ADULT INTAKE

PLEASE COMPLETE THIS FORM AND BRING TO YOUR FIRST APPOINTMENT

First name: _____Initial:_____ Last name: _____ M __ F__Other__

Date of birth: _____ Occupation: _____

Address:_____

Please list only the numbers at which we may contact you.

Home phone: _____Bus. phone: _____ Ext: _____

Cell Phone: _____ Fax: _____ Email: _____

How did you hear about Snow Naturopathic?_____

Marital Status: _____ Name of Spouse: _____ # Dependents: ____

Emergency contact: _____ Phone: _____

Relation: _____

Other health care providers:

Name: _____ Name: _____ Name:_____

Designation: _____ Designation: _____ Designation:_____

Phone: _____ Phone: _____ Phone: _____

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHORIZED US IN WRITING TO DO SO. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

What health concerns brought you to this office today?

1. _____ 2. _____

3. _____ 4. _____

_____

If this is a chronic condition, how long have you had this condition? _____

Who diagnosed your illness? _____When was the diagnosis made?_____

What specialists have you seen? (Indicate the year of consultation) _____

_____

If you are female, are you currently pregnant? YES NO

CURRENT MEDICATIONS

List all CURRENT prescribed medications:

Drug name:_____Dosage:_____Length taken:_____
Drug name:_____Dosage:_____Length taken:_____
Drug name:_____Dosage:_____Length taken:_____
Drug name:_____Dosage:_____Length taken:_____

List all CURRENT non-prescription medications used:

_____
_____
_____

List all CURRENT vitamins, minerals, herbs, that you take *more than occasionally*:

_____
_____
_____

List all PAST prescribed medications that you've taken for *longer than 3 months*:

_____
_____
_____

List any prescribed medication you've had an adverse reaction to in the past. Indicate the drug name, when you took it and the reaction you had:

Drug name:_____Dosage:_____Length taken:_____
Drug name:_____Dosage:_____Length taken:_____
Drug name:_____Dosage:_____Length taken:_____

List all known allergies:

_____
_____
_____

How many times have you been treated with antibiotics in the past 5 years? _____

Family Medical History

	Age	Health problems	If deceased, cause	Age at death
Father				
Mother				
Siblings				

Children				
Grandparents				
Aunts				
Uncles				

MEDICAL HISTORY
Please check only those that pertain to <u>you personally</u>

☐Alcohol Abuse	☐Female Gynecological problems	☐Skin problems
☐Allergies	☐Gallstones	☐Stroke
☐Anemia	☐Gum/Teeth problems	☐Suicide
☐Asthma	☐Heart Attach	☐Thyroid problems
☐Arthritis	☐Heart problems	☐Tuberculosis
☐Back, Muscle, Joint pain	☐High blood pressure	☐Ulcers
☐Bladder/Urinary problems	☐Kidney problems	☐Venereal disease
☐Candida	☐Measles	☐Chronic fatigue
☐Epilepsy	☐Depression	☐Liver problems
☐Diabetes	☐Overweight	☐Chronic sinusitis
☐Rheumatic fever	☐Psychological problems	☐Cancer
☐Lung problems	☐Pneumonia	☐Gout
☐Mononucleosis	☐Eczema	☐Bowel disease
☐Influenza	☐Hay fever	☐Constipation
☐Rheumatism	☐Pleurisy	☐Hives
☐Malaria	☐Chronic swollen glands	☐Hypoglycemia

Date of last physical exam: _____ For what reason? _____

Do you get regular SCREENING TESTS done by another doctor? (Pap, blood test, etc)

YES NO

Last time you had bloodwork done: _____

PERSONAL HEALTH HABITS

Height:_____Current weight:_____ Weight 1 year ago:_____

Max weight:_____ Year:_____

Smoker? YES NO Amount/day? _____ Years smoked?_____

Year stopped?_____

Are you exposed to smoking at home or work? YES NO

Alcohol use? YES NO Type:_____ Frequency:_____

Recreational drug use? YES NO Type:_____ Frequency:_____

Caffeine use? YES NO Type:_____ Frequency:_____

Are there any food groups that you avoid? YES NO

What?_____ Why?_____

Do you have any dietary restrictions? (religious, vegetarian/vegan, etc.):

_____

Are you frequently exposed to toxins or other hazards? YES NO

What kind? _____

Do you exercise regularly? YES NO Type:_____ Frequency:_____

How many hours do you sleep per night? _____ Do you wake rested? YES NO

How would you describe the emotional climate of you home? _____

What level of personal stress are you experiencing right now?

☐Minimal ☐Average ☐Considerable ☐Unbearable

The main stressor is:

☐Financial ☐Job related ☐Marriage ☐Health ☐Interpersonal

☐Family ☐Unfulfilled expectations ☐Other:_____

What do you do to deal with stress? _____

Do you take vacations? YES NO

What are your hobbies? _____

How would you describe your general state of health?

EXCELLENT GOOD FAIR POOR

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

_____

_____

_____

SYMPTOMS REVIEW

Please check 'Y' if you have the symptom now, and 'P' if the symptom is in the past.

SKIN	Y	P	**NOSE&SINUSES**	Y	P	**CARDIOVASCULAR**	Y	P
Rashes			Frequent colds			Angina		
Hives			Nose bleeds			Murmurs		
Acne			Stuffiness			Chest pain		
Boils			Hay fever			Swelling in ankles		
Eczema			Infections			Palpitation, fluttering		
Psoriasis			Other			Last ECG		
Dry skin						Other		
Itching			**MOUTH&THROAT**					
Lumps			Hoarseness			**BREASTS**		
Night sweats			Gum problems			Lumps		
Other			Difficulty swallowing			Pain/tenderness		
			Dental problems			Nipple discharge		
HEAD			Sores			Last mammogram		
Tension headaches			Dryness			Other		
Migraine headaches			Sore throat					
Head injury			Loss of taste			**GASTROINTESTINAL**		
Dizziness			Other			Trouble swallowing		
Other						Heartburn		
			NECK			Change in appetite		
EYE			Lumps			Nausea		
Impaired vision			Swollen glands			Vomiting		
Contact lenses			Goiter			Vomiting blood		
Eye pain			Pain or stiffness			Belching		
Tearing			Other			Passing gas		
Dryness						Abdominal pain		
Double vision			**RESPIRATORY**			Indigestion		
Glaucoma			Cough			Diarrhea		
Cataracts			Sputum			Constipation		
Blurring			Spitting up blood			Blood in stool		
Light sensitive			Wheezing			Hemorrhoids		
Itching			Asthma			Black, tarry stool		
Redness			Bronchitis			Jaundice		
Discharge			Pneumonia			Liver disease		
Blind spot			Pleurisy			Gallbladder disease		
Other			Emphysema			Food allergy		
			Difficulty breathing			Hiatus hernia		
EARS			Pain on breathing			Last colonoscopy		
Impaired hearing			Shortness of breath			Other		
Earache			Shortness of breath night					
Dizziness			Shortness of breath lying			**BLOOD/LYMPHATIC**		
Discharge			Positive tuberculin test			Anemia		
Infections			Last TB test			Easy bleeding/bruising		
Excessive wax			Last Chest X-ray			Past transfusions		
Other			Other			Lymph node swelling		
						Other		

URINARY			**FEMALE REPRODUCT**					
Pain on urination			Menopause			**ENDOCRINE**		
Increased frequency			Age of onset			Depression		
Frequency at night			Hormone therapy			Angry		
Inability to hold urine			Last gynecological exam			Mood swings		
Frequent infection			Last pap smear			Anxiety		
Kidney stones			Other			Nervousness		
Blood in urine						Tension		
Reduced urine flow			**MUSCULOSKELETAL**			Phobias		
Other			Broken bones			Insomnia		
			Muscle spasms/cramps			Sexual difficulties		
MALE REPRODUCTIVE			Weakness			Drug abuse		
Hernia			Joint swelling			Psychiatric care		
Testicular masses			Backache			Psychological counseling		
Testicular pain			Other			Other		
Impotence								
Premature ejaculation			**PERIPHERAL VASCUL**					
Venereal disease			Deep leg pain					
Discharge of sores			Cold hands/feet					
Sexually active			Varicose veins					
Last prostate exam			Thrombophlebitis					
Last PSA level			Leg cramps					
Other			Extremity numbness					
			Extremity coldness					
FEMALE REPRODUCTIVE			Extremity swelling					
Age of first menses:			Extremity ulcers					
Last menstrual period:			Other					
#days of menses:								
Length of cycle			**NEUROLOGIC**					
Bleeding between period			Fainting					
Irregular cycles			Seizure/convulsions					
Pain during intercourse			Paralysis					
Painful menses			Muscle weakness					
Excessive flow			Numbness or tingling					
PMS			Loss of memory					
#pregnancies:			Involuntary movements					
#live births:			Loss of balance					
#miscarriages:			Speech problems					
#abortions:			Other					
Difficulty conceiving								
Sexual difficulties								
Vaginal discharge								
Vaginal itching								
Sexually active								