Holistic Therapies LLC

The Healing Power of Nature

Patient Intake Form

Today's Date _____

Patient Information

Name _____

Address_____

_____

City _____ State ____ Zip _____

Home Phone _____

E-mail Address _____

Date of Birth _____ Age _____

Social Security # _____

Gender: ☐ Male ☐ Female

Relationship Status:

☐ Married ☐ Partnered ☐ Single

☐ Divorced ☐ Widowed ☐ Separated

Occupation _____

Employer_____

Work Address_____

City _____ State ____ Zip _____

Work Phone _____

Hours worked per week: _____

Spouse/Partner Information

Name _____

Occupation _____

Employer_____

Work Address_____

City _____ State ____ Zip _____

Work Phone _____

Who may we thank for your referral?

_____

Emergency Contact

Name _____

Relationship_____

Address_____

City _____ State ____ Zip _____

Home Phone _____

Health Insurance

Name of Insured _____

Relationship _____

Primary Carrier _____

Group # _____ Account # _____

Other Healthcare Professionals

Are you being seen by other healthcare professionals?

☐ Yes ☐ No

Occupation _____

Name _____

Address_____

_____

City _____ State ____ Zip _____

May we contact this person regarding your healthcare?

☐ Yes ☐ No

Occupation _____

Name _____

Address_____

_____

City _____ State ____ Zip _____

May we contact this person regarding your healthcare?

☐ Yes ☐ No

Authorization of Treatment

I, the undersigned, hereby authorize the doctor to perform diagnostic tests deemed necessary for my care and to perform any and all forms of treatment, medication and therapy that are indicated and are in accordance with the standards of Naturopathic care.

Patient's Signature _____ Date_____

Parent/Guardian _____ Relationship to Patient _____

Patient Name _____ Today's Date _____

Current Health Condition

What are your health concerns? *Please list them in the order of importance for you today.*

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

Are there any factors that have contributed to the onset and perpetuation of your health concerns?

_____

_____

What measures have you taken to improve your current health status?

_____

_____

What are your goals for treatment? *Please describe them.*

1. _____
2. _____

How motivated are you to receive help and make changes for your health? *Please circle your level of motivation*

Least Motivated 1 2 3 4 5 6 7 8 9 10 Most Motivated

What health issues are you currently being treated for?

_____

_____

Do you have any concerns with our office sharing information with your other provider(s)? _____

_____

General and Personal Information

Height_____ Current weight_____ Weight 1 year ago? _____ Preferred weight _____

Blood Type _____

# of Pregnancies _____ Outcome of Pregnancies _____

Date of Last physical exam _____ Name of Practitioner _____

Results of your last physical exam? _____

History of trauma? _____History of abuse? _____ Have you received treatment for either of these issues? _____

Current Medications

Do you use any of the following? *Please check all the boxes that apply.*

- ☐ Antibiotics
- ☐ Anti-inflammatory medications
- ☐ Pain relievers
- ☐ Cholesterol lowering medications
- ☐ Stomach aids or digestive medications
- ☐ Antidepressants
- ☐ Other psychiatric medications
- ☐ Blood pressure medications
- ☐ Hormones of any kind
- ☐ Sleeping Pills

Patient Name _____ Today's Date _____

Please list the prescription medications, over-the-counter medications, vitamins, herbs, and nutritional supplements you use. Feel free to use the back of this page, or attach another, if you need more space.

Name	Dose per day	Date Started	Prescriber	Reason for use
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Hospitalizations

List the date and type of any hospitalizations, surgeries or serious injuries you have had in your life

_____

_____

_____

_____

Diet, Lifestyle, and Habits

Please describe your typical daily meals

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Do you have or use any of the following? *Please check all the boxes that apply.*

- □ Fast food outlets
- □ Coffee Cups per day _____
- □ Sodas Frequency_____
- □ Canned foods
- □ Teas (caffeinated)
- □ Salt or sugar your foods
- □ Cravings for sweets
- □ Cravings for salty starches
- □ Afternoon or evening cravings
- □ Reward yourself with food(s)
- □ Cravings for comfort food(s)
- □ Eat near bedtime or at night
- □ Irritable if not eating regularly
- □ History of dieting
- □ History of eating disorders
- □ Tobacco
  How often_____ Year Stopped _____
- □ Alcohol How often_____
- □ Marijuana How often_____
- □ Other recreational drugs
  Type _____ How often_____
  _____ How often_____

What kind of foods do you crave? _____

What foods give you problems and what problems do they cause? _____

Are you on a special or restricted diet? □ Yes □ No, Type? _____

How often do you eat out and what type of food do you eat out? _____

Do you eat quickly? □ Yes □ No Do you eat while multi-tasking? □ Yes □ No

Do you use NutriSweet, aspartame or artificial sweeteners? □ Yes □ No Type? _____

Do your bowel movements tend to be: □ hard □ soft □ loose □ float □ constipated □ diarrhea

How many bowel movements do you have per day? _____

Patient Name _____ Today's Date _____

Allergies

Please describe what type of allergies or hypersensitivity reactions you notice

Food: _____

Medications: _____

Chemicals: _____

Animals: _____

Considering the past 6 months, please answer the following:

Describe type, duration and frequency of exercise you performed _____

How many hours do you typically spend in front of computers or televisions during a day/week? _____

How many hours of sleep do you get a night? _____ Is it restful? _____

Do you have trouble falling asleep or staying asleep? _____

What have been your hobbies or interests? _____

Describe your supportive relationships and/or communities/groups you participated in. _____

Do you attend any religious ceremony or perform any spiritually oriented practice? _____

List the most significant stressful events in your life

_____

_____

_____

_____

Patient Medical History

Please **check** any of the conditions you **have ever** had and **circle** the conditions that are current health concerns.

Health Conditions

- ☐ AIDS or HIV+
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder/Urinary Problems
- ☐ Blood Pressure Problems
- ☐ Cancer
  Type _____
- ☐ Chest Pain
- ☐ Colitis/Irritable Bowel
- ☐ Frequent Colds, Flus, Sore Throats
- ☐ Diabetes
- ☐ Digestive Disorders
- ☐ Ear Problems
- ☐ Eating Disorder
  Type _____
- ☐ Edema
- ☐ Epilepsy
- ☐ Eye Problems
- ☐ Fatigue, chronic
- ☐ Female Gynecological Problems
- ☐ Frequent Antibiotic use
- ☐ Gall Bladder/Liver Problems
- ☐ Problems with Gums/Teeth
- ☐ Hair Falling Out
- ☐ Hay Fever
- ☐ Headaches
- ☐ Heart Disorders
- ☐ Hemorrhoids
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Joint Problems
- ☐ Kidney Problems
- ☐ Lung Problems
- ☐ Menstrual Problems
- ☐ Osteoporosis
- ☐ Panic Attacks
- ☐ Parasites
- ☐ Prostate Problems
- ☐ Psychological Difficulties
  (depression, suicidal thoughts, etc.)
- ☐ Sexual Abuse
- ☐ Sinusitis
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Varicose Vein
- ☐ Weight Gain

Infectious Disease

Indicate when you acquired disease

- ☐ Chicken Pox _____
- ☐ Hepatitis _____
  Type _____
- ☐ Measles _____
- ☐ Mumps _____
- ☐ Mononucleosis_____
- ☐ Epstein Barr_____
- ☐ Rheumatic Fever_____
- ☐ Sexually Transmitted Disease
  _____
  Type _____
  (Herpes, Chlamydia, gonorrhea, etc.)
- ☐ TB _____
- ☐ Other
  _____
  _____
  _____

Patient Name _____ Today's Date _____

Family Medical History

Please check and list who has been affect by each condition and on which side of the family, including self.

□ AIDS _____	□ Diabetes _____	□ Senility _____
□ Alcoholism_____	□ Eczema _____	□ Seizures _____
□ Allergies _____	□ Gout _____	□ Sexually Transmitted Disease
□ Anemia _____	□ Heart Disease _____	_____
□ Arthritis _____	□ Hemophilia _____	□ Skin Problems_____
□ Asthma _____	□ High Blood Pressure _____	□ Stroke _____
□ Breast Cancer _____	□ HIV+ _____	□ Suicide _____
□ Cervical Cancer _____	□ Kidney Disorders _____	□ TB _____
□ Ovarian Cancer _____	□ Mental Illness _____	□ Thyroid Disease _____
□ Prostate Cancer _____	□ Migraines _____	□ Ulcer _____
□ Uterine Cancer _____	□ Obesity _____	□ Other _____
□ Other Cancer _____	□ Osteoporosis _____	_____
_____	□ Psoriasis _____	_____

Occupational and Exposure History

What is your occupation? _____

Average hours you work per week? _____ Do you enjoy your job? _____

Do you work indoors or outdoors? _____ Do they have full spectrum lighting? _____

Do you have specialized air filtration at your work? _____

Do you work with or in the presence of toxic fumes or chemicals? _____

Have you ever? □ Yes □ No Explain _____

Are you exposed to second-hand smoke? □ Yes □ No Explain _____

Do any of your hobbies involve toxic materials? □ Yes □ No

What kind (paint, plastic, glass, lead)? _____

Do you use any kind of specialized home air filtration? □ Yes □ No

What type? _____

Type of home heating system used? _____

Living location: □ Urban □ Suburban □ Country □ Lakeside □ Mountain

Do you wear sunglasses, contacts or glasses when outside? □ Yes □ No

Do you have any respiratory disorders? _____

(sinusitis, asthma, emphysema, bronchitis)

Do you have household pets? □ Indoor □ Outdoor □ Both

Type? _____

Patient Name _____ ____ Today's Date _____

Review of Systems

In this section, check the box if you have the symptom currently or if you have experienced it in the past 6 months.

Mental/Emotional
- ☐ Mood swings
- ☐ Seasonal depression
- ☐ Depression
- ☐ Considered/attempted suicide
- ☐ Poor concentration
- ☐ Anxiety or nervousness
- ☐ Tension or chronic stress feelings
- ☐ Memory problems
- ☐ Easily stressed
- ☐ Sleep disruption or disturbance

Endocrine
- ☐ Hair loss
- ☐ Brittle nails
- ☐ Excessive thirst
- ☐ General fatigue
- ☐ Fatigue after meals
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive hunger

Head
- ☐ Headaches
- ☐ Migraines
- ☐ Head injury
- ☐ Jaw pain/TMJ

Immune
- ☐ Chronic fatigue syndrome
- ☐ Swollen glands
- ☐ Reaction to vaccines
- ☐ Ongoing infections
- ☐ Slow wound healing
- ☐ Colds/flu more than once yearly
- ☐ Autoimmune disease
- ☐ History of autoimmune disease in family
  Who _____

Ears
- ☐ Impaired hearing
- ☐ Earaches
- ☐ Ringing
- ☐ Itching inside or outside
- ☐ Frequent popping

Nose and Sinuses
- ☐ Frequent head colds
- ☐ Stuffiness
- ☐ Sinus pain
- ☐ Nose bleeds
- ☐ Hay fever
- ☐ Loss of smell

Eyes
- ☐ Spots in vision
- ☐ Blurriness
- ☐ Color blindness
- ☐ Double vision
- ☐ Glasses
- ☐ Cataracts
- ☐ Eye pain/strain
- ☐ Glaucoma
- ☐ Uncomfortable tearing or dryness

Mouth and Throat
- ☐ Teeth grinding
- ☐ Frequent sore throat
- ☐ Gum bleeding/pain/disease
- ☐ Copious saliva
- ☐ Sore tongue/lips
- ☐ Hoarseness
- ☐ Jaw clicks

Neck
- ☐ Lumps
- ☐ Goiter/enlargement in front of throat
- ☐ Pain or stiffness

Peripheral Vascular
- ☐ Easy bleeding/bruising
- ☐ Deep leg pain
- ☐ Varicose veins
- ☐ Anemia
- ☐ Cold hands/feet

Neurological
- ☐ Seizures
- ☐ Muscle weakness
- ☐ Vertigo/dizziness
- ☐ Paralysis
- ☐ Numbness or tingling

Patient Name _____ Today's Date _____

Intestinal
- ☐ Trouble swallowing
- ☐ Change in thirst
- ☐ Change in appetite
- ☐ Nausea/vomiting
- ☐ Burning pain in stomach
- ☐ Heartburn
- ☐ Jaundice
- ☐ Gallbladder disease
- ☐ Liver disease
- ☐ Abdominal pain or cramps
- ☐ Excessive belching or excess gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Black stools
- ☐ Blood in stools

Musculoskeletal
- ☐ Joint pain or stiffness
- ☐ Muscle spasms or cramps
- ☐ Arthritis
- ☐ Weakness
- ☐ Sciatica

Skin
- ☐ Rashes
- ☐ Itchiness
- ☐ Acne, boils
- ☐ Color changes
- ☐ Lumps, Bumps
- ☐ Eczema
- ☐ Hives
- ☐ Perspire when not exercising
- ☐ Difficulty perspiring

Urinary
- ☐ Pain with urination
- ☐ Urgency
- ☐ Frequency at night
- ☐ History of frequent infections
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Splitting of stream

Respiratory
- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ Pain with breathing
- ☐ Shortness of breath

Respiratory (continued)
- ☐ Lung congestion/sputum
- ☐ Bronchitis
- ☐ Pneumonia

Cardiovascular
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Rheumatic fever
- ☐ Ankle swelling
- ☐ Angina/chest pain
- ☐ Heart murmurs
- ☐ Fainting

Reproduction/Sexuality
- ☐ Sexually active
- ☐ Use of birth control
  What type _____
  How long _____
- ☐ History of STDs _____
- ☐ Libido concerns_____

Female Reproduction
(Questions apply to lifetime, not just last 6 months)
- ☐ Age at first menses (first period) _____
- ☐ Date last menstrual period began _____
  Usual length of cycle _____
  Duration of menstruation _____
- ☐ Age of last menses (if menopausal) _____
- ☐ Menopausal symptoms _____
- ☐ Date of last annual exam/Pap _____
- ☐ Abnormal Gynecological exam
  When/Outcome _____
- ☐ Number of live births _____
- ☐ Number of miscarriages _____
- ☐ Bleeding/spotting between periods
- ☐ PMS
- ☐ Pain with sexual activity
- ☐ Infertility concerns

Male Reproduction
(Questions apply to lifetime, not just last 6 months)
- ☐ Hernias
- ☐ Prostate disease
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Testicular masses or pain
- ☐ Discharge or sores on penis
- ☐ Genital herpes
- ☐ Infertility concerns

Patient Name _____ Today's Date _____

Please list any other health concerns you wish to address that have not been covered in this questionnaire:

_____

_____

_____

_____

_____

Thank you for filling out this form. This information is vital to developing your individualized health care plan. Please mail this packet back to the office at least 3 days prior to your appointment or bring it with you at your scheduled appointment time and we will review it as time permits.

The doctors are looking forward to working with you.

Signature: _____ Date: _____

Electronic Communications Policy: We will only accept electronic communications via E-Mail sent to info@holistictherapies.us and facsimiles sent to 303-679-1921. We ask that these communications be limited. All communications received will be answered as quickly as possible and in the order it was received. We encourage you to write down all of your questions and make an appointment to see the doctor to get all of your questions, concerns and care plans taken care of quickly, orderly and at one time. Text messages regarding care will not be accepted or permitted; you may however, schedule a phone appointment with the doctor through our office.