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PATIENT INTAKE FORM

Date:

Name:

Date of Birth:

Address:

Home phone:

Work phone:

Cell phone:

Email:

Would you like to join our newsletter? _____ **Yes** _____ **No**

How did you hear about our practice:

____ Google _____ NYANP.org _____ Naturopathic.org _____ Other online _____ Newspaper
____ Friend (Whom May we Thank? _____) _____ Facebook

“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 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

- Headaches
- Weight
- Vision
- Nose/sinuses (example: allergies, sinus infections)
- Throat (example: recent or recurrent infections)
- Digestive tract problems (example: bowel problems, hemorrhoids, hernias, diarrhea, bloating)

How often do you have a bowel movement?

- Energy
- Body temperature
- Other eye problems (infections, sties)
- Mouth/teeth/gums (including dental procedures)
- Skin (eczema, infections, rashes)
- Heart disease (rheumatic fever, shortness of breath, palpitations)
- Stomach (ulcers, reflux, etc)
- Musculoskeletal concerns (arthritis, joint problems, Osteoporosis, muscle pain, weakness):
- Other: _____

WOMEN:

- Are you currently experiencing any gynecological symptoms or problems? _____
- Are you currently sexually active? _____ Partner(s) is/are Male Female
- If sexually active, do you perform safe sex practices? _____
- Any problems related to sexual function? _____
- History of sexually transmitted diseases? _____ 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? _____
- Any cervical cancer history? _____ if yes, when: _____
- Any ovarian cancer history? _____ if yes, when: _____
- Do you perform regular breast self exams? yes no
- If menopausal or perimenopausal: List symptoms and concerns: _____
- _____
- Any personal history of breast cancer? _____

FOR WOMEN WHO ARE OF MENSTRUATING AGE:

- Onset of first menses was age ____ . Periods generally last ____ days and occur every ____ days.
- Date of last period _____ Bleeding is Heavy Moderate Light
- Do you experience PMS symptoms? _____ List: _____

MEN:

- Are you currently sexually active? _____ Partner(s) is/are Male Female
- History of sexually transmitted diseases? _____ Genital warts? _____
- Date of last prostate exam? _____
- Trouble with urination? (frequency, hesitancy, pain, dribbling) _____

Trouble with sexual function/libido?__ __ If yes, explain:

FOR CHILDREN 10 YEARS AND BELOW:

Was this child's pregnancy full term? Yes/no Child's Birth weight?

Vaginal or caesarian delivery?_____

Any complications with delivery?_____

Any medications given in pregnancy or delivery? Yes/no Which ones?_____

Did the mother have gestational diabetes or hypertension during pregnancy? Yes/no

Has the child received vaccines? y/n Starting at what age?__ Was there any reactions to vaccine(s)? y/n

Do they get sick often? Yes/no Where (chest, ear, throat)?_____

PLEASE DESCRIBE YOUR FAMILY'S HEALTH: (be sure to include current age or age of death, major illness history, 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:

Age:	Description:

DIET: Please describe a typical day's diet for you

Breakfast	Lunch	Dinner	Snacks (what hour)

Sources and amounts of:

Caffeine:_____

Alcohol:_____

Smoking history and amount:_____

WEIGHT and HEIGHT:

	Current	Past year	Past 5 years
Weight			
Height			

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

- 1.
- 2.
- 3.

LIFESTYLE:

Marital Status: _____

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?: _____

What is your favorite magazine and newspaper? _____

What is your favorite radio station? _____

Do you or anyone in the family smoke? _____

Do you have pets? _____

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 colonoscopy? _____

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, bleeding and/or gingivitis? Circle which and explain:

Do you feel that you have had any significant environmental toxic exposure? _____

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)

What do you believe is your greatest challenge?

Thank you for your time and for filling this form out as completely as possible. Please remember all information given is strictly confidential. Please print a copy and bring to your first appointment.