

INTAKE FORM

ADULT CONSULTATION

PATIENT INFORMATION

First Name _____ Last _____

Address _____

City _____ State _____ Zip _____

Phone _____ Birthdate _____ Age _____

Email _____ Gender Male Female

Date of first visit _____

Marital Status: Married Separated Divorced Single Widowed Partnership

Living With: Spouse Children Parents Friends Alone

Occupation _____ Hours per Week _____ Retired

Employer _____ Social Security# _____

How did you hear about us?

Has any other family member been a patient?

EMERGENCY CONTACT

Name _____ Relationship _____

Phone _____ Alt. Phone _____



HEALTH HISTORY

Are you currently receiving health care? Yes No

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?

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

Do you have any known contagious diseases at this time? Yes No

If yes, what? _____

FAMILY HISTORY

	FATHER	MOTHER	BROTHERS	SISTERS	G'PARENTS
Age (if living)	_____	_____	_____	_____	_____
Health	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Epilepsy					
Anemia					



FAMILY HISTORY (cont.)

	FATHER	MOTHER	BROTHERS	SISTERS	G'PARENTS
Kidney Disease					
Glaucoma					
Tuberculosis					
Cause of Death					

CHILDHOOD ILLNESSES

Scarlet Fever	Yes	No	Diphtheria	Yes	No	Rheumatic Fever	Yes	No
Mumps	Yes	No	Measles	Yes	No	German Measles	Yes	No

X-RAYS AND SPECIAL STUDIES

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

Electrocardiogram	Yes	No	Electroencephalogram	Yes	No
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IMMUNIZATIONS

Polio	Yes	No	Pertussis	Yes	No
Tetanus shot	Yes	No	Diphtheria	Yes	No
Measles/Mumps/Rubella	Yes	No	Other _____		

ALLERGIES

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental? _____

CURRENT MEDICATIONS

Laxatives	Yes	No	Pain relievers	Yes	No	Antacids	Yes	No
Cortisone	Yes	No	Appetite suppressants	Yes	No	Antibiotics	Yes	No
Tranquilizers	Yes	No	Thyroid medication	Yes	No	Sleeping pills	Yes	No



CURRENT MEDICATIONS (cont.)

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

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

HABITS (Y=Yes / P=Past / N=Never)

Hobbies / Interests? _____

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

Is there any information about your health you would like to add?

GENERAL

Weight (lbs.) _____ Weight 1 year ago (lbs.) _____ Max Weight (lbs.) _____ When _____
 Height _____ When during the day is your energy the best? _____ Worst? _____



REVIEW OF SYSTEMS (Y=Condition you have now / P=Condition you've had in the past / N=Never had the condition)

MENTAL/EMOTIONAL

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

ENDOCRINE

Hypothyroid?	Y	P	N	Heat or cold intolerance?	Y	P	N
Hypoglycemia?	Y	P	N	Diabetes?	Y	P	N
Excessive thirst?	Y	P	N	Excessive hunger?	Y	P	N
Fatigue?	Y	P	N	Seasonal depression?	Y	P	N

IMMUNE

Vaccinations?	Y	P	N	Reactions to vaccinations?	Y	P	N
Chronic Fatigue Syndrome?	Y	P	N	Chronic infections?	Y	P	N
Chronically swollen glands?	Y	P	N	Slow wound healing?	Y	P	N

NEUROLOGIC

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

SKIN

Rashes?	Y	P	N	Eczema, hives?	Y	P	N
Acne, Boils?	Y	P	N	Itching?	Y	P	N
Color change?	Y	P	N	Perpetual hair loss?	Y	P	N
Lumps?	Y	P	N	Night sweats?	Y	P	N

HEAD

Headaches?	Y	P	N	Head Injury?	Y	P	N
Migraines?	Y	P	N	Jaw/TMJ problems	Y	P	N



REVIEW OF SYSTEMS (Y=Condition you have now / P=Condition you've had in the past / N=Never had the condition)

EYES

Spots in eyes?	Y	P	N	Cataracts?	Y	P	N
Impaired vision?	Y	P	N	Glasses or contacts?	Y	P	N
Blurriness?	Y	P	N	Eye pain/strain?	Y	P	N
Color blindness?	Y	P	N	Tearing or dryness?	Y	P	N
Double vision?	Y	P	N	Glaucoma?	Y	P	N

EARS

Impaired hearing?	Y	P	N	Ringing?	Y	P	N
Earaches?	Y	P	N	Dizziness?	Y	P	N

NOSE & SINUSES

Frequent colds?	Y	P	N	Nose bleeds?	Y	P	N
Stuffiness?	Y	P	N	Hayfever?	Y	P	N
Sinus problems?	Y	P	N	Loss of smell?	Y	P	N

MOUTH & THROAT

Frequent sore throat?	Y	P	N	Copious saliva?	Y	P	N
Teeth grinding?	Y	P	N	Sore tongue/lips?	Y	P	N
Gum problems?	Y	P	N	Hoarseness?	Y	P	N
Dental cavities?	Y	P	N	Jaw clicks?	Y	P	N

NECK

Lumps?	Y	P	N	Swollen glands?	Y	P	N
Goiter?	Y	P	N	Pain or stiffness?	Y	P	N

RESPIRATORY

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



REVIEW OF SYSTEMS (Y=Condition you have now / P=Condition you've had in the past / N=Never had the condition)

CARDIOVASCULAR

Heart disease?	Y	P	N	Angina?	Y	P	N
High/low blood pressure?	Y	P	N	Murmurs?	Y	P	N
Blood clots?	Y	P	N	Fainting?	Y	P	N
Phlebitis?	Y	P	N	Palpitations/Fluttering?	Y	P	N
Rheumatic Fever?	Y	P	N	Chest pain?	Y	P	N
Swelling in ankles?	Y	P	N				

GASTROINTESTINAL

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

URINARY

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

MALE REPRODUCTION

Hernias?	Y	P	N	Testicular masses?	Y	P	N
Testicular pain?	Y	P	N	Prostate disease?	Y	P	N
Venereal disease?	Y	P	N	Discharge or sores?	Y	P	N
Are you sexually active?	Y		N	Chlamydia?	Y	P	N
Sexual orientation: _____				Gonorrhea?	Y	P	N
Impotence?	Y	P	N	Condyloma?	Y	P	N
Premature ejaculation?	Y	P	N	Herpes?	Y	P	N
Birth control? Type? _____				Syphilis?	Y	P	N



REVIEW OF SYSTEMS (Y=Condition you have now / P=Condition you've had in the past / N=Never had the condition)

FEMALE REPRODUCTION / BREASTS

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

MUSCULOSKELETAL

Joint pain or stiffness? _____	Y	P	N	Arthritis?	Y	P	N
Broken bones? _____	Y	P	N	Weakness?	Y	P	N
Muscle spasms or cramps? _____	Y	P	N	Sciatica?	Y	P	N

BLOOD / PERIPHERAL VASCULAR

Easy bleeding or bruising? _____	Y	P	N	Anemia?	Y	P	N
Deep leg pain? _____	Y	P	N	Cold hands/feet?	Y	P	N
Varicose veins? _____	Y	P	N	Thrombophlebitis?	Y	P	N



THANK YOU!

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:

1. 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.
2. 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.
3. 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.
4. 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.

CONSENT OF FINANCIAL RESPONSIBILITY

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.

Signature: _____ Date _____

Submit this form to Admin@NaturalPathsToWellness.com or fax to 717.430.0016

