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NATUROPATHIC ADULT INTAKE FORM

Date:_____

Client Name:_____

A NOTE TO MY CLIENTS: Naturopathic and preventative health care are only possible when the physician has a complete picture of the patient physically, mentally and emotionally. Therefore, please take this time to carefully and thoroughly complete this health history questionnaire.

I. HEALTH CONCERNS

In your opinion, what are your most important health concerns?

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

Others: _____

II. HISTORY OF THE PRESENT ILLNESS

A. ETIOLOGY

How did these conditions develop? Are there traumatic events (surgeries, drug reactions, etc.) that you can identify having caused or clearly aggravated your health problems.

_____
_____
_____

B. PRIOR TREATMENTS AND RESPONSES

Please list all of the former treatments you have used, both conventional and alternative and the degree of effectiveness of each treatment. Please be specific about the benefits you received (if any) from each treatment.

_____
_____
_____

III. PAST MEDICAL HISTORY

A. YOUR HEALTH HISTORY

NOW	PAST	NEVER		NOW	PAST	NEVER	
☐	☐	☐	Anemia	☐	☐	☐	Diabetes
☐	☐	☐	Arthritis	☐	☐	☐	Hypoglycemia
☐	☐	☐	Asthma	☐	☐	☐	Allergies
☐	☐	☐	Alcoholism	☐	☐	☐	Candida (Yeast)
☐	☐	☐	Bleeding	☐	☐	☐	Emphysema
☐	☐	☐	Cancer	☐	☐	☐	Eczema
☐	☐	☐	Colitis	☐	☐	☐	Drug/alcohol use (Specify)
☐	☐	☐	Heart Murmur				_____
☐	☐	☐	High Bl. Pressure	☐	☐	☐	Headache
☐	☐	☐	Injury (serious)	☐	☐	☐	Pneumonia
☐	☐	☐	Kidney Disease	☐	☐	☐	Rheumatism
☐	☐	☐	Liver Dz/Jaundice	☐	☐	☐	Thyroid
☐	☐	☐	Overweight				☐Hyper ☐Hypo
☐	☐	☐	Ulcers	☐	☐	☐	Tuberculosis
_____			Other (specify)	☐	☐	☐	Venereal Disease

B. CHILDHOOD ILLNESSES

Rubella (German measles)	Measles	Mumps	Chicken Pox
Pertusis (Whooping cough)	Polio	Rheumatic Fever	Scarlet Fever
Roseola	Asthma	Others	_____

Adverse reactions to childhood vaccinations? _____

C. HOSPITALIZATIONS

Type of illness or operation/procedure	Date	Summary of findings
_____	_____	_____
_____	_____	_____

D. IMAGING

(Chest-Spinal X-Rays, CT Scans, Mammograms, Ultrasounds, MRI, angiogram, arterial-venous studies, etc.)

	Date	Summary of findings
_____	_____	_____
_____	_____	_____

E. PROCEDURES

(PAP, EKG, Stress test, holter monitor, spirometry, sigmoid/colonscopy, TB test, IVP, cystoscopy, bronchoscopy, last glaucoma check, etc.)

	Date	Summary of findings
_____	_____	_____
_____	_____	_____

F. CHRONOLOGY Now that your medical past is clear, please use the space below to very briefly list the chronology of major life stresses that have adversely affected your health beginning from conception (en utero) to the present. Include life stressors, drug or surgical complications, major illnesses and any significant mental, emotional, and physical trauma. Simply list the date and event. Example: 1982: divorce -> irregular menstrual cycle, 1989: mono -> Chronic fatigue.

_____

_____

_____

_____

IV. FAMILY HISTORY Please list ages and if deceased, what they died from and at what age. As well, please list any chronic health problems of your living relatives.

A. ANCESTRAL MEDICAL HISTORY

Mother: _____

Father: _____

Brothers: _____ Sisters: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Children: _____

B. Has any BLOOD RELATIVE had any of the following:

YES	NO	DK (DON'T KNOW)		YES	NO	DK (DON'T KNOW)	
☐	☐	☐	Anemia	☐	☐	☐	Hay Fever/Allergies
☐	☐	☐	Arthritis	☐	☐	☐	Heart Attack
☐	☐	☐	Asthma	☐	☐	☐	High Bl. Pressure
☐	☐	☐	Bleeding (easily)	☐	☐	☐	Seizures/Epilepsy
☐	☐	☐	Cancer (see below)	☐	☐	☐	Sickle Cell Anemia
☐	☐	☐	Diabetes	☐	☐	☐	Stroke
☐	☐	☐	Eczema	☐	☐	☐	Thyroid ☐Hyper ☐Hypo
☐	☐	☐	Glaucoma	☐	☐	☐	Tuberculosis
☐	☐	☐	Gout	☐	☐	☐	Ulcers

_____ Other

_____ If the answer to cancer is yes, please specify what type

V. ALLERGIC HISTORY

A. Please list any drugs, food, airborne or other substances you are allergic to.

_____

B. What happens when you have an "allergy attack?"

_____

C. List any chronic problems you have that may have resulted from a prior medication? What was the medicine and what problems did you develop?

_____

D. What prior types of allergy testing have you had?

Intradermal	Blood IgG food	Blood IgE inhalant/food	Cylotoxic
Electroacupuncture	Kinesiology	Food intolerance testing	None

VI. SOCIAL HISTORY

Does income meet monthly expenses? Yes No

Are you currently married?_____divorced? _____ number of children? _____

Have you traveled outside the US in the past year? Yes No Where? _____

VII. MEDICATIONS

A. Drugs and other medication allergies: _____

B. List any chronic problems you have that may have resulted from a prior medication. List the prescription and the problem. _____

_____

C. Please bring all prescription, over the counter drugs and supplements with you to your first visits. Please list the drugs and natural medicine products you take, the dose per pill, # of pills taken, time of day taken, and length of time you have been taking them.

Medications:_____

_____

_____

Supplements:_____

_____

_____

VIII. HEALTH HABITS

A. ALCOHOL

How often do you drink: wine _____ beer_____ other alcohol _____

B. TOBACCO

Have you used tobacco in the past? Yes No

If yes, for how long and how much? _____

Are you currently using tobacco? Yes No If yes, how much? _____/day

C. OTHER DRUGS

Do you now or have in the past used marijuana or other drugs? Yes No

If yes, please specify which drugs and if you have ever developed any chronic problems from their use?

_____

D. CHEMICAL EXPOSURES

Have you ever been chronically exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc) while at work, home or traveling? Yes No

If yes, please describe: _____

E. EXERCISE

Do you exercise? Yes No

Which of the following do you do on a regular basis:

Jog Swim Walk Bicycle Gardening Yoga Breathing Exercises

Meditation Weight lifting Other: _____

How often do you exercise and for how long? _____

F. RELAXATION

Do you make time for rest, relaxation or meditation during the day and/or before bed? ☐ Yes ☐ No

How often? _____How do you relax?_____

G. HOBBIES

What are your interests or hobbies? _____

_____

H. DIET

How many meals do you generally eat each day? ☐ One ☐ Two ☐ Three ☐ More

Where do you usually buy your food? _____

Who cooks the food you eat? _____

Are there foods that you have excluded from your diet? ☐ Yes ☐ No If yes, why?

_____

List any food you crave, regardless of their nutritional value (include sweets, chocolate, salty, sour, bread, rich/fatty foods, etc.)

_____

List any food to which you have a bad reaction: _____

Are you satisfied with your diet as it is now? ☐ Yes ☐ No If no, why not?

_____

Please list the foods that you typically eat for each meal. Make sure to include foods that are not eaten frequently. Please underline the foods that are eaten more frequently. For example, if you eat cereal almost every day for breakfast, but only have eggs once a week, then underline the cereal but still make sure to include the eggs on the list.

Breakfast:_____
_____
_____

Lunch:_____
_____
_____

Dinner:_____
_____
_____

Snack:_____
_____

Dessert:_____
_____

For each food class, please indicate how often you eat it. Write down whatever is most appropriate, be it once a day, 4 times a week, 3 times a day, etc....

Meat (beef, chicken, steak, turkey, ham, pork, luncheon meats, burgers): _____

Dairy (milk, cheese, yogurt, ice cream):_____ Eggs: _____

Bread: _____Beans: _____ Fruit: _____

Fish (including tuna): _____Salads: _____ Vegetables: _____

Nuts and seeds (including peanut butter): _____Rice: _____

Sweets (cookies, candy, cake, ice cream, etc.): _____Cereal: _____

Pasta: _____ Tofu: _____

For the liquids, please list how many 8 ounce cups you drink per day or per week.

Water: _____ Juice: _____ Milk: _____

Coffee (regular or decaff): _____Tea: _____

Soda: _____ Other: _____

In general, are you thirsty? ☐ Yes ☐ No

What temperature do you prefer to drink? Hot Cold Room Temperature

J. PERSONAL CARE Which of the following do you use on a regular basis:

☐ Dry brushing of skin ☐ Enemas ☐ Colonic Irritation ☐ Hot/Cold Baths ☐ Saunas

☐ Shower ☐ Steam ☐ Mineral Bath ☐ Oils ☐ Clay Baths ☐ Electric hair dryer/Blanket

☐ Toothbrush/_day ☐ Flossing ☐ Hair Spray ☐ Deodorant ☐ Cosmetics

What type of clothing do you wear? ☐ Cotton ☐ Wool ☐ Synthetic ☐ Dyed
Do you dislike wearing tight fitting clothes or neck ties? ☐ Yes ☐ No

K. SLEEP

Do you have trouble falling asleep? ☐ Yes ☐ No If so, what keeps you awake?

_____

Do you sleep straight through the night? ☐ Yes ☐ No
Do you wake feeling refreshed? ☐ Yes ☐ No
Do you have recurring dreams? ☐ Yes ☐ No If yes, what is the theme? _____
What position do you sleep in? _____
Is there a position that you cannot sleep in? ☐ Yes ☐ No If yes, which one? _____

L. JOB SATISFACTION

How do you feel about your work? Do you enjoy it; are you satisfied and fulfilled by it; does it provide you with the necessities of life; is it a job that you feel you must do in order to make a living?

_____

_____

IX. HOME ENVIRONMENT AND OTHER ENVIRONMENTALEXPOSURES

A. Which of the following do you routinely use at home?

☐ Forced air ☐ Radiant Heat ☐ Gas Heat ☐ Oil Heat ☐ Electric Heat
☐ Wood Stove ☐ AC ☐ Electric Blanket ☐ T.V. ☐ Microwave
☐ Feather Pillow ☐ Heated Waterbed ☐ Computer screen
☐ Other (specify) _____

B. WATER ☐ Distilled ☐ Filtered ☐ Spring ☐ Well ☐ Deionized ☐ Tap

C. Are your home and/or work environments well ventilated? ☐ Yes ☐ No
☐ Damp ☐ Moist

D. Are there unusual/unpleasant smells in your work/living environment? ☐ Yes ☐ No

E. When were the ducts in your house last cleaned _____

F. Which of the following are most bothersome to you or are known allergies?

Sunshine	Dust	Dampness	Lack of sunshine	Mold
Dryness	New Moon	Tobacco smoke	Cold	Seashore
Perfume	Heat	Storms Approaching	Car Fumes	Mountains
Spring	Fall	Summer	Winter	Pollen
Dogs	Cats	Fluorescent lighting	Grass/weed	Poor Air ventilation

Change of weather (specify) _____
Chemicals (specify) _____
Foods (specify) _____
Other (specify) _____

G. Do you get outdoors daily, even in the winter? Yes No

X. REVIEW OF SYMPTOMS

NOTE: Please indicate if these symptoms apply to you NOW or in the PAST by writing a (**N**) for NOW or a (**P**) for Past. As well, please mark a **(1) =MILD**, **(2) =MODERATE**, **(3) = SEVERE** next to the following symptoms which apply to you. If none apply, please leave blank. For example, you would write N, 3 for headaches if you have them now and they are severe.

Integument (Skin)

_____Skin rough, dry, scaly, bumpy, itchy (Please circle if applicable)
_____Rashes, warts, moles, cysts (Please circle those applicable)
_____Have any of these changed in color or size recently?
_____Light or dark patches of skin (circle those applicable)
_____Pimples - List location(s) _____
_____Color changes, ridges, pits, white spots on nails (please circle)
_____Loss of hair - List location(s) _____
_____Hives - List what causes them _____
_____Scars - List location(s) _____

Hematopoietic, Lymph, Immune

_____Painful lymph nodes
_____Difficulty stopping bleeding
_____Bleeding from unusual places
_____Bruising easily
_____Wounds heal slowly
_____Anemia
_____Swollen glands
_____Fluid retention

Endocrine

_____Unexplained weight loss/gain
_____Prefers hot weather
_____Prefers cold weather
_____Can't stand cold
_____Can't stand heat
_____Cold hands or feet
_____Chronic fatigue
_____Weakness
_____Increased thirst
_____Increased hunger

Head

_____Head injury
_____Dizziness
_____Severe headaches/migraines
_____Double vision
_____Fainting Spells
_____Seizures, convulsions

Eyes

_____Glasses or contacts
_____Blurriness
_____Tearing/dryness
_____Cataracts
_____Double vision
_____Glaucoma
_____Spots in eyes
_____Eye pain/strain

Ears

_____Discharge from ears
_____Ringing in ears
_____Date of last hearing test
_____Pain in ears
_____Hearing problems
_____Sensitivity to noise

Nose

_____Nose bleeds
_____Nasal scabs/crusts
_____Sinus congestion
_____Loss of smell

Mouth

_____Sore mouth or tongue
_____Speech difficulties
_____Bleeding gums
_____Loss of teeth
_____Cold sores, blisters
_____Amount of Mercury amalgams

Throat

_____Persistent hoarseness
_____Difficulty swallowing
_____Recurrent strep throat
_____Loss of voice
_____Pain
_____Chronic sore throat

Neck

_____Stiffness
_____Swelling
_____Injuries
_____Pain (describe area/type)

Pulmonary (Respiratory)

_____Unexplained fever
_____Chest pain while breathing
_____Wheezing
_____Difficulty breathing at night
_____Dry sweats
_____Night sweats
_____Shortness of breath
_____Daily cough

Have you ever been exposed to T.B. (Tuberculosis)? Yes No
How many pillows do you sleep on? _____

Cardiovascular

_____Chest pain when walking
_____Chest pain when sit/lying
_____Ankle or abdominal swelling
_____Heart palpations-fibrillation, flutter, skipping beat, beating fast, beating slow (circle if yes)
_____Leg vein problems
_____Leg pain when walking
_____Numbness/tingling in extremities
_____Heart murmur (list type)_____

Have you had rheumatic fever of syphilis? Yes No
If yes, when? _____
How far can you walk? _____
How many stairs can you climb before having to stop? _____
What symptoms make you stop? _____

Urinary

_____Frequent urination
_____Night urination
_____Difficulty holding urine
_____Painful urination
_____Difficult starting urine
_____Blood in urine

Male Reproductive

_____Prostate problems
_____Swelling, lumps, pain in testicles
_____Discharge from penis
_____Infertility
_____Hernias
_____Painful erection
_____Difficulty achieving/ maintaining erection
_____Difficulty or premature ejaculation
_____Date of last prostate exam

Are you currently sexually active? Yes No
What type of contraception do you use? _____

Gastrointestinal

_____Constipation
_____Diarrhea
_____Alternating constipation, diarrhea
_____Change in bowel movements
_____Vomiting blood
_____Strain at stooling
_____Hemorrhoids
_____Black stools
_____Blood in stools
_____Stools- yellow, grey, green, foul odor, black, undigested matter (circle applicable)
_____Frequency of bowel movements per day
_____Frequent/severe nausea
_____Heartburn
_____Trouble swallowing
_____Excessive belching
_____Excessive lower bowel gas
_____Difficulty belching, stomach cramps, colic
_____Abdominal bloating/distension
_____Distress from fat or greasy foods
_____Bad breath
_____Bad taste in mouth
_____Date of last hemoccult test (hidden blood in stool)

_____Body odor (including feet)
_____Indigestion immediately after a meal
_____Indigestion 2-3 hours after meals with fullness, bloating, or pain
_____Stomach pain 5-6 hours after eating, usually at night relieved by eating or drinking
_____Symptoms worse with worry, stress & tension
_____Nervous, shaky with headaches relieved by sweets
_____Sudden strong cravings for sweets or alcohol
_____Irritable if late for a meal, miss meal or prior to breakfast
_____Loss of appetite
_____Insatiable appetite
_____Weight change – increase or decrease (circle which)
_____Diet but fail to lose weight
_____Eat but fail to gain weight
_____Overweight
_____Underweight
_____Compulsive eating
_____Addictive eating
_____Anorexia
_____Bulimia
_____Stomach/abdominal pain
_____Yellow jaundice
_____Intestinal parasites suspected

Female Reproductive

_____Lump in breast(s)
_____Nipple discharge
_____Breast pain
_____Pelvic pain
_____Discharge from vagina
_____Vaginal itching/burning
_____Genital eruptions
_____ Painful periods

_____Painful sex
_____Lack of sexual desire
_____Difficulty feeling sexual arousal
_____Never/seldom have orgasms
_____Menstruation excessive
_____Menstruation absent
_____Bleed/spot between periods

Have you ever used birth control pills? Yes No If yes, how long? _____
Side effects? _____
Have you ever used an I.U.D.? Yes No
How long? _____ What kind? _____
Side effects? _____
Are you currently sexually active? Yes No
Current form of contraception _____
Age of first menstruation
Did you have a normal puberty? Yes No
Periods occur every _____days Regular? Yes No
Periods usually last _____days (average)
Date of last period _____

Please mark B if before, D if during, or A if after menstruation.

PMT-A ("Anxiety")
_____Nervous tension
_____Irritability
_____Mood changes
_____Anxiety
_____Insomnia

PMT-D ("Depression")
_____Depression
_____Forgetful
_____Crying
_____Confusion

PMT-C ("Craving")
____Headaches
____Craving for sweets
____Increased Appetite
____Heart pounding
____Dizziness or fainting
____Fatigue

PMT-H ("Hyperhydration")
_____ Weight gain
_____ Abdominal bloating
_____ Extremity swelling
_____ Breast tenderness

Have you had in the past, or do you currently have problems with infertility? Yes No If yes, please explain

_____

_____

_____# of pregnancies _____# of births _____# of miscarriages _____# of abortions

Have you had any complications due to pregnancy? Yes No If yes, please explain.

_____

_____

Pituitary

_____Failing memory
_____Low blood pressure
_____Increase sex desire
_____Splitting headaches
_____Menstrual disorders
_____High/Low sugar tolerance
_____Intestinal bloating
_____Abnormal thirst
_____Decrease sex desire
_____Chunky hips or waist
_____Ulcers, colitis

Thyroid

_____Overweight
_____Difficulty losing weight
_____Constipation
_____Tired upon rising
_____Easily fatigued
_____Dry or scaly skin
_____Chilly/sensitive to cold
_____Mental slowness
_____Decrease appetite
_____Nervousness
_____Heart palpitations
_____Irritable/restless
_____Increased appetite
_____Underweight
_____Flush/get hot easily
_____Insomnia

Adrenals

_____Easily stressed
_____Easily/chronically fatigued
_____Dizziness
_____Headaches
_____Hot flashes
_____Bronzing on the skin
_____Craves salt
_____Nails weak, ridged
_____Tendency to get hives
_____Rheumatism/arthritis
_____Poor circulation
_____Increased blood pressure
_____Weak after getting a cold
_____Facial hair (women)

Sympathetic Nervous System

_____Upset from acid foods
_____Cold extremities
_____Light sensitive
_____Decreased urine output
_____Heart pounds when lying
_____Reduced appetite
_____Frequent cold sweats
_____Dry eyes, nose, mouth
_____Nervousness
_____Wound heal slowly
_____Gag easily
_____Very quick mentally

Parasympathetic Nervous System

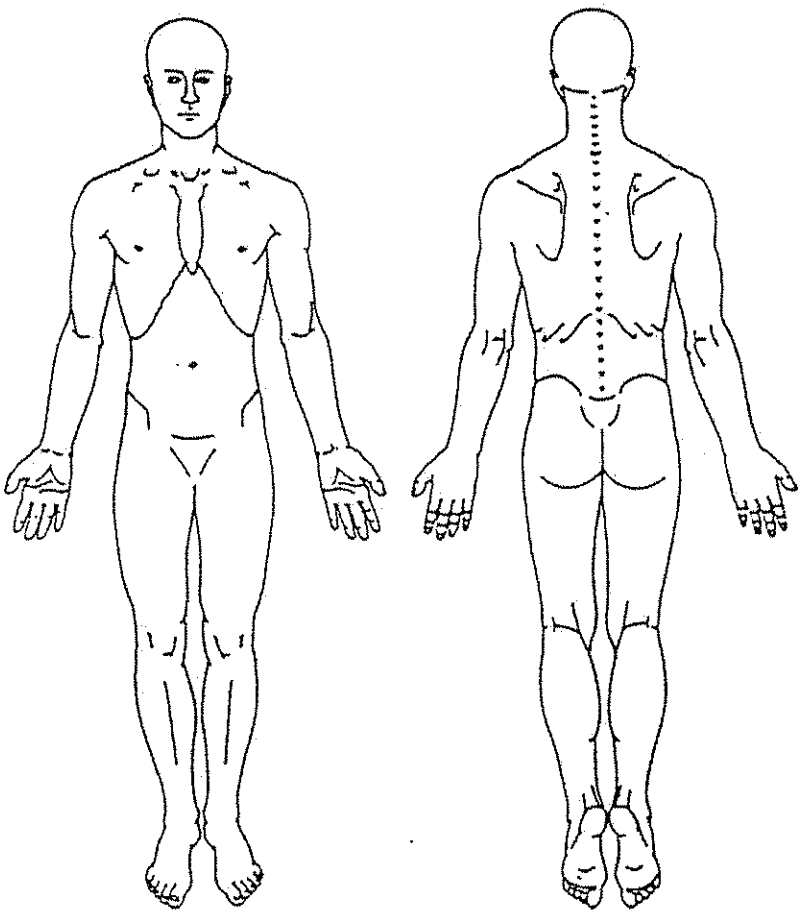
_____Joint stiffness on rising
_____Frequent vomiting
_____Alternating constipation/diarrhea
_____Pulse slow/irregular
_____Breathing irregularly
_____Poor circulation
_____Eyelids swollen/puffy
_____Muscle/leg/toe cramps
_____Butterfly stomach cramps
_____Digestion rapid
_____Indigestion after eating
_____Perspiration scant/absent
_____Perspire easily/profusely

Central and Peripheral Nervous System

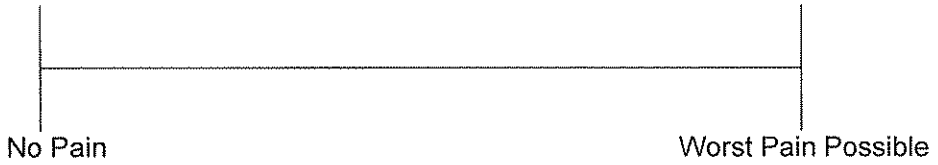
_____Loss of balance/fainting
_____Convulsions (seizures)
_____Tremor (shaking, trembling)
_____Is one arm or leg shorter than the other? Yes No
_____Lack of strength
Where? _____
_____Dizziness regularly
_____Numbness/tingling (circle)
_____Temporary loss of sensation
_____Continual headaches
_____Blurred/double vision
_____Paralysis

Spine and Extremities

_____Muscle cramps
_____Backaches (mark location on diagram below)
_____Burning on soles of feet or palms of hands (circle)
_____Joint pains/swelling, stiffness (mark location on diagram below)
_____Coughing, sneezing, or straining at stools that intensifies back pain
_____Redness on palms of hand



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.



General Status

Listed below are factors which may or may not influence your state of being. Please mark the appropriate box signifying their influence.

BETTER	WORSE		BETTER	WORSE
		Winter		Spring
		Summer		Autumn
		Cold		Heat
		Dampness		Storms
		Sun		Wind
		Open air		Confined (stuffy) air
		Change of weather		Moonlight
		Ocean seashore		Mountains
		Physical exertion		Upon rising
		Morning		Afternoon
		Evening		Night
		Bath		Warm application
		Cold application		Traveling
		Before menstruation		During menstruation
		After menstruation	_____	Other

What are your best and worst times of day? _____

What time of day is your energy level highest and lowest? _____

_____

Mental Status

_____Anxiety
_____Restlessness
_____Excessive worry
_____Depression
_____Despair/Discontent
_____Suicidal thoughts
_____Suicide attempts
_____Loneliness/feel alone
_____Mood swings
_____Prefer to be with company
_____Prefer to be alone don't seek out company
_____Afraid when left alone
_____Would rather be left alone when not feeling well

_____Memory difficulty, forgetting
_____Mental confusion
_____Decreased concentration, comprehension
_____Make many mistakes
_____Shy, timid
_____Critical of self
_____Critical of others
_____Lack self-confidence
_____Suspicious/jealous
_____Organized, neat/clean
_____Affectionate
_____Assertive, powerful
_____Confident, secure
_____Intimate with others

THANK YOU FOR YOUR THOROUGHNESS