Alternative Healthcare Consultants

Naturopathic Medical Intake Form-Adult

Name _____Date of First Visit _____

Address _____

City _____ State _____Zip Code _____

Telephone # (home) _____(work) _____

Age _____Date of Birth _____Gender: female ____male ____

Email_____

Married ____ Separated ____ Divorced ____ Widowed ____Single ____ Partnership____

Live with: Spouse ____ Partner ____ Parents ____ Children ____ Friends ____ Alone ____

Occupation _____Hours per week _____Retired _____

Employer _____S.S.# _____

(Work address) _____

Health insurance co. name and address _____

Telephone number_____ Policy/Group # _____

Policy holder's name _____ Employer _____

Identification/Social Security # _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

Next of Kin or other to reach in an emergency _____

Relationship _____Phone _____

Address _____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

HEALTH HISTORY QUESTIONNAIRE

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PROVIDER HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Are you currently receiving healthcare? Y○ N○

If yes, where and from whom?_____

_____

If no, when and where did you last receive medical or health care?

_____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

1)_____
2) _____
3) _____
4) _____
5) _____
6) _____

Do you have any known contagious diseases at this time? Y○ N○

If yes, what?_____

FAMILY HISTORY

	FATHER	MOTHER	BROTHERS	SISTERS	G'PARENTS
Age (if living)	_____	_____	_____	_____	_____
Health (G=good P=poor)	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____
Mark (x) those applicable					
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Asthma/Hayfever/Hives	☐	☐	☐	☐	☐

Anemia	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Cause of Death	☐	☐	☐	☐	☐

For all the following sections

Y = a condition you have now **P** = a condition you have had in the past **N** = never had the condition

Childhood Illnesses

Scarlet fever	Y○	N○	Diphtheria	Y○	N○	Rheumatic fever	Y○	N○
Mumps	Y○	N○	Measles	Y○	N○	German measles	Y○	N○

Hospitalization and Surgery

What hospitalizations or surgeries have you had?

_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

X-Rays and Special Studies

X-rays, CAT scans, or other studies you have had:

_____

_____

Electrocardiogram	Y○	N○	Electroencephalogram	Y○	N○

Immunizations

Polio	Y○	N○	Pertussis	Y○	N○
Tetanus shot	Y○	N○	Diphtheria	Y○	N○
Measles/Mumps/Rubella	Y○	N○	Other _____		

Allergies

Are you hypersensitive or allergic to...
Any drugs? _____
Any foods? _____
Any environmentals? _____

Current Medications

Do you take or use?

Laxatives	Y○	N○	Pain relievers	Y○	N○	Antacids	Y○	N○
Cortisone	Y○	N○	Appetite suppressants	Y○	N○	Antibiotics	Y○	N○
Tranquilizers	Y○	N○	Thyroid medication	Y○	N○	Sleeping pills	Y○	N○

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

HABITS (Y = now, P = past, N = never)

Main interests and hobbies?_____

	Y	P	N		Y	P	N
Do you exercise?	○	○	○				
If yes, what kind?_____ How often? _____							
Average 6-8 hrs. sleep?	○		○	Enjoy your work?	○		○
Sleep well?	○		○	Take vacations?	○		○
Awaken rested?	○		○	Spend time outside?	○		○
Have a supportive relationship?	○		○	Watch television?	○		○
Have a history of abuse?	○		○	how many hours? _____			
Any major traumas?	○	○	○	Read?	○		○
Use recreational drugs?	○	○	○	how many hours? _____			
Been treated for drug dependence?	○	○	○				
Do you eat three meals a day?	○		○	Use alcoholic beverages?	○	○	○
Do you eat out often?	○		○	Treated for alcoholism?	○	○	○
Do you go on diets often?	○		○	Do you use tobacco?	○	○	○
Do you drink coffee?	○	○	○	Smoked previously?	○	○	○
Do you drink black or green tea?	○	○	○	how many years? _____			
Do you drink cola or other sodas?	○	○	○	how many packs per day? _____			
Do you eat refined sugar?	○	○	○				
Do you add salt?	○	○	○				

Do you have a religious or spiritual practice? N☐ If yes, what?_____
Is there any information about your health you would like to add? _____

_____

GENERAL

Weight _____ lbs. Weight 1 year ago _____ lbs.
Maximum Weight _____ When _____
Height _____
When during the day is your energy the best? _____ worst? _____

REVIEW OF SYSTEMS

FOR THE FOLLOWING, PLEASE CIRCLE

Y = a condition you have now **P** = a condition you have in the past **N** = never had the condition

MENTAL/ EMOTIONAL

	Y	P	N		Y	P	N
Treated for emotional problems?	○	○	○	Depression?	○	○	○
Mood Swings?	○	○	○	Anxiety or nervousness?	○	○	○
Considered/Attempted suicide?	○	○	○	Tension?	○	○	○
Poor concentration?	○	○	○	Memory problems?	○	○	○

ENDOCRINE

Hypothyroid?	○	○	○	Heat or cold intolerance?	○	○	○
Hypoglycemia?	○	○	○	Diabetes?	○	○	○
Excessive thirst?	○	○	○	Excessive hunger?	○	○	○
Fatigue?	○	○	○	Seasonal depression?	○	○	○

IMMUNE

Vaccinations?	○	○	○	Reactions to vaccinations?	○	○	○
Chronic Fatigue Syndrome?	○	○	○	Chronic infections?	○	○	○
Chronically swollen glands?	○	○	○	Slow wound healing?	○	○	○

NEUROLOGIC

Seizures?	○	○	○	Paralysis?	○	○	○
Muscle weakness?	○	○	○	Numbness or tingling?	○	○	○
Loss of memory?	○	○	○	Easily stressed?	○	○	○
Vertigo or dizziness?	○	○	○	Loss of balance?	○	○	○

SKIN

Rashes?	○	○	○	Eczema, Hives?	○	○	○
Acne, Boils?	○	○	○	Itching?	○	○	○
Color Change?	○	○	○	Perpetual Hair Loss?	○	○	○
Lumps?	○	○	○	Night Sweats?	○	○	○

HEAD

Headaches?	○	○	○	Head Injury?	○	○	○
Migraines?	○	○	○	Jaw/TMJ problems	○	○	○

EYES

Spots in Eyes?	○	○	○	Cataracts?	○	○	○
Impaired vision?	○	○	○	Glasses or contacts?	○	○	○
Blurriness?	○	○	○	Eye pain/strain?	○	○	○
Color blindness?	○	○	○	Tearing or dryness?	○	○	○
Double Vision?	○	○	○	Glaucoma?	○	○	○

EARS

Impaired hearing?	○	○	○	Ringing?	○	○	○
Earaches?	○	○	○	Dizziness?	○	○	○

NOSE AND SINUSES

Frequent colds?	○	○	○	Nose Bleeds?	○	○	○
Stuffiness?	○	○	○	Hayfever?	○	○	○
Sinus problems?	○	○	○	Loss of smell?	○	○	○

MOUTH AND THROAT

Frequent sore throat?	○	○	○	Copious saliva?	○	○	○
Teeth grinding?	○	○	○	Sore tongue/lips?	○	○	○

Gum problems?	○	○	○	Hoarseness?	○ ○ ○
Dental cavities?	○	○	○	Jaw clicks?	○ ○ ○

NECK

Lumps?	○	○	○	Swollen glands?	○ ○ ○
Goiter?	○	○	○	Pain or stiffness?	○ ○ ○

RESPIRATORY

Cough?	○	○	○	Sputum?	○ ○ ○
Spitting up blood?	○	○	○	Wheezing	○ ○ ○
Asthma?	○	○	○	Bronchitis?	○ ○ ○
Pneumonia?	○	○	○	Pleurisy?	○ ○ ○
Emphysema?	○	○	○	Difficulty breathing?	○ ○ ○
Pain on breathing?	○	○	○	Shortness of breath?	○ ○ ○
Shortness of breath at night?	○	○	○	" " " lying down?	○ ○ ○
Tuberculosis?	○	○	○		

CARDIOVASCULAR

Heart disease?	○	○	○	Angina?	○ ○ ○
High/Low Blood Pressure?	○	○	○	Murmurs?	○ ○ ○
Blood clots?	○	○	○	Fainting?	○ ○ ○
Phlebitis?	○	○	○	Palpitations/Fluttering?	○ ○ ○
Rheumatic Fever?	○	○	○	Chest pain?	○ ○ ○
Swelling in ankles?	○	○	○		

GASTROINTESTINAL

Trouble swallowing?	○	○	○	Heartburn?	○ ○ ○
Change in thirst?	○	○	○	Change in appetite?	○ ○ ○
Nausea?	○	○	○	Vomiting? (Illness or Induced)	○ ○ ○
Vomiting blood?	○	○	○	Bowel Movements: How often? _____	
Blood in stool?	○	○	○	Is this a change?_____	
Pain or cramps?	○	○	○	Constipation?	○ ○ ○
Belching or passing gas?	○	○	○	Diarrhea?	○ ○ ○
Black stools?	○	○	○	Gall Bladder disease?	○ ○ ○
Jaundice (yellow skin)?	○	○	○	Ulcer?	○ ○ ○
Liver Disease?	○	○	○	Hemorrhoids?	○ ○ ○

URINARY

Pain on urination?	○	○	○	Increased frequency?	○ ○ ○
Frequency at night?	○	○	○	Inability to hold urine?	○ ○ ○
Frequent infections?	○	○	○	Kidney stones?	○ ○ ○

MALE REPRODUCTION

Hernias?	○	○	○	Testicular masses?	○ ○ ○
Testicular pain?	○	○	○	Prostate disease?	○ ○ ○
Venereal disease?	○	○	○	Discharge or sores?	○ ○ ○
Are you sexually active?	○		○	Chlamydia?	○ ○ ○
Sexual orientation: _____				Gonorrhea?	○ ○ ○
Impotence?	○	○	○	Condyloma?	○ ○ ○

Premature ejaculation? ○ ○ ○ Herpes? ○ ○ ○
Birth control? Type? _____ Syphilis? ○ ○ ○

FEMALE REPRODUCTION/BREASTS

Age of first menses? _____
Age of last mense? _____ Are cycles regular? ○ ○
Length of cycle? _____ days Bleeding between cycles? ○ ○ ○
Duration of menses? _____ days Pain during intercourse? ○ ○ ○
Painful menses? ○ ○ ○ Clotting? ○ ○ ○
Heavy or excessive flow? ○ ○ ○ Discharge? ○ ○ ○
PMS? ○ ○ ○ Birth control? ○ ○ ○
If yes, what are your symptoms? What type? _____
_____ Number of pregnancies _____
_____ Number of live births _____
Endometriosis? ○ ○ ○ Number of miscarriages _____
Ovarian cysts? ○ ○ ○ Number of abortions _____
Difficulty conceiving? ○ ○ ○ Menopausal symptoms? ○ ○ ○
Cervical Dysplasia? ○ ○ ○ Abnormal PAP? ○ ○ ○
Sexual difficulties? ○ ○ ○ Chlamydia? ○ ○ ○
Gonorrhea? ○ ○ ○ Condyloma? ○ ○ ○
Herpes? ○ ○ ○ Syphilis? ○ ○ ○
Are you sexually active? ○ ○ Sexual orientation: _____
Do you do breast self exams? ○ ○ ○ Breast lumps? ○ ○ ○
Breast pain/tenderness? ○ ○ ○ Nipple discharge? ○ ○ ○

MUSCULOSKELETAL

Joint pain or stiffness? ○ ○ ○ Arthritis? ○ ○ ○
Broken bones? ○ ○ ○ Weakness? ○ ○ ○
Muscle spasms or cramps? ○ ○ ○ Sciatica? ○ ○ ○

BLOOD/PERIPHERAL VASCULAR

Easy bleeding or bruising? ○ ○ ○ Anemia? ○ ○ ○
Deep leg pain? ○ ○ ○ Cold hands/feet? ○ ○ ○
Varicose veins? ○ ○ ○ Thrombophlebitis? ○ ○ ○

Natural Paths to Wellness

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At Natural Paths to Wellness, we understand that unanticipated events occur in everyone's life. In our commitment to provide a quality experience to all of our clients and out of consideration for our Naturopaths' time, we have adopted the following policies:

- A credit card will be required for all new patient appointments to guarantee your appointment and reserve that time for you. Your card will not be charged unless you fail to provide 24 hours notice of cancellation, however, you may use it to pay for services at the completion of your appointment.

- 50% of the amount of the services scheduled for a new patient appointment and 100% of the amount of services scheduled for a return appointment will be charged in full for clients who "no-show" or fail to cancel their reservation within a 24-hour time period. The determined amount will be charged to the credit card on file.

- Financial responsibility for services you receive at the office is yours alone and is due at the time of service. Cash, check, debit cards, and all major credit cards (except American Express) are accepted as forms of payment.

- Please arrive for your appointment(s) on or before your scheduled starting time. If late arrival is inevitable, your service(s) may be shortened in order to keep on schedule.

We thank you for your confidence in our office and look forward to providing you with competent care and courteous service.

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO NATURAL PATHS TO WELLNESS FOR ALL CARE AND SERVICES PROVIDED TO ME AND/OR MY DEPENDENTS.

*Name of Responsible Party*_____
*Relationship to Patient*_____
*Signature*_____*Date:*_____
*Witness*_____*Date:*_____