INTAKE FORM

I. PERSONAL INFORMATION

Today's Date__________________

Full Name____I like to be called ________________
(First Middle Initial Last)

Age_______ Date of Birth________________ Gender_______ Social Security #

Address______________________________________Email___________________________________

City_________________________________ State____________________ Zip __________________

Phone (best to be reached)_________________ (alternate)_________________May we leave messages?__

Occupation____Hours per week __________________

Employer _______________________________ Education_____________________________________

Military Service?_________

Are you: ____Married ____Separated ____Divorced
____Single ____Cohabitating ____Widowed

Live with: ____Spouse ____Parents ____Alone
____Children ____Partner ____Friends

Children's Ages____

Emergency Contact (name and relation)____

Contact's Phone (home)_____________________ (work)__________________ (cell)_______________

How did you hear about our clinic?

____

II. PERSONAL HEALTH HISTORY

Please list your 3-5most important health concerns:

1) ____
2) ____
3) ____
4) ____
5) ____

Please check the relevant areas and give some details below.

☐ Alcoholism ☐ Diabetes ☐ Liver Disorders
☐ Allergies ☐ Gout ☐ Psychological Disorders
☐ Anemia ☐ Heart Disorders ☐ Skin Disorders
☐ Arthritis ☐ Herpes Genitalis ☐ Stroke
☐ Asthma ☐ High Blood pressure ☐ Thyroid Disorders
☐ Cancer ☐ Hypoglycemia ☐ Tuberculosis
☐ Colitis ☐ Injury (serious) ☐ Venereal Disease
☐ Other: ____

Please note when and why you had following exams:

X-Rays: ____________________________________ MRI/Cat Scans: ______________________________
Ultrasounds: ________________________________TB Test: ____________________________________
HCV: _______________________________________ HIV:____
Last Dental Visit: _____________________________Last Eye Exam: ______________________________

HOSPITALIZATIONS: (Dates and type of illness/operation)

____
____
____

KNOWN ALLERGIES: (to medications, foods, pollens, etc.)

____
____
____

MEDICATIONS & SUPPLEMENTS: (prescription & non-prescription items), and for WHAT CONDITION:

1) 4)

2) 5)

3) 6)

III. FAMILY HISTORY

Do your close relatives (parents, siblings, children) have any of the following medical conditions? Please circle and indicate the relative with the disease:

Disease	Specify illness	Relatives	Disease	Specify illness	Relatives
High Blood Pressure			Birth Defects		
Heart Attack			Suicide		
Stroke			Depression		
Obesity			Mental Illness		
Diabetes			Alcoholism		
Glaucoma			Epilepsy		
Asthma			Ulcers		
Hay Fever			Arthritis		
Eczema			Gout		
Skin Disease			Thyroid disease		
Food allergies			Easy Bleeding		
Emphysema			Sickle Cell		
Tuberculosis			Anemia		
Lung Cancer			Osteoporosis		
Breast Cancer			Arthritis		
Other Cancer			Other		

Natural Rhythms
AYURVEDIC NATUROPATHY

IV. <u>Review of Systems:</u>

Present Weight: Weight one year ago: Height:

Good Energy: Yes No Past Fatigue: Yes No Past

If you have fatigue, when is it the worst? Morning Afternoon Evening

If you have fatigue, can you do what you need to during the day? Yes No

Please check any of the symptoms you've had in the past or have now:

Skin
□ Rash
□ Hives
□ Psoriasis/Eczema
□ Dry skin
□ Cancer
□ Color change
□ Lump
□ Itchy
□Warts/moles
□ Perspiration
Head
□ Headache
□ Dandruff
□ Oil/dry hair
□ Migraines
□ Head Injury
□ Hair loss
Nose
□ Frequent colds
□ Congestion
□ Polyps
□ Nosebleeds
□ Post Nasal Drip
□ Seasonal Allergies
Eyes
□ Dry/watery
□ Double Vision
□ Blurry Vision
□ Cataracts
□ Glaucoma
□ Strain
□ Itchy
□ Styes
□ Discharge
□ Dark under eyelid
Mouth and Throat
□ Canker Sores
□ Sore Throat
□ Cold Sores
□ Gum Disease
□ Loss of Taste
□ Cavities
□ Hoarseness
□ Dentures
Respiratory
□ Asthma
□ Bronchitis
□ Cough
□ Pneumonia
□ Painful Breathing
□ TB
□ Shortness of Breath with Exertion
□ Shortness of Breath sitting
□ Shortness of Breath lying down
□ Wheezing
Neck
□ Stiffness
□ Full movement
□ Swollen Glands
□ Tension
Cardiovascular
□ Arrhythmias
□ Chest Pain
□ Edema
□ High Blood Pressure
□ Low Blood Pressure
□ Palpitations
□ Murmurs
□ Rheumatic Fever
Urinary Tract
□ Discharge/blood
□ Frequent Infections
□ Kidney Stones
□ Incontinence
□ Pain with Urination
□ Urgency
Gastrointestinal
Bowel Movement Frequency: ___ / day
□ Bloating
□ Constipation/Diarrhea
□ Nausea/ Vomiting
□ Change in appetite
□ Recent Bowel Changes
□ Heartburn
□ Indigestion
□ Hemorrhoids
□ Ulcers
□ Pancreatitis
□ Gall Bladder Disease
□ Liver Disease
□ Other: ______________________
Musculoskeletal
□ Weakness
□ Stiffness
□ Arthritis
□ Leg Cramps
□ Tremors
□ Pain
Nervous
□ Carpal Tunnel Syndrome
□ Paralysis
□ Sciatica
□ Tingling/ Numbness
□ Seizures
□ Fainting
Mental/ Emotional
□ Anxiety
□ Anger/ Irritability
□ Depression
□ Eating Disorder
□ Fear/ Panic
□ High Strung/ Tense
□ Psych hospitalization
□ Suicidal
Endocrine
□ Diabetes
□ Fatigue
□ Thyroid
□ Other: ______________________
Male Genitalia
Sexual Orientation: Hetero Homo Bi
Sexually Active: Yes No
□ Hernia
□ Discharge
□ Impotency
□ Prostate Disease/ Symptoms: _______
□ Testicular Pain/ Swelling
□ STD: ____________
Female Genitalia
Sexual Orientation: Hetero Homo Bi
Sexually Active: Yes No
Age Period began: _____
Period lasts _____ days
How often periods occur: every ____ days
□ Heavy Menstrual Bleeding
□ Menstrual Pain
□ Menstrual Cramping
□ PMS
□ Food Cravings
Number of pregnancies: _____
Number of live births: ____
Number of abortions: ____
Number of miscarriages: ___
Date of last Pap Smear: ________ Normal Abnormal
□ Dry Vagina
□ Pain with intercourse
□ STD: ___________
□ Healthy Libido
□ Vaginitis
Age at Menopause: ____
□ Use of Hormones:
□ Use of Birth Control:
____

V. NUTRITION

How much water do you drink a day?________________ Do you use a water filter?_________________

Generally, what does your diet consist of (typical breakfast, lunch, dinner?

_BF:____

_Lunch:____

_Dinner:____

What times or how frequently do you eat?___________________ Who prepares your food?

____

Do you snack? On what?

____

What food(s), condiments(s), or any other substances (e.g. tobacco, alcohol, coffee, etc.) do you crave?

____

Are you repelled by, or do you dislike any foods? Please identify:

____

____

Are there any foods that do not agree with you or aggravate you? Explain:

____

____

VI. TOXIN EXPOSURE

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials?

____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing?

____

Are you particularly sensitive to perfumes, gasoline or other vapors?

____

Do you use pesticides, herbicides or other chemicals around your home?

____

CONGRATULATION!!! YOU MADE IT!