



Naturopathic Wellness Center, P.L.L.C.

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Patient Intake Form

First Name: _____ Last Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address _____

Highest level of education: _____

Occupation: _____ Employer _____ Hours work per week: _____

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

Date of Birth: _____ Age _____ Place of Birth _____

Social Security Number: _____

Person to call in case of Emergency: _____ Relationship to you: _____

Phone number contact for them: _____

Regular Physician: _____

How did you hear of the clinic: _____

I understand and agree that I am financially responsible for all charges and payment must be made at the time of visit unless other arrangements are made in advance. I understand and agree that I will pay a fee for the doctor's time if I fail to cancel or reschedule an appointment without 24 hours notice. I understand and agree that these charges will be billed to the credit card number I have given and authorized for the purposes of billing any and all missed appointments without 24 hour notification.

Patient's Signature _____ Date _____

List in Order of Importance what your problems are:

- 1.
- 2.
- 3.
- 4.
- 5.

Last time you had blood work done and with what doctor: _____

Family history

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	_____	_____	_____	_____	_____	_____
Age when died	_____	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer (type)	Y N	Y N	Y N	Y N	Y N	Y N
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-immune disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries and Hospitalizations—including date occurred:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please Note When and Why You Had Each of The Following:

X-rays: _____
 MRI/Cat Scans: _____
 Ultrasounds: _____
 Accidents: _____

Please List All Sensitivities/Allergies/Reactions

Drugs: _____
 Foods: _____
 Environment: _____

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	D I N	Diphtheria:	D I N
Mumps:	D I N	Tetanus:	D I N
Rubella:	D I N	Whooping Cough:	D I N
Chickenpox:	D I N	Hemophilus (Hib):	D I N
German Measles:	D I N	Hepatitis B:	D I N

Any vaccination reactions: _____

List Yes, No, or Past regarding use of the following:

Antacids:	Y N P	Steroids:	Y N P
Smoking:	Y N P	Packs per day if Yes/Past:	_____
Analgesics:	Y N P	Laxatives:	Y N P
Coffee:	Y N P	Cups per day if Yes/Past:	_____
Soda Pop:	Y N P	Ounces per day if Yes/Past:	_____
Alcohol:	Y N P	How often and how much if Yes/Past:	_____
Any alcohol addiction:	Y N P		
Any alcohol treatment:	Y N P		
Recreational drugs:	Y N P		
Any drugs addiction:	Y N P		
Any drug treatment:	Y N P		

List all Prescription Medicines and Nutrient Supplement/Herbs Taking:

Review Of Systems:

Present Weight: _____ Weight one year ago: _____
Height: _____ Maximum weight and when: _____
Minimum Weight as adult and when: _____
Ideal Weight: _____

REGARDING THE NEXT LONG SECTION: Please Circle Y if you have the problem NOW, N if you've NEVER had the problem, P if you had the problem in the PAST.

Good Energy: Y N P

Fatigue: Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst?: _____

If you have fatigue, can you do what you need to during the day?: Y N

Skin:

Rash: Y N P

Hives: Y N P

Psoriasis/eczema: Y N P

Dry: Y N P

Cancer: Y N P

Color Change: Y N P

Lump: Y N P

Itchy: Y N P

Warts/moles: Y N P

Perspiration: Y N P

Head:

Headache: Y N P

Dandruff: Y N P

Oil/dry hair: Y N P

Migraine: Y N P

Head Injury: Y N P

Hair loss: Y N P

Eyes:

Dry/Watery: Y N P

Double vision: Y N P

Glaucoma: Y N P

Strain: Y N P

Itchy: Y N P

Blurry vision: Y N P

Cataracts: Y N P

Styes: Y N P

Discharge: Y N P

Dark under eyelid: Y N P

Nose:

Frequent colds: Y N P

Congestion: Y N P

Polyps: Y N P

Nosebleeds: Y N P

Post nasal drip: Y N P

Seasonal allergies: Y N P

Mouth/Throat:

Canker sores: Y N P

Sore throat: Y N P

Dentures: Y N P

Loss of taste: Y N P

Cold sores: Y N P

Gum disease: Y N P

Cavities: Y N P

Hoarseness: Y N P

Neck:

Stiffness: Y N P

Full movement: Y N P

Swollen glands: Y N P

Tension: Y N P

Respiratory:

Cough:	Y N P	TB:	Y N P
Shortness of breath with exertion:	Y N P	Bronchitis:	Y N P
Shortness of breath sitting:	Y N P	Pneumonia:	Y N P
Shortness of breath lying down:	Y N P	Asthma:	Y N P
Wheezing:	Y N P	Painful breathing:	Y N P

Cardiovascular:

High blood pressure:	Y N P	Rheumatic Fever:	Y N P
Low blood pressure:	Y N P	Murmurs:	Y N P
Arrhythmias:	Y N P	Palpitations:	Y N P
Edema:	Y N P	Chest pain:	Y N P

Gastrointestinal:

Heartburn:	Y N P	Bowel movement frequency:	_____
Indigestion:	Y N P	Recent change in BM:	Y N P
Bloating:	Y N P	Diarrhea or constipation:	Y N P
Nausea:	Y N P	Hemorrhoids:	Y N P
Vomiting:	Y N P	Gall bladder disease:	Y N P
Change in Appetite:	Y N P	Liver disease:	Y N P
Pancreatitis:	Y N P	Ulcer:	Y N P

Urinary Tract:

Incontinence:	Y N P	Pain with urination:	Y N P
Frequent infections:	Y N P	Kidney stones:	Y N P
Urgency:	Y N P	Discharge/blood:	Y N P

Male Genitalia:

Testicular pain/swelling:	Y N P	Sexually active:	Y N P
Hernia:	Y N P	Sexually transmitted disease:	Y N P
Discharge:	Y N P	Prostate disease/symptoms:	Y N P
Impotency:	Y N P	Sexual orientation: Hetero Homo Bi	

Female Genitalia:

Age periods began: _____	How often periods occur: _____
How long periods last: _____	Menopausal since what age: _____
	Times Pregnant: _____

Periods:

Heavy Bleeding:	Y N P	How many births:	_____
Cramping:	Y N P	Miscarriages:	_____
Pain:	Y N P	Abortions:	_____
PMS:	Y N P	Sexual Active:	Y N P
Food Cravings:	Y N P	Healthy Libido:	Y N P
Last Pap Smear: _____		Pain With Intercourse:	Y N P
Diagnosis: _____		Dry Vagina:	Y N P
Any abnormal paps:	Y N P	Vaginitis:	Y N P
When was abnormal:	Y N P		
Any Birth Control (please list types and ages used): _____			
Sexually Transmitted Diseases:	Y N P		
Mammography:	Y N P		
Dexa Scan:	Y N P	If Yes, what were the results: _____	
Use of Hormones:	Y N P		

Musculoskeletal:

Weakness: Y N P
Stiffness: Y N P
Tremors: Y N P

Arthritis: Y N P
Leg cramps: Y N P
Pain: Y N P

Nervous:

Paralysis: Y N P
Tingling/numbness: Y N P
Seizures: Y N P

Sciatica: Y N P
Carpal tunnel syndrome: Y N P
Fainting: Y N P

Mental/Emotional:

Depression: Y N P
Suicidal: Y N P
Anxiety: Y N P

Anger/irritability: Y N P
High-strung/tense: Y N P
Fear/Panic: Y N P

Exercise:

How often: _____
What type(s): _____
For How long: _____

Hobbies:

Sleep:

How long per night: _____
If you wake up frequently, what is the reason: _____
Nightmares: Y N P
Wake refreshed: Y N P
Must Nap during the day: Y N P
Sleep walk: Y N P
Grind Teeth: Y N P
Snore: Y N P

Food:

Appetite Good?: Y N P
Foods crave: _____
Foods Dislike: _____
Foods that don't sit well: _____
List your typical eating habits:
Morning _____
Afternoon _____
Evening _____
How many times a week do you eat out? _____ Do you cook? Y N

