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NATUROPATHIC ASSESSMENT
ADULT INTAKE FORM Date: _____

Name: _____ Date of Birth ____/____/____
mm dd yr

Age _____ Gender _____ Ethnicity _____ Occupation: _____

Home Address _____ City _____

State ____ Zip Code _____ Email _____

Phone: Home _____ Work _____ Other (specify) _____

Referred By: _____

OTHER HEALTH CARE PROVIDERS

Medical Doctor_____

Chiropractor or Other _____

MEDICAL HISTORY

What are your present health concerns? Please list in their order of significance that motivated you to come in today.

1. _____
2. _____
3. _____
4. _____

Please list the 4 most significant, stressful events in your life, from most recent to most distant. Are any of these situations continuing to impact your life?

1._____Date:_____
2._____Date:_____
3._____Date:_____
4._____Date:_____

Indicate any serious conditions, illnesses, injuries and hospitalizations you have had, along with dates:

_____
_____
_____

Do you have any known allergies or intolerances (medicines, environmental, food, etc.)?

_____
_____

Do you get regular screening tests done by another doctor (blood tests, PAP, etc)? Yes No

How many times have you been treated with antibiotics? _____
Did you have any childhood disease other than chickenpox, measles, mumps?_____

FAMILY HISTORY AND COMPLETE HEALTH APPRAISAL

Please check Yes or No to each question. If yes, please circle the item in the list that applies. In addition, please check Family for all that applies to your Father, Mother or Siblings

Constitutional fatigue, insomnia, weight change, fever	**YES**	**NO**	**Family**
Skin rashes, lumps, ichy skin, acne, eczema, change in hair or nails, night sweats			
Head, Eyes, Ears, Nose and Throat Frequent headaches, head injury, vision changes, glasses or contacts, redness of eyes, double vision, blurred vision, spots in eyes, glaucoma, cataracts, tearing or dryness			
Difficulty hearing, ringing in ears, dizziness, itching in ears			
Frequent colds, nosebleeds, sinus trouble, stuffiness, gum disease, dental trouble, bleeding gums, sore tongue, hoarseness, goiter, TMJ			
Genitourinary Urinary frequency, urgency, inability to hold urine, kidney infections, bladder infections, kidney stones			
Peripheral Vascular Leg cramps, clotting problems, blood clots, varicose veins			
Endocrine Diabetes, thyroid disease, heat or cold intolerance, excessive thirst, excessive sweating, excessive hunger, excess hair loss, hormone therapy			
Female Menses Spotting, irregularity, menstrual pain, miscarriages, abortions, menopause, birth control pills			
Respiratory Frequent cough, spitting up blood, wheezing, asthma, bronchitis, emphysema, pneumonia, pleurisy, sputum/phlegm			
Cardiovascular Heart problems, high/low blood pressure, rheumatic fever, heart murmur, palpitations, shortness of breath, ankle swelling, chest pain			
Gastrointestinal Nausea, vomiting, heartburn, gas/bloating, hemorrhoids, change in bowel habits, constipation, diarrhea, blood in stools, tarry stools			
Jaundice, liver problems, gall bladder problems, hepatitis			
Musculoskeletal Joint pain, hip pain, neck pain, knee pain, back pain, carpal tunnel, muscle weakness			
Neurovascular Fainting, seizures, paralysis, involuntary movements, numbness or tingling, loss of balance, loss of memory			
Hematologic Anemia, blood transfusions, easy bleeding or bruising, cold hands or feet, blood disorder			
Sexual History Herpes, Syphilis, Chlamydia, Gonorrhea, Sores/discharge, impotence, testicular pain/swelling			
Mood Depression, anxiety, tension, phobias, nervousness			

Patient Name: _____

List all **current** medications (prescription and over-the-counter)
If there is not enough room below please attach a separate page

Medication	Reason	Dosage

List all **current** supplements/vitamins/minerals/homeopathic remedies/herbal remedies

Supplement	Brand/Manufacturer	Reason	Dosage

HABITS AND HOBBIES

Eating Habits:
Please list what you typically eat in one day:
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages _____

Sleeping Habits:
Do you sleep well? Yes No

Lifestyle and Psychological History:
Are you: Single Married Separated Divorced Widowed Living with a partner
Are you currently in a supportive relationship? _____
Do you enjoy your work? _____

Do you exercise? Yes No
Please indicate your frequency of use of the following:

Pain Relievers	_____/d	_____/wk	Alcohol	_____/d	_____/wk
Tobacco	_____/d	_____/wk	Caffeine/coffee	_____/d	_____/wk
Laxatives	_____/d	_____/wk	Recreational Drugs	_____/d	_____/wk

Did you ever smoke? Yes No If yes, when? _____
Have you ever been exposed to toxic chemicals, solvents, pesticides, herbicides, heavy metals while at work, home, or traveling? Specify _____
_____
What are your main interests and hobbies? _____
_____
Do you find your life stressful? How do you cope with stressful situations in your life?
_____
_____

Thank you for taking the time to fill in this comprehensive questionnaire. It will be a valuable resource in understanding your health.