ADULT INTAKE FORM

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Patient's Name:_____ Date: _____

Age:____ Date of Birth:____/____/_____ female male

Mother's name:_____ Father's name _____

Address:_____City:_____ State:_____ Zip _____

Home Phone (_____)_____ Work Phone (_____)_____ _____

Occupation (past and/or present)_____Part or Full Time or Retired

Soc. Sec. #_____ Education: _____

☐Married ☐Separated ☐Divorced ☐Widowed ☐Single ☐Cohabitating

Live with: ☐Spouse ☐Partner ☐Relatives ☐Children
☐Friends ☐Parents ☐Alone

Next of Kin or other to reach in case of emergency_____ Relationship _____

Address _____Phone_____ Work Phone _____

Name of Family Doctor:_____ Phone _____

Insurance

Name policy is in: _____ Health insurance: Company:_____

Policy/I.D. No.:_____ Group/code No.: _____

A NOTE TO OUR PATIENTS: Naturopathic, holistic, and preventive health care require the physician to have a complete picture of the patient physically, mentally and emotionally. Please take the time to complete this health history questionnaire carefully and thoroughly.

Current Health Condition

When, where and from whom did you last receive medical or health care? _____

Reason? _____

How did you hear about this clinic: _____

List of most important health problems, in order of importance:

1) _____
2) _____
3) _____
4) _____

Which of the above problems are of most immediate concern? _____

Do you have any contagious diseases at this time: Yes No
If yes, what? _____

CURRENT MEDICATIONS

Do you take or use:

☐Laxatives	☐Pain relievers	☐Antacids
☐Appetite suppressants	☐Cortisone	☐Tranquilizers
☐Thyroid medication	☐Antibiotics	☐Sleeping pills
☐Nasal decongestants	☐Birth control pills	☐Hormones

Please list any prescription or over-the-counter medications, vitamins or other supplements you are taking and dosages:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Children
Ages (if living)	_____	_____	_____	_____	_____
Health	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____
Check those applicable:					
Anemia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma/Hayfever/Hives	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Seizures/Epilepsy	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐
Cause of death	☐	☐	☐	☐	☐

CHILDHOOD ILLNESSES

☐Rubella (German 3-day measles)	☐Measles (2 week)	☐Mumps	☐Chickenpox
☐Whooping cough	☐Rheumatic fever	☐Polio	☐Scarlet fever
☐Roseola	☐Asthma	☐Others _____	

IMMUNIZATIONS

☐Pertussis ☐Tetanus ☐Polio ☐Diptheria

☐Measles/Mumps/Rubella ☐Hepatitis ☐Others _____

X-RAYS AND SPECIAL STUDIES

Electrocardiogram (EKG) Electroencephalogram (EEG) Intravenous Pyelogram (IVP)

What x-rays, CAT scans, or other studies have you had?_____

_____

HOSPITALIZATION AND SURGERY

What hospitalizations or surgeries have you had? _____

_____

_____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs: _____

_____

Any foods: _____

_____

Any chemicals or environmental toxins: _____

_____

What happens to you when you have an “allergy attack?” _____

_____

What prior types of allergy testing have you had?

☐Intradermal Scratch ☐Blood IgG food ☐Blood IgE ☐inhalant/food

☐Electroacupuncture (EAV) ☐Kinesiology ☐Cytotoxic ☐Food Intolerance ☐None

TYPICAL FOOD INTAKE

Breakfast _____

_____

Lunch: _____

_____

Dinner:_____

_____

Snacks: _____

_____

GENERAL INFORMATION

Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum weight:_____ lbs. When: _____

Height: _____ ft.-in.

When is your energy the best during the day?_____ Worst?_____

REVIEW OF SYMPTOMS

FOR THE FOLLOWING, PLEASE MARK:

YES=a condition you now have **NEVER**=a condition you never had **PAST**=a condition you have had before

HEAD

Headaches/migraines.....Y ... N ....P
Double vision.....Y ... N ....P
Dizziness.....Y ... N ....P
Head injury.....Y ... N ...P
Jaw/TMJ problems.....Y ... N ...P
Fainting spells.....Y ... N ...P

EYES

Glasses or contacts.....Y ... N ....P
Spots in eyes.....Y ... N ....P
Blurriness.....Y ... N ....P
Color blindness.....Y ... N ....P
Sensitivity to light.....Y ... N ....P
Impaired vision.....Y ... N ...P
Cataracts.....Y ... N ...P
Eye pain/strain.....Y ... N ...P
Tearing or dryness.....Y ... N ...P
Glaucoma.....Y ... N ...P

EARS

Discharge from ears.....Y ... N ....P
Hearing problems.....Y ... N ....P
Sensitivity to noise.....Y ... N ....P
Pain in ears.....Y ... N ...P
Ringing in ears.....Y ... N ...P
Many ear infections.....Y ... N ...P

NOSE and SINUSES

Frequent colds.....Y ... N ....P
Stuffiness.....Y ... N ....P
Sinus problems.....Y ... N ....P
Nose bleeds.....Y ... N ...P
Hayfever.....Y ... N ...P
Loss of smell.....Y ... N ...P

MOUTH and THROAT

Frequent sore throat.....Y ... N ....P
Teeth grinding.....Y ... N ....P
Bleeding gums.....Y ... N ....P
Speech difficulties.....Y ... N ....P
Copious saliva.....Y ... N ...P
Mouth ulcers.....Y ... N ...P
Hoarseness.....Y ... N ...P
Loss of voice.....Y ... N ...P

NECK

Lumps ..... Y ... N ....P
Goiter ..... Y ... N ....P
Swollen glands ..... Y ... N ...P
Pain or stiffness ..... Y ... N ...P

CARDIOVASCULAR

Heart disease ..... Y ... N ....P
High blood pressure ..... Y ... N ....P
Blood clots ..... Y ... N ....P
Phlebitis ..... Y ... N ....P
Rheumatic fever ..... Y ... N ....P
Swelling in ankles ..... Y ... N ....P
Angina ..... Y ... N ...P
Low blood pressure ..... Y ... N ...P
Fainting ..... Y ... N ...P
Palpitations ..... Y ... N ...P
Chest pain ..... Y ... N ...P
Heart murmurs ..... Y ... N ...P

RESPIRATORY

Cough ..... Y ... N ....P
Spitting up blood ..... Y ... N ....P
Asthma ..... Y ... N ....P
Pneumonia ..... Y ... N ....P
Difficulty breathing ..... Y ... N ....P
Shortness of breath ..... Y ... N ....P
Tuberculosis ..... Y ... N ....P
Night sweats ..... Y ... N ....P
Sputum production ..... Y ... N ...P
Wheezing ..... Y ... N ...P
Bronchitis ..... Y ... N ...P
Pleurisy Emphysema ..... Y ... N ...P
Pain on breathing ..... Y ... N ...P
Pain on lying down ..... Y ... N ...P
Pain at night ..... Y ... N ...P

GASTROINTESTINAL

Trouble swallowing ..... Y ... N ....P
Bad breath ..... Y ... N ....P
Change in thirst ..... Y ... N ....P
Nausea ..... Y ... N ....P
Vomiting blood ..... Y ... N ....P
Blood in stool ..... Y ... N ....P
Pain or cramps ..... Y ... N ....P
Belching ..... Y ... N ....P
Passing gas ..... Y ... N ....P
Eating disorder ..... Y ... N ....P
Black stools ..... Y ... N ....P
Liver disease ..... Y ... N ....P
Heartburn ..... Y ... N ...P
Bad taste in mouth ..... Y ... N ...P
Change in appetite ..... Y ... N ...P
Vomiting ..... Y ... N ...P
Constipation ..... Y ... N ...P
Diarrhea ..... Y ... N ...P
Gall bladder disease ..... Y ... N ...P
Ulcers ..... Y ... N ...P
Hemorrhoids ..... Y ... N ...P
Distress from eating fats ..... Y ... N ...P
Jaundice ..... Y ... N ...P
Bad body odor ..... Y ... N ...P

Bowel movements: How often _____
Is this a change? Yes No

MALE REPRODUCTION

Hernias ..... Y ... N ....P
Testicular pain..... Y ... N ....P
Discharge or sores ..... Y ... N ....P
Syphillis ..... Y ... N ....P
Gonorrhea ..... Y ... N ....P
Premature ejaculation..... Y ... N ....P
Vasectomy ..... Y ... N ....P
Testicular mass ..... Y ... N ...P
Prostate disease ..... Y ... N ...P
Herpes..... Y ... N ...P
Chlamydia ..... Y ... N ...P
Condyloma ..... Y ... N ...P
Impotence ..... Y ... N ...P
Painful erections..... Y ... N ...P
Sexual orientation: Heterosexual Bisexual Homosexual Sexually active ..... Y ... N ...P

FEMALE REPRODUCTION/BREASTS

Age of first menses _____
Length of cycle _____
Duration of menses _____
Painful menses ..... Y ... N ..P
PMS..... Y ... N ....P
If yes, please list your symptoms:.... _____
Number of pregnancies_____
Endometriosis..... Y ... N ....P
Ovarian cysts..... Y ... N ....P
Difficulty conceiving ..... Y ... N ....P
Cervical dysplasia..... Y ... N ....P
Sexual difficulties..... Y ... N ....P
Pelvic pain ..... Y ... N ....P
Gonorrhea ..... Y ... N ....P
Herpes..... Y ... N ....P
Do you do breast exams..... Y ... N ....P
Breast lumps..... Y ... N ....P
Cycles regular ..... Y ... N ...P
Bleeding between cycles..... Y ... N ...P
Pain during intercourse ..... Y ... N ...P
Clotting ..... Y ... N ...P
Birth control ..... Y ... N ...P
Type_____
Number of live births _____
Number of miscarriages .....
Number of abortions _____
Menopausal symptoms ..... Y ... N ...P
Abnormal PAP ..... Y ... N ...P
Vaginal discharge ..... Y ... N ...P
Chlamydia ..... Y ... N ...P
Condyloma ..... Y ... N ...P
Syphilis..... Y ... N ...P
Breast pain/tenderness ..... Y ... N ...P
Nipple discharge ..... Y ... N ...P
Sexual orientation: Heterosexual Bisexual Homosexual Sexually active ..... Y ... N ...P

URINARY

Pain on urination..... Y ... N ....P
Frequency at night..... Y ... N ....P
Many urinary infections ..... Y ... N ....P
Blood in urine ..... Y ... N ....P
Increased frequency..... Y ... N ...P
Inability to hold urine ..... Y ... N ...P
Problems starting urine ..... Y ... N ...P
Kidney stones..... Y ... N ...P

MUSCULOSKELETAL

Joint pain or stiffness ..... Y ... N ....P
Broken bones ..... Y ... N ....P
Muscle spasms or cramps ..... Y ... N ....P
Arthritis ..... Y ... N ...P
Weakness ..... Y ... N ...P
Back pain ..... Y ... N ...P

BLOOD/PERIPHERAL VASCULAR

Easy bleeding/bruising ..... Y ... N ....P
Deep leg pain ..... Y ... N ....P
Varicose veins ..... Y ... N ....P
Fluid retention ..... Y ... N ....P
Anemia ..... Y ... N ...P
Cold hands/feet ..... Y ... N ...P
Thrombophlebitis ..... Y ... N ...P
Bleeding from unusual places ..... Y ... N ...P

EMOTIONAL

Treated for emotional problems ..... Y ... N ....P
Mood swings ..... Y ... N ....P
Considered/attempted suicide ..... Y ... N ....P
Excessive worry ..... Y ... N ....P
Anxiety/nervousness ..... Y ... N ...P
Depression ..... Y ... N ...P
Tension ..... Y ... N ...P
Panic attacks ..... Y ... N ...P

NEUROLOGIC

Seizures/epilepsy ..... Y ... N ....P
Muscle weakness ..... Y ... N ....P
Loss of memory ..... Y ... N ....P
Vertigo or dizziness ..... Y ... N ....P
Paralysis ..... Y ... N ...P
Numbness or tingling ..... Y ... N ...P
Easily stressed ..... Y ... N ...P
Loss of balance ..... Y ... N ...P

ENDOCRINE

Hypothyroid ..... Y ... N ....P
Hypoglycemia ..... Y ... N ....P
Excessive thirst ..... Y ... N ....P
Fatigue ..... Y ... N ....P
Unexplained weight loss/gain ..... Y ... N ....P
Heat/cold intolerance ..... Y ... N ...P
Diabetes ..... Y ... N ...P
Excessive hunger ..... Y ... N ...P
Seasonal depression ..... Y ... N ...P
Change in sexual desire ..... Y ... N ...P

IMMUNE

Vaccinations ..... Y ... N ....P
Chronic fatigue syndrome ..... Y ... N ....P
Chronically swollen glands ..... Y ... N ....P
Reactions to vaccinations ..... Y ... N ...P
Chronic infections ..... Y ... N ...P
Slow wound healing ..... Y ... N ...P

SKIN

Rashes ..... Y ... N ....P
Acne/boils ..... Y ... N ....P
Color changes ..... Y ... N ....P
Lumps ..... Y ... N ....P
Eczema/hives ..... Y ... N ...P
Itching ..... Y ... N ...P
Hair loss ..... Y ... N ...P
Warts ..... Y ... N ...P

HABITS

Use alcoholic beverages .....Y ... N ....P Ever treated for alcoholism ..... Y ... N ...P

If yes, list types and amounts: _____

Use recreational drugs .....Y ... N ....P Ever treated for drug dependence . Y ... N ...P

If yes, list types and amounts: _____

Smoke tobacco products.....Y ... N ....P Chew tobacco products..... Y ... N ...P

If yes, list types and amounts: _____

Drink coffee .....Y ... N ....P

If yes, amount: _____

Drink black tea.....Y ... N ....P Drink cola ..... Y ... N ...P

Eat out often .....Y ... N ....P Go on diets often..... Y ... N ...P

Eat excessive sugar .....Y ... N ....P Eat excessive salt ..... Y ... N ...P

LIFE STYLE

Main interests and hobbies:_____

_____

Do you exercise? Yes No

If yes, what kind?_____

_____

Do you have a religious or spiritual practice? Yes No

If yes, what kind?_____

_____

Do you eat 3 meals a day? Yes No

If no, how many? _____

Do you average 6-8 hours sleep? Yes No

If no, how many? _____

Do you sleep well? Yes No

If no, what is the problem? _____

_____

_____

Do you awaken rested? Yes No

If no, what is the problem? _____

_____

_____

Do you enjoy your work? Yes No

If no, why not? _____

_____

_____

Do you spend time outside? Yes No

If yes, how much and in what form? _____

_____

_____

Do you watch television? Yes No

If yes, how much? _____

_____

_____

Do you read? Yes No

If yes, what and how much? _____

_____

_____

Do you take vacations? Yes No

If yes, how long and what kind? _____

_____

_____

Do you have a supportive relationship? Yes No

If no, what's wrong with it? _____

_____

_____

Do you have a history of abuse or trauma? Yes No

If yes, please describe: _____

_____

_____

CURRENT ILLNESS OR CONDITION

How does your condition affect you?_____

_____

_____

What do you think is happening? _____

_____

_____

Why? _____

_____

_____

What do you feel needs to happen for you to get better? _____

_____

_____

What do you enjoy most in life?_____

_____

_____

How much change are you willing to make at this time for improving your health?

_____

_____

MINIMAL SOME COMPLETE

Is there any information about your health you would like to add? _____

_____

_____

Thank you for your thoughtfulness in answering these questions.

Payment Details

☐ Cash ☐ Check ☐ Visa ☐ Mastercard

Name on Card:_____ Credit Card Number_____

Expiration Date:_____ 3 Digit Security Code:_____ (on back of card)

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT:

By signing this, I hereby authorize the JUDY M. LEE N.D., C.H.M. to treat me using naturopathic medicines according to the principles of naturopathic practice. I understand JUDY M. LEE N.D., C.H.M. will make the best effort to treat but make no guarantee to cure me.

I certify that the above information is true. I understand that charges will be made and herby agree that I am financially responsible for any such charges.

Signed: _____ Dated: _____