Never Past Currently Number of drinks/wk: _____
 Have you been treated for alcoholism? Yes No
 Have you ever used recreational drugs? Yes No If yes, please explain _____

Answer or check those applicable:

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Age (at death)						
Cause of death						
Anemia						
Asthma						
Hay fever, Hives						
Cancer						
Diabetes						
Epilepsy						
Glaucoma						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Stroke						
Tuberculosis						
Other:						

REVIEW OF SYSTEMS

For the following please circle:

Y = Yes/Current issue

N = No/Never had

P = Past problem

D.O.B

Name:

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PERSONAL MEDICAL HISTORY

MENTAL/EMOTIONAL

Depression	Y	N	P
Mood Swings	Y	N	P
Anxiety/Nervousness	Y	N	P
Tension	Y	N	P
Memory Problems	Y	N	P
Poor Concentration	Y	N	P
Considered suicide	Y	N	P
Attempted suicide	Y	N	P
Other			

SKIN

Rashes	Y	N	P
Itching	Y	N	P
Changes in skin color	Y	N	P
Acne/boils	Y	N	P
Eczema	Y	N	P
Lumps/bumps	Y	N	P
Hair Loss	Y	N	P
Other			

HEAD

Headaches	Y	N	P
Head	Y	N	P
Injury	Y	N	P
Jaw issues or TMJ	Y	N	P
Other			

NECK

Lumps in neck	Y	N	P
Swollen Glands	Y	N	P
Goiter	Y	N	P
Pain or Stiffness in neck	Y	N	P
Other			

EYES

Impaired Vision	Y	N	P
Glasses or Contacts	Y	N	P
Eye Pain or strain	Y	N	P
Tearing or dryness	Y	N	P
Double Vision	Y	N	P
Glaucoma	Y	N	P
Cataracts	Y	N	P
Color blindness	Y	N	P
Other			

EARS

Impaired hearing	Y	N	P
Ringing in ears	Y	N	P
Earaches	Y	N	P
History of ear infections	Y	N	P
Other			

NOSE, THROAT, MOUTH

Stuffy Nose	Y	N	P
Frequent Colds	Y	N	P
Frequent sore throats	Y	N	P
Sinusitis	Y	N	P
Hoarseness	Y	N	P
Sore Tongue or lips	Y	N	P
Gum Problems	Y	N	P
Tooth Problems	Y	N	P
Teeth grinding	Y	N	P
Other			

RESPIRATORY

Cough	Y	N	P
Excess Sputum	Y	N	P
Coughing up Blood	Y	N	P
Wheezing	Y	N	P
Asthma	Y	N	P

D.O.B

Name:

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PERSONAL MEDICAL HISTORY

RESPIRATORY CONT.

Bronchitis	Y	N	P
Pneumonia	Y	N	P
Pleurisy	Y	N	P
Emphysema	Y	N	P
Pain with Breathing	Y	N	P
Shortness of Breath	Y	N	P
-Lying down?	Y	N	P
Tuberculosis	Y	N	P

Other _____

CARDIOVASCULAR

High Blood Pressure	Y	N	P
Heart Disease	Y	N	P
Angina	Y	N	P
Chest Pain	Y	N	P
Murmurs	Y	N	P
Rheumatic Fever	Y	N	P
Swelling in ankles	Y	N	P
Palpitations, Fluttering	Y	N	P

Other _____

PERIPHERAL VASCULAR

Deep Leg Pain	Y	N	P
Cold Hands and Feet	Y	N	P
Varicose Veins	Y	N	P
Thrombophlebitis	Y	N	P

Other _____

BLOOD

Anemia	Y	N	P
Easy Bleeding or Bruising	Y	N	P
Previous Blood Transfusion	Y	N	P

Other _____

GASTROINTESTINAL

Trouble Swallowing?	Y	N	P
Change in Thirst	Y	N	P
Change in Appetite	Y	N	P
Nausea	Y	N	P
Vomiting	Y	N	P
Vomiting Blood	Y	N	P

Frequency of Bowel Movements:

--	--

Times _____ Each Day

Is this a change?	Y	N	P
Blood in Stool	Y	N	P
Black stools	Y	N	P
Diarrhea	Y	N	P
Constipation	Y	N	P
Abdominal pain or cramps	Y	N	P
Heartburn	Y	N	P
Belching or passing gas	Y	N	P
Jaundice (yellow skin)	Y	N	P
Liver Disease	Y	N	P
Gall Bladder Disease	Y	N	P
Ulcer	Y	N	P
Hemorrhoids	Y	N	P

Other _____

URINARY

Pain on Urination	Y	N	P
Increased Frequency	Y	N	P
Frequency at Night	Y	N	P
Inability to hold urine	Y	N	P
Frequent infections	Y	N	P
Kidney Stones	Y	N	P

Other _____

D.O.B

Name: _____

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PERSONAL MEDICAL HISTORY

NEUROLOGIC

Fainting	Y	N	P
Vertigo or Dizziness	Y	N	P
Seizures	Y	N	P
Paralysis	Y	N	P
Muscle Weakness	Y	N	P
Numbness/Tingling	Y	N	P
Loss of Memory	Y	N	P
Loss of Balance	Y	N	P
Other			

ENDOCRINE

Hypothyroid	Y	N	P
Heat/Cold Intolerance	Y	N	P
Excessive Thirst	Y	N	P
Excessive Hunger	Y	N	P
Fatigue	Y	N	P
Hyperthyroid	Y	N	P
Diabetes	Y	N	P
-Type 1 or 2?	1		2
Seasonal depression	Y	N	P
Other			

MUSCULOSKELETAL

Joint Pain or Stiffness	Y	N	P
Arthritis	Y	N	P
Broken Bones	Y	N	P
Muscle Spasms	Y	N	P
Weakness	Y	N	P
Sciatica	Y	N	P
Other			

IMMUNE

Reactions to vaccines	Y	N	P
Persistent swollen glands	Y	N	P
Slow wound healing	Y	N	P

Chronic fatigue	Y	N	P
Chronic infections	Y	N	P
Night sweats	Y	N	P
Other			

BREASTS

Do you perform self-exams?	Y	N	P
Breast Lumps	Y	N	P
Pain or Tenderness	Y	N	P
Nipple discharge	Y	N	P
Other			

FEMALE REPRODUCTIVE

Are you sexually active?	Y	N	P
Sexual orientation:			
Birth control?	Y	N	P
Type:			
Do you use it every time?	Y	N	
STI protection?	Y	N	
Type:			
Do you use it every time?	Y	N	
Regular partner(s)?	Y	N	
Age of first Menses			
Age of Last Menses (if menopausal):			
Date of last Pap smear:			
Abnormal Pap smear?	Y	N	
If yes, date:			
Duration of Menses:			DAYS
Length of Cycle:			DAYS
Regular Cycles	Y	N	P
Bleeding Between Periods	Y	N	P
Painful Menses	Y	N	P
Excessive/Heavy Flow	Y	N	P
PMS	Y	N	P
If so, what symptoms?			

D.O.B

Name:

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PERSONAL MEDICAL HISTORY

FEMALE REPRODUCTIVE CONTINUED

Pain with Intercourse	Y	N	P
Sexual Difficulties	Y	N	P
Difficulty Conceiving	Y	N	P
Number of Pregnancies:			
Number of Live Births:			
Number of Miscarriages:			
Number of Abortions:			
Menopausal Symptoms	Y	N	P
Vaginal odor	Y	N	P
Vaginal Discharge	Y	N	P
Endometriosis	Y	N	P
Ovarian Cysts	Y	N	P
Gonorrhea	Y	N	P
Chlamydia	Y	N	P
Genital	Y	N	P
Warts	Y	N	P
Herpes	Y	N	P
Syphilis	Y	N	P
Other			

Chlamydia	Y	N	P
Genital Warts	Y	N	P
Herpes	Y	N	P
Syphilis	Y	N	P
Prostate Disease	Y	N	P
What Type?			
Impotence	Y	N	P
Premature Ejaculation	Y	N	P
Other			

MALE REPRODUCTIVE

Are you sexually active?	Y	N	
Sexual orientation:			
Birth control?	Y	N	
Type:			
Do you use it every time?	Y	N	
STI protection?	Y	N	
Type:			
Do you use it every time?	Y	N	
Do you have regular partner(s)?	Y	N	
Hernias	Y	N	P
Testicular Masses	Y	N	P
Testicular Pain	Y	N	P
Penile Discharge or Sores	Y	N	P
Gonorrhea	Y	N	P

D.O.B

Name:

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