Holistic Therapies

The Healing Power of Nature

1301-C Bergen Parkway, Evergreen CO 80439
(303) 679-3402, Fax (303) 679-1921

Today's Date ___________________

Patient Intake Form

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 ________________________________

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

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 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 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 ______________________
Alcoholism___________________
Allergies ____________________
Anemia ____________________
Arthritis _____________________
Asthma ____________________
Breast Cancer ________________
Cervical Cancer _______________
Ovarian Cancer _______________
Prostate Cancer _______________
Uterine Cancer ________________
Other Cancer _________________
____

Diabetes _____________________
Eczema ______________________
Gout _________________________
Heart Disease __________________
Hemophilia ___________________
High Blood Pressure ____________
HIV+ ________________________
Kidney Disorders _______________
Mental Illness __________________
Migraines _____________________
Obesity _______________________
Osteoporosis __________________
Psoriasis ______________________

Senility _______________________
Seizures ______________________
Sexually Transmitted Disease
____
Skin Problems__________________
Stroke ________________________
Suicide _______________________
TB ___________________________
Thyroid Disease ________________
Ulcer ________________________
Other ________________________
____
____

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 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
- Pleurisy
- 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 ________________
- Age of last menses (if menopausal) ______________
- Menopausal symptoms _________________________
- Date of last annual exam/Pap ___________________
- Number of live births _________________________
- Number of miscarriages _______________________
- Usual length of cycle __________________________
- Duration of menstruation ________________________
- 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:

____

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____

____

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

Dr. Kiker looks forward to working with you.

Signature: _______________________________________ Date: ________________________