Natural Choices Health Clinic

Your natural choice for health care

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Patient Profile Intake Form

By completing this profile of your health history we can offer you more complete naturopathic care. Please be assured that we will keep this information confidential.

Name:_____ Age:_____ Birth Date:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Social Security Number (if applicable):_____

Home Phone:_____ Work Phone:_____ Other Phone:_____

Email:_____ Other Contact:_____

Married Partnered Divorced Widowed Single Children: Y / N

How did you hear about us? _____

Please list, in order of importance, your health concerns and/or health goals:

1._____

2._____

3._____

Where, when and for what reason did you last receive health care?

_____

_____

FAMILY HEALTH HISTORY

Please indicate if a family member (i.e.; Mother, Father, Grandparents, or Siblings) has had any of the following. If yes, please specify which family member in the space provided.

Y=YES **N**=NO

Asthma	Y	N	_____
Cancer	Y	N	_____
Diabetes	Y	N	_____
Glaucoma	Y	N	_____
Heart disease	Y	N	_____
Hypertension	Y	N	_____
Kidney disease	Y	N	_____
Mental illness	Y	N	_____
Tuberculosis	Y	N	_____
Stroke	Y	N	_____
Substance abuse	Y	N	_____

Please indicate if you have had any of the following:

CHILDHOOD ILLNESSES

Scarlet fever	Y	N	Diphtheria	Y	N
Chicken pox	Y	N	Mumps	Y	N
Rheumatic fever	Y	N	Polio	Y	N
Pertussis	Y	N	Hepatitis	Y	N

IMMUNIZATIONS

Polio	Y	N	Measles	Y	N
Mumps	Y	N	Rubella	Y	N
Pertussis	Y	N	Diphtheria	Y	N
Hepatitis b	Y	N	Tetanus	Y	N

Date of Tetanus shot:_____

Additional immunizations:_____

_____

ALLERGIES

Please list all allergies you are aware of:

Drugs:_____

Foods:_____

Environmental:_____

HOSPITALIZATION

Please list any illnesses and/or surgeries that required hospitalization

_____

_____

_____

MEDICATIONS

Please indicate if you are currently taking or have taken the following:

C=Currently Taking **P**=Taken in the past **N**=Never taken/used

Appetite suppressants	C	P	N	Laxatives	C	P	N
Sleeping aid	C	P	N	Tobacco	C	P	N
Birth control	C	P	N	Cortisone	C	P	N
Thyroid medication	C	P	N	Pain relief	C	P	N

Please list any prescription, over the counter drugs, vitamins, or any other supplements you are currently taking:_____

_____

_____

HABITS

Do you…

Awaken rested?	Y	N	Average hours of sleep _____	
Enjoy work?	Y	N		
Watch television?	Y	N	Hours per week	_____
Read?	Y	N	Hours per week	_____
Take vacations?	Y	N	How often?	_____

Have you ever been treated for drug or alcohol abuse?	Y	N
Do you use recreational drugs?	Y	N
Do you drink alcoholic beverages?	Y	N _____ Per week

What are your main hobbies and interests?_____

_____

What forms of exercise do you get and how often?_____

_____

CONDITIONS

C=Condition you currently have **N=**Never had **P=**Have had in the past

SKIN

Scarlet Fever	C	N	P	Boils	C	N	P
Color Change	C	N	P	Eczema	C	N	P
Hives	C	N	P	Itching	C	N	P
Lumps	C	N	P	Moles	C	N	P
Rashes	C	N	P	Scaling	C	N	P

HEAD

Hair loss	C	N	P	Headaches	C	N	P
Skull fracture	C	N	P	Head injury	C	N	P

EYE

Eye pain	C	N	P	Cataracts	C	N	P
Double vision	C	N	P	Dryness	C	N	P
Glasses/contacts	C	N	P	Glaucoma	C	N	P
Impaired vision	C	N	P	Tearing	C	N	P

EAR

Discharges	C	N	P	Earaches	C	N	P
Dizziness	C	N	P	Ringing	C	N	P
Impaired hearing	C	N	P	Trauma	C	N	P

NOSE/SINUSES

Frequent colds	C	N	P	Hay fever	C	N	P
Nose bleeds	C	N	P	Sinus pain	C	N	P
Runny nose	C	N	P	Stuffiness	C	N	P

MOUTH/THROAT

Bleeding gums	C	N	P	Hoarseness	C	N	P
Difficulty swallowing	C	N	P	Dental cavities	C	N	P
Sore throat	C	N	P	Difficulty speaking	C	N	P
Canker sores	C	N	P	Sore tongue	C	N	P

NECK

Goiter	C	N	P	Lumps	C	N	P
Pain or stiffness	C	N	P	Swollen glands	C	N	P
Trauma	C	N	P				

RESPIRATORY

Asthma	C	N	P	Bronchitis	C	N	P
Emphysema	C	N	P	Difficulty breathing	C	N	P
Pleurisy	C	N	P	Pneumonia	C	N	P
Shortness of breath	C	N	P	Sputum	C	N	P
Lying down	C	N	P	Tuberculosis	C	N	P
At night	C	N	P	Spitting up blood	C	N	P
With exertion	C	N	P	Wheezing	C	N	P

CARDIOVASCULAR

Angina	C	N	P	High blood pressure	C	N	P
Dizziness standing	C	N	P	Murmurs	C	N	P
Heart disease	C	N	P	Leg pain when walking	C	N	P
Palpitations	C	N	P	Ankles swelling	C	N	P
Rheumatic fever	C	N	P				

GASTROINTESTINAL

Belching/passing gas	C	N	P	Blood in stool	C	N	P
Change in appetite	C	N	P	Change in thirst	C	N	P
Heartburn	C	N	P	Gallbladder disease	C	N	P
Hemorrhoids	C	N	P	Jaundice	C	N	P
Liver disease	C	N	P	Ulcers	C	N	P
Vomiting	C	N	P	Vomiting blood	C	N	P

URINARY

Frequent infections	C	N	P	Night frequency	C	N	P
Increased frequency	C	N	P	Inability to hold	C	N	P
Kidney stones	C	N	P	Kidney pain	C	N	P
Pain w/ urination	C	N	P	Urethral discharge	C	N	P

FEMALE REPRODUCTIVE SYSTEM

Age menses began: _____
Age of last menses (if menopausal)_____
Duration of menses:_____
Length between cycles: _____

Are cycles regular	Y	N		Breast lumps/implants	C	N	P
Painful menses	Y	N		Venereal disease	C	N	P
Pain during intercourse	Y	N		Birth control	C	N	P
Excessive flow	Y	N		What type?_____			
Are you sexually active?	Y	N		Number of pregnancies: _____			
Sexual difficulties?	Y	N		Number of live births: _____			
Do you do monthly breast self-exams?	Y	N		Number of miscarriages:_____			
				Number of abortions: _____			
				Difficulty conceiving	C	N	P
				Date of last mammogram_____			
				Nipple discharge	C	N	P
				Date of last pap: _____			

MALE REPRODUCTIVE SYSTEM

Hernias	C	N	P	Are you sexually active?	Y	N	
Testicular pain	C	N	P	Sexual difficulties	C	N	P
Testicular masses	C	N	P	Discharge or sores	C	N	P
Prostate disease	C	N	P	Venereal disease	C	N	P

MUSCULOSKELETAL

Joint pain/stiffness	C	N	P	Broken bones	C	N	P
Joint swelling	C	N	P	Muscle cramps/spasms	C	N	P
Arthritis	C	N	P	Weakness	C	N	P

PERIPHERAL VASCULAR

Cold hands/feet	C	N	P	Varicose veins	C	N	P
Deep leg pains	C	N	P	Numb hands/feet	C	N	P
Thrombophlebitis	C	N	P				

NEUROLOGICAL

Dizziness	C	N	P	Numbness/tingling	C	N	P
Fainting	C	N	P	Loss of memory	C	N	P
Seizures	C	N	P	Paralysis	C	N	P

ENDOCRINE/BLOOD

Anemia	C	N	P	Excessive thirst	C	N	P
Bruise bleed easily	C	N	P	Hot/cold intolerance	C	N	P
Excessive hunger	C	N	P	Hypothyroid	C	N	P

MENTAL/ EMOTIONAL

Anxiety	C	N	P	Excessive fears	C	N	P
Depression	C	N	P	Mood swings	C	N	P
Excessive anger	C	N	P	Tension	C	N	P

THANK YOU!