inner source
HEALTH

Doctors of Naturopathic Medicine / Licensed Acupuncturists
www.InnerSourceHealth.com

PATIENT INTAKE FORM

Date:

Name:

Date of Birth:

Address:

Home phone:

Work phone:

Cell phone:

Email:

How did you hear about our practice
Internet: google ____ facebook ____NYANP _____ AANP____ yahoo _____
Advertisement _____ (where)
Friend/family_____
Other: _____

"X" all that apply: Is it o.k. to leave a phone/mail message regarding your care at:

- ☐ home
- ☐ work
- ☐ cell phone
- ☐ email

Emergency Contact Information:

Name:
Relationship:
Phone Number:
Please list your health concerns in order of priority along with other practitioners you may be seeing for the condition:
1.
2.
3.
4.
5.

What do you believe is causing your most important health concerns?

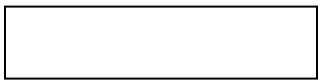
Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

Medications:	Reason:	Date began:	Dose:	Helps? Yes or no

Supplements:	Reason:	Date began:	Dose:	Helps? Yes or no

PLEASE CHECK AND DESCRIBE ANY PROBLEMS OR CHANGE IN FUNCTION IN THE PAST OR PRESENT IN ANY OF THESE AREAS (the notes in parentheses are examples. Please don't limit your responses to these).

___ Weight
___ Energy
___ Sleep
___ Mood (e.g. anxiety, depression)
___ Body temperature
___ Headaches
___ Visual changes or other eye conditions (e.g. styes, cataracts, glaucoma, double vision, floaters)
___ Nose/sinuses (e.g. allergies, sinus infections)
___ Mouth/teeth/gums (including dental procedures)
___ Throat and lungs (e.g. recent or recurrent infections, asthma, COPD)
___ Heart disease (e.g. rheumatic fever, chest pain, palpitations)
___ Digestive tract problems (e.g. low appetite, constipation, diarrhea, bloating, hemorrhoids)

How often do you have a bowel movement? 

___ Stomach (ulcers, reflux, etc)
___ Skin (eczema, infections, rashes)
___ Musculoskeletal concerns (arthritis, joint pain, muscle pain, weakness, osteoporosis)
___ Urinary tract problems (infection, incontinence)
___ Other:_____

WOMEN:
Date or age of last menstrual period: _____
Onset of first menses was age____. Periods generally last(ed) ___ days and occur(ed) every ___ days.
Bleeding is/was __Heavy __Moderate __Light
Spotting between periods? If yes, please describe_____
Do/did you experience PMS symptoms?_____ List:_____
Are you currently experiencing any gynecological symptoms or problems?_____
Are you currently sexually active?_____ Partner(s) is/are __Male __Female
If sexually active, what are your safe sex practices?_____
Any problems related to sexual function/libido?_____
History of sexually transmitted infections?_____ Genital warts?_____
Number of pregnancies?____ Births?____ Abortions?____ Miscarriages?____
Date of last Pap Smear?_____ Abnormal Pap?_____
How frequent do you have a gyn exam/ pap smears? _____
History of cervical cancer ? _____if yes, when:_____
History of ovarian cancer? _____if yes, when:_____
History of breast cancer?_____if yes, when:_____
Do you perform regular breast self exams? _____yes ____no
If menopausal or perimenopausal: List symptoms and concerns _____
_____

MEN:
Are you currently sexually active?_____ Partner(s) is/are __Male __Female
If sexually active, what are your safe sex practices?_____
Trouble with sexual function/libido?____ If yes, explain: _____
History of sexually transmitted infections?_____ Genital warts?_____
Date of last prostate exam?_____
Trouble with urination? (frequency, hesitancy, pain, dribbling)_____

FOR CHILDREN 10 YEARS AND BELOW:
Was this child's pregnancy full term?
Vaginal or caesarian delivery?
Any complications with delivery?
Any medications given during pregnancy or delivery?
Did the mother have gestational diabetes or hypertension during pregnancy?

PLEASE DESCRIBE YOUR FAMILY'S HEALTH: (be sure to include current age or age of death, history of major illnesses, including diabetes, heart disease, osteoporosis, cancer, allergies, etc.)

Member	Living?/Age	Major illness or chronic conditions
Mother		
Father		
Siblings		
Mat. Grandmother		
Mat. Grandfather		
Pat. Grandmother		
Pat. Grandfather		

SURGERIES/HOSPITALIZATIONS:

Age:	Description:

DIET: Please describe a typical days diet for you

Breakfast	Lunch	Dinner	Snacks (what hour)

Sources and amounts of:

Caffeine:_____

Alcohol:_____

Smoking history and amount:_____

History of drug or alcohol abuse? If yes, please describe:_____

WEIGHT and HEIGHT:

	Current	Past year	Past 5 years
Weight			
Height			

BLOOD TYPE:

ALLERGIES: please list any life threatening or severe allergies to drugs or foods that you know of:

1.
2.
3.

LIFESTYLE:

What are your current primary sources of stress?

1.
2.
3.

How much do you think they impact you life?_____

Occupation? _____ Do you like your work? _____

How many hours do you work per week?_____ Number of play/relaxation hours?_____

What do you do in order to manage stress and take care of yourself? : _____

What is your exercise routine? (type of exercise, frequency and duration): _____

What is your favorite magazine and newspaper? _____

What is your favorite radio station? _____

OTHER MEDICAL/SAFETY QUESTIONS:

Date of last full physical?_____ if abnormal, explain:_____

Date of last dermatology checkup?_____ if abnormal, explain:_____

Any personal history of skin cancer? ____yes _____no

If over age 50, have you had a colonoscopy? ____yes _____no

Dates of colonoscopies? _____

Any positive findings on colonoscopy? ___yes___no, if yes, explain:_____

Date of last visual acuity exam?_____if abnormal, explain: _____

Date of last ophthalmologic exam? _____ if abnormal, explain: _____

Do you use seat belts while riding in a car? ____yes _____no

Do you have a fire alarm in your home? ____yes _____no

Do you have a carbon monoxide (CO) detector in your home? ____yes _____no

Do you have a fire extinguisher in your home? ____yes _____no

Do you visit the dentist regularly? ___yes ____no If yes, how frequent? _____

Do you have dental problems, gum inflammation or gingivitis? Circle which and explain: ____

Please list your three greatest stressful life events and their date:
1)
2)
3)

Please list your three happiest life events and their date:
1)
2)
3)

Take a minute to imagine what good health means to you. What would it look like if all the health concerns you currently have were successfully solved? What would you be able to do? How would you feel?

What do you believe is your greatest challenge?

And finally, what do you think you need to do in order for you vision of health to happen?

Thank you for your time and for filling this form out as completely as possible. Please remember all information given is strictly confidential. Return this form via email to info@innersourcehealth.com or via fax to 631-421-1059.