

Family Tree Naturopathic and Midwifery New Patient Intake Form

Please fill this out entirely and bring it with you to your first office visit. Thanks!

Name _____ Date of Birth _____ SSN _____

Age ____ Gender _____ Occupation _____

Employer _____ Hrs per week ____ Live alone? Y/N

Address _____ City _____ State ____ Zip ____

Phone (H) _____ (C) _____

Email _____

Emergency contact _____ Phone _____

Insurance co. _____ Insurance ID _____ Grp _____

Insurance address _____ Phone _____

Our office may need to reach you by phone occasionally. In order to protect your privacy, please select the place where you would like messages left for you.

- ◇ Home phone
- ◇ Cell phone
- ◇ At work: please fill in your work number _____
- ◇ With family members
- ◇ Never leave messages

Were you referred to this clinic? Y/N If yes, by whom? _____

If not, how did you hear about our clinic? _____

What are your primary health concerns?

When was the last time you received medical care and why?

Are you aware of having allergies to any of the following? Describe reaction.

Drugs: _____

Foods: _____

Chemicals/perfumes: _____

Animals: _____

General Information:

Ht _____ Wt _____ Wt 1 year ago _____ Max weight _____ When _____

What time of day is your energy/alertness best? ____ Worst? ____ Blood type ____

Primary interests and hobbies _____

Primary form(s) of exercise _____

Please let us know if you or any family member has had these conditions. Check all boxes that apply and indicate whom the condition applies to.

- | | |
|--|--|
| <input type="checkbox"/> Anemia_____ | <input type="checkbox"/> Alzheimer's_____ |
| <input type="checkbox"/> Cancer_____ | <input type="checkbox"/> Arthritis_____ |
| <input type="checkbox"/> Heart disease_____ | <input type="checkbox"/> Diabetes_____ |
| <input type="checkbox"/> Mental illness_____ | <input type="checkbox"/> Hypertension_____ |
| <input type="checkbox"/> Multiple Sclerosis_____ | <input type="checkbox"/> Kidney disease_____ |
| <input type="checkbox"/> Stroke_____ | <input type="checkbox"/> Parkinson's_____ |
| <input type="checkbox"/> Asthma_____ | <input type="checkbox"/> Other (Please list) _____ |
| <input type="checkbox"/> Epilepsy_____ | _____ |

Please list, by name, any medications, vitamins, supplements, or herbs that you take regularly at this time. Include dosage, if known.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Which diagnostic studies have you had *in the past year*?

- | | | |
|--------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> EKG | <input type="checkbox"/> CT Scan | <input type="checkbox"/> MRI |
| <input type="checkbox"/> X-ray | <input type="checkbox"/> EEG | <input type="checkbox"/> Other |
| <input type="checkbox"/> DEXA | <input type="checkbox"/> Mammogram | _____ |

Which medications, either by Rx or over-the-counter, are you taking (or have taken in the past 6 months)?

- | | | |
|--|---|---|
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> H2 blocker | <input type="checkbox"/> Thyroid med. |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Ulcer meds | <input type="checkbox"/> Cholesterol med. |
| <input type="checkbox"/> Pain relievers | <input type="checkbox"/> Appetite suppressant | <input type="checkbox"/> Sleeping med. |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Tranquilizers | _____ |
| <input type="checkbox"/> Prednisone | | |

Which of the following immunizations have you received?

- | | | |
|--------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Polio | <input type="checkbox"/> Yearly Flu |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Other: |
| <input type="checkbox"/> MMR | <input type="checkbox"/> Hepatitis B | _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pertussis | |

Wellness Survey: Please circle the appropriate response.

Y/N Get 6-8 hrs sleep/night?

Y/N Drink alcohol?

Y/N Sleep well?

Drinks/week _____

Y/N Awaken rested?

Y/N Use tobacco? Packs/day _____

Y/N Watch TV? Hrs daily ____

How many years: _____

Y/N Read? Hrs daily ____

Y/N Use recreational drugs?

Y/N Eat 3 meals/day?

Y/N Drink coffee/tea/soda? _____

Y/N In a supportive relationship?

Y/N Use products with artificial sweetener?

Y/N Eat out > 3x's/week?

Y/N Add salt/sugar to food?

Y/N History of abuse?

Y/N Enjoy your work?

Y/N Go on diets > twice/year?

Y/N Take vacations?

Y/N Had recent major life trauma?

Y/N Spend time outdoors?

Y/N Treated for drug/alcohol dependence?

In this section, please indicate if you have had the symptom *in the past 6 months*.

Head

- Earache
- Itching in or out of ears
- Ringing in ears
- Impaired hearing
- Frequent popping
- Frequent head colds
- Stuffiness
- Sinus pain
- Nose bleeds
- Headaches/migraines
- Hay fever
- Loss of Smell
- Head injury
- Vision changes
- Color blindness
- Cataracts
- Eye pain
- Glaucoma
- Excess tearing/dryness of eyes

Neurological

- Seizures
- Mood swings
- Muscle weakness
- Considered/attempted suicide
- Loss of memory
- Poor concentration
- Vertigo/dizziness
- Depression/seasonal depression
- Paralysis
- Anxiety/Easily stressed
- Numbness/tingling

Neck

- Lumps
- Pain or stiffness
- Goiter

Endocrine

- Hair loss
- Brittle nails
- Excessive thirst
- General fatigue
- Fatigue after meals
- Heat intolerance/Cold intolerance
- Night sweats

Mouth/Throat

- Frequent sore throat
- Teeth grinding
- Gum disease
- Dental cavities
- Copious saliva
- Sore tongue/lips
- Jaw Pain/clicking

Respiratory

- Cough
- Asthma
- Pneumonia
- Emphysema
- Pain with breathing
- Hoarseness
- Shortness of breath
- Lung congestion
- Wheezing
- Bronchitis
- Difficulty breathing

Immune system

- Chronic fatigue
- Swollen glands
- Reaction to vaccine
- Ongoing infection
- Slow wound healing
- Colds/flu more than once/year

Skin

- Rashes
- Acne
- Color changes
- Lumps
- Eczema
- Hives or itching

Cardiovascular

- Heart disease
- High blood pressure
- Low blood pressure
- Blood clots
- Phlebitis
- Rheumatic fever
- Ankle swelling
- Chest pain
- Fainting
- Heart palpitations

Blood/peripheral vascular

- Easy bleeding/bruising
- Deep leg pain
- Varicose veins
- Anemia
- Cold hands or feet

Digestive

- Trouble swallowing
- Change in thirst
- Change in appetite
- Nausea/Vomiting
- Burning stomach pain
- Jaundice
- Gallbladder issues
- Liver disease
- Hemorrhoids
- Heartburn/reflux
- Abdominal pain/cramps
- Excessive belching/gas
- Constipation
- Diarrhea
- Black colored stools
- Blood in stools

Musculoskeletal

- Joint pain or stiffness
- Broken bones
- Muscle spasm or cramps
- Arthritis
- Strain or sprain
- Weakness
- Sciatica

Urinary

- Pain with urination
- Frequent infections
- Unable to hold urine
- Kidney stones
- Splitting of urine stream
- Waking at night to urinate

Female Reproductive (skip if male)

Age at first menses _____

Length of menstrual cycle

(start of one period to start of next period) _____

Duration of bleeding _____

- Irregular cycles
- Painful menses
- Heavy flow
- Light flow
- Clotting
- Discharge
- PMS
- Menopausal symptoms
- Endometriosis
- Bleeding between periods
- Ovarian cysts
- Uterine fibroids
- Abnormal Pap smear (ever)
- Date of last Pap _____
- Sexually active
- Pain during sex
- Sexual difficulties
- Sexually transmitted infection
- Use of birth control
- If so, which type? _____
- Difficulty conceiving

Number of pregnancies _____

Number of live births _____

Number of miscarriages _____

Number of abortions _____

- Regular self-breast exams
- Breast pain or tenderness
- Breast lumps
- Nipple discharge

Male reproductive (skip if female)

- Discharge from penis
- Sores on penis
- Hernias
- Prostate disease
- Impotence
- Testicular masses
- Sexually active?
- Use condoms?
- Premature ejaculation
- Sexually transmitted infection

☆ ***I certify that the above information is true to the best of my knowledge:***
