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NATUROPATHIC ASSESSMENT
INTAKE FORM Age 12 –18 Date: _____

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

Age _____ Gender _____ Ethnicity _____

Home Address _____ City _____

State ____ Zip Code _____ Email _____

Phone: Home _____ Work _____ Other (specify) _____

Contact Person: _____ Telephone _____

Referred By: _____

OTHER HEALTH CARE PROVIDERS

Medical Doctor_____ Chiropractor/Other Provider_____

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:_____

Indicate any serious conditions, illnesses, injuries, traumas 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, etc)? Yes No
What was the date of your last medical exam? _____

How many times have you been treated with antibiotics? _____
Do you have a history of any childhood diseases or chronic infections as a child?_____

How would you rate your current state of health? (0 = very bad, 10 = the best it could be)

0 1 2 3 4 5 6 7 8 9 10

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:
With whom do you live with? _____
Are you a student? Yes No
Do you work? Yes No If so, where? _____

Do you exercise regularly? 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? _____
_____
How would you rate the stress level in your home? (0 = no stress, 10 = high stress)
0 1 2 3 4 5 6 7 8 9 10

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

Adolescent Intake Form (Individuals aged 12-18)

This form is to be completed by the patient only. All information will be kept confidential.

Education

What school do you attend?_____ Grade:_____
Have you ever repeated a grade? □ Yes □ No If so which one(s)? _____
Have you experienced any of the following problems at school?

☐ Suspension ☐ Lack of friends ☐ Trouble completing homework

☐ Fighting ☐ Problems with reading/writing ☐ Trouble attending most classes

Social

Do you smoke? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
Do you take recreational drugs? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No
If yes, have you ever had unprotected sex? ☐ Yes ☐ No
Are you satisfied with your current weight? ☐ Yes ☐ No
Have you ever taken laxatives, vomited, skipped meals to lose weight? ☐ Yes ☐ No
Do you get sad or depressed often? Yes No Please explain _____
_____
Do you have a part-time job? _____
What do you do for fun? Any hobbies? _____

Female

Age of first menstrual period? _____
Are your periods regular (do you get a period every month)? ☐ Yes ☐ No
What is the length of each period (how long bleeding lasts)?_____days
Do you have any cramps with your period? ☐ Yes ☐ No If yes, what helps to relieve them?_____
Do you have any spotting or bleeding between periods? ☐ Yes ☐ No
Do you or have you ever taken birth control pills? ☐ Yes ☐ No
Do you experience any of these symptoms with menstruation (before or during)?

☐ Bloating ☐ Tender breasts ☐ Mood swings ☐ Irritability ☐ Crying

☐ Headache ☐ Feeling tired ☐ Food cravings ☐ Acne ☐Other:_____

Male

At what age did you start to notice pubic hair _____ change in your voice_____

Review of organ systems (to be completed by both male and female)

Please check if you have any of the following now or if you had them in the past.

☐ Chills/excessive sweating	☐ Fainting	☐ Nausea/vomiting/diarrhea
☐ Recent weight loss/gain	☐ Hayfever/itchy eyes	☐ Blood in bowel movement
☐ Snoring	☐ Acne	☐ Pain with urination
☐ Bad breath	☐ Cough/wheeze	☐ Discharge from penis or vagina
☐ Frequent runny nose	☐ Shortness of breath	☐ Unexplained lumps
☐ Problems with teeth/gums	☐ Clumsiness	☐ Easy bruising/bleeding
☐ Trouble hearing	☐ Muscle/joint pain	☐ Tire easily with exertion
☐ Anxiety/stress	☐ Depression	☐ Bad temper