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

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 environmentals? _____

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. _____
2. _____
3. _____
4. _____
5. _____
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? *(Illness or Induced)*	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?_____

Age of last mense?_____

Length of cycle?_____

Duration of menses? ○ Y ○ P ○ N

Painful menses? ○ Y ○ P ○ N

Heavy or excessive flow? ○ Y ○ P ○ N

PMS? ○ Y ○ P ○ N

If yes, what are your symptoms?_____

_____

Endometriosis? ○ Y ○ P ○ N

Ovarian cysts? ○ Y ○ P ○ N

Difficulty conceiving? ○ Y ○ P ○ N

Cervical Dysplasia? ○ Y ○ P ○ N

Sexual difficulties? ○ Y ○ P ○ N

Gonorrhea? ○ Y ○ P ○ N

Herpes? ○ Y ○ P ○ N

Are you sexually active? ○ Y ○ N

Do you do breast self exams? ○ Y ○ P ○ N

Breast pain/tenderness? ○ Y ○ P ○ N

Are cycles regular? ○ Y ○ N

Bleeding between cycles? ○ Y ○ P ○ N

Pain during intercourse? ○ Y ○ P ○ N

Clotting? ○ Y ○ P ○ N

Discharge? ○ Y ○ P ○ N

Birth control? ○ Y ○ P ○ N

What type?_____

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages:_____

Number of abortions: _____

Menopausal symptoms? ○ Y ○ P ○ N

Abnormal PAP? ○ Y ○ P ○ N

Chlamydia? ○ Y ○ P ○ N

Condyloma? ○ Y ○ P ○ N

Syphilis? ○ Y ○ P ○ N

Sexual orientation: _____

Breast lumps? ○ Y ○ P ○ N

Nipple discharge? ○ Y ○ P ○ N

MUSCULOSKELETAL

Joint pain or stiffness? ○ Y ○ P ○ N

Broken bones? ○ Y ○ P ○ N

Muscle spasms or cramps? ○ Y ○ P ○ N

Arthritis? ○ Y ○ P ○ N

Weakness? ○ Y ○ P ○ N

Sciatica? ○ Y ○ P ○ N

BLOOD / PERIPHERAL VASCULAR

Easy bleeding or bruising? ○ Y ○ P ○ N

Deep leg pain? ○ Y ○ P ○ N

Varicose veins? ○ Y ○ P ○ N

Anemia? ○ Y ○ P ○ N

Cold hands/feet? ○ 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 Doctors' time, we have adopted the following policies:

1. A credit card will be required for all new patient appointments to reserve that time for you. Your card will not be charged unless you fail to provide a 24 business hour notice of cancellation. If you wish, you may use it to pay for services and/or supplements at the completion of your appointment.

2. $155 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 within a 24 business hour time period. This does not include weekends. If you have to cancel an appointment for a Monday, please be sure to do it the business day prior. (Friday) 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. Please note that insurance will not cover the cost of your services. If you have a FSA or HSA credit card, you may use that for payment, however, we can not guarantee that all plans will approve these expenses.

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