NEW EARTH NATUROPATHIC

Adult Intake Form

Please fill out this form to the best of your knowledge. There is no correct or incorrect answer.

Date:			
Client Name:			
Age: **Date of Birth:**	**Height**:	**Weight**:	
Gender: Female Male	**Sexual Orientation:**		
Relationship/Marital Status	**If married, #years:**	**# of Children:**	
Occupation:	**Employer:**		
Highest level of education:			
Address:____ **City:**	**State:**	**Zip:**	
Home Phone:	**Cell Phone:**		
Work Phone:	**E-mail:**		
Person to Contact in Case of Emergency:			
Relationship to Client:			
Phone:			

How Did You Hear About Us?	
( ) Yellow Pages	**( ) Other Practitioner :** NAME
( ) Internet Search	**( ) Client Referral :** NAME
( ) Our Website _	**( ) Other**

Primary Care Doctor:

If patient is a Minor, Name of Parent/Guardian(s)

HEALTH CONCERNS:

Please list your current health concerns in order from the most bothersome to least bothersome. Please include mental, emotional, and physical concerns.   1)
2)
3)
4)
5)
6)
7)

HOSPITALIZATIONS, SURGERIES, AND MAJOR ILLNESSES

Date	Condition or Procedure
1)	
2)	
3)	
4)	
5)	
6)	
7)	

MEDICATIONS:

Please list the medication and dosages that you are currently taking. Please include both prescription and over the counter.

	Medication	Condition Treated	Dosage
1)			
2)			
3)			
4)			
5)			
6)			
7)			

SUPPLEMENTS:

Please list all of the supplements that you are currently taking including dosages and brand names.

	Supplement	Brand	Dosage
1)			
2)			
3)			
4)			
5)			
6)			
7)			

ALLERGIES:

Please list any medication, food, environmental, or other allergies:

FAMILY HISTORY:

	Children	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents
Alcoholism/Addiction						
Allergies						
Alzheimer's Disease						
Anemia/Clotting disorder						
Anxiety Disorder						
Arthritis						
Asthma						
Birth Defect						
Cancer:________________						
Cancer:________________						
Cancer: _______________						
Depression or Bipolar						
Diabetes						
Epilepsy/Seizures						
Gallbladder Disease						
Heart Attack						
High Cholesterol						
High Blood Pressure						
Hypoglycemia						
Kidney Disease						
Liver Disease						
Migraines						
Stroke						
Thyroid disease						
Tuberculosis						
Other:						

SOCIAL:

Exercise
Type:
Duration/Minutes
Frequency
Other:

Sleep: _________**hrs/night**

Any trouble falling sleep, waking at night (time)_________, falling back asleep, waking
Do you wake refreshed? Y N

Water intake: #cups/day (8oz/cup):

Alcohol : Y N
#drinks _____per________________

Coffee/tea: Y N # cups/day: regular / decaf

Soda: Y N #cups/day: regular / diet

Cigarettes/Chewing Tobacco: Y N Past #pk/day #yrs:
Recreation Drug Use: Y N Explain:
Past Drug Rehab? Y N Explain:
Do you currently have a Spiritual practice?
What are your greatest sources of stress, past or present?
What do you do for stress relief?

REVIEW OF SYSTEMS:

General Symptoms

Now	Past	General Symptoms
		Tired, weak, lack of energy
		Depression, moodiness
		Worry, anxiety, nervousness
		Sleeplessness or too much sleep
		Frequent colds or other illnesses
		Headaches, migraines
		Dizziness, fainting, blacking out
		Cannot sweat/ too much sweat/ night sweats

EYES

Now	Past	EYES
		Nearsightedness or farsightedness
		Blurred or failing vision
		Dry, burning or itching eyes
		Eyes water excessively
		Night blindness
		Bloodshot, red or puffy eyes
		Mucus or discharge in eyes
		Pain in eyes
		Last eye exam:

Ears

Now	Past	Ears
		Earaches
		Noises or ringing in ears
		Ear discharges
		Loss of hearing
		Excess earwax

Chest

Now	Past	Chest
		Cough frequently
		Spitting up mucous or blood
		Difficultly breathing
		Chest pain
		Wheezing
		Palpitations

Skin and Hair

Now	Past	Skin and Hair
		Acne or pimples
		Hives
		Stretch marks
		Skin rashes, sores, ulcers
		Dryness, roughness or scaling skin
		Hair loss or thinning
		Dry, course hair
		Bruise easily
		Nails weak, ridged or split easily
		Brown spots or bronzing on skin
		Warts, moles or skin tags
		Sunburn easily
		Cuts heal slowly or scar badly
		Flush easily
		Athletes foot

Nose and Mouth

Now	Past	Nose and Mouth
		Allergies, sinusitis, runny nose
		Dry mouth or nose
		Nosebleeds
		Cracks in corners of mouth
		Dry or chapped lips
		Sore throats or tonsillitis
		Sore, red, or cracked tongue
		Cold sores or herpes
		Loss of smell or taste
		Bleeding gums
		Hoarseness
		Grinding teeth
		Dental problems
		Difficulty swallowing

Gastrointestinal

Now	Past	Gastrointestinal
		Loss of appetite
		Nausea or vomiting
		Bad breath
		Metallic or bitter taste in mouth
		Heartburn
		Indigestion
		Heaviness after eating
		Bloating or gas
		Belching
		Constipation
		Foul odor of stool or gas
		Diarrhea
		Light colored or greasy stools
		Undigested food in stool
		Blood in stool or on paper
		Hemorrhoids
		Rectal pain/itching

Cardiovascular

Now	Past	Cardiovascular
		Heart beats fast or irregularly
		Tightness in chest
		Discomfort in high altitude
		Dizzy or weak on standing
		Swollen feet, ankles or legs
		Cold hands or feet
		Hands or feet turn blue
		Leg pain with walking
		High blood pressure
		Low blood pressure

Musculoskeletal

Now	Past	Musculoskeletal
		Muscle pain
		Weakness
		Joint pain (specify_____________)
		Joint swelling
		Back pain
		Neck pain
		Joint stiffness
		Numbness or tingling
		Decreased range of motion

Urinary

Now	Past	Urinary
		Difficulty urinating
		Urinate frequently at night
		Bed Wetting
		Incomplete urination or dribbling
		Pain when urinating
		Bladder or kidney infection
		Kidney stones
		Urine leakage
		Blood in urine

Female

Now	Past	Female
		Irregular periods
		Pain prior to or with periods
		Depressed or irritable around periods
		Painful or swollen breasts
		Lumps in breast
		Nipple discharge
		Vaginal discharge
		Vaginal pain or itching
		Heavy periods
		Hot flashes
		Diminished or excessive sex drive
		Difficulty reaching orgasm
		Miscarriages (How many?______)
		Abortions (How many?______)
		Pain with intercourse
		Pelvic pain
		Pain with intercourse
		Inability to conceive

Male

Now	Past	Male
		Prostate problems
		Sexual difficulty
		Genital discharge
		Pain in genitals
		Painful testicles

Vaccinations:____

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Any reactions?

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New Earth Naturopathic
760.604.2324

PAST MEDICAL CONDITIONS:

Please check any conditions in your history:

☐	ADD/ADHD	☐	Chemical Dependency	☐	HIV Positive	☐	Prostate Problems
☐	AIDS	☐	Chicken Pox	☐	Kidney Disease	☐	Psoriasis/Eczema
☐	Alcoholism/Addiction	☐	Depression/Anxiety/Bipolar	☐	Leg Cramps	☐	Psychiatric Hospitalization
☐	Allergies	☐	Diabetes	☐	Liver disease	☐	Rheumatic Fever
☐	Anemia	☐	Emphysema	☐	Lyme Disease	☐	Scarlet Fever
☐	Anorexia	☐	Epilepsy	☐	Measles	☐	Sexual Abuse
☐	Appendicitis	☐	Gall Bladder Disease	☐	Migraine/Headaches	☐	Stroke
☐	Arthritis	☐	Glaucoma	☐	Miscarriage	☐	Suicide Attempt
☐	Asthma	☐	Goiter	☐	Mononucleosis	☐	Thyroid Condition
☐	Bleeding Disorder	☐	Gonorrhea	☐	Multiple Sclerosis	☐	Tonsillitis
☐	Breast Lump	☐	Gout	☐	Mumps	☐	Tuberculosis
☐	Bronchitis	☐	Heart Disease	☐	Pacemaker	☐	Typhoid Fever
☐	Bulimia	☐	Hernia	☐	Physical Abuse	☐	Ulcers
☐	Cancers	☐	Herpes (Oral / Genital)	☐	Pneumonia	☐	Vaginal Infections
☐	Cataracts	☐	High Cholesterol Disease	☐	Polio	☐	Venereal

Additional Comments: ____

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☐ **I certify that the above information is correct to the best of my knowledge:**
I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Clinic Policy requires payment at time of services.

______________________________ ______________________________ ____________

Client's Signature **Parent or Guardian's Signature** **Date**

______________________________ ______________________________

Please Print Name **Please Print Name**