Junction Naturopathic Medicine
4302 SW Alaska St. Suite 200
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ADULT NEW PATIENT INTAKE FORM

Name: _____ Date of birth: _____ Today's Date: _____

A note to our patients: Optimal naturopathic care is only possible when the physician has a complete picture of you physically, mentally and emotionally. Our request is that you please complete this questionnaire as thoroughly as possible. Thank you.

Please List SPECIFIC HEALTH CONCERNS in order of importance to you:

1._____

Date Began:_____/_____/_____

What makes it better?_____Worse?_____

Have you seen other health care providers for this? ☐Yes ☐No If yes, who? _____

If yes, what medications or treatments were given?_____

2._____

Date Began:_____/_____/_____

What makes it better?_____Worse?_____

Have you seen other health care providers for this? ☐Yes ☐No If yes, who? _____

If yes, what medications or treatments were given?_____

3._____

Date Began:_____/_____/_____

What makes it better?_____Worse?_____

Have you seen other health care providers for this? ☐Yes ☐No If yes, who? _____

If yes, what medications or treatments were given?_____

What do you think may have caused your health condition(s)? _____

_____

Do you have any specific goals for your health? _____

_____

(please use a separate page for the above two q's if need be)

What is your weakest organ system and why? _____

Health as a child? ☐good ☐fair ☐poor Breast-fed? ☐yes ☐no Vaginal birth? ☐yes ☐ no

Sleep Quality: ☐Fitful ☐Interrupted ☐Calm ☐Restful ☐Deep Average hours of sleep?_____

Do you wake feeling rested? (Y N) please circle

Do you nap during the day? (Y N) How long? _____

Do you have trouble falling asleep? (Y N)

What time do you fall asleep? ____

Do you wake during the night? (Y N)

if yes, do you have trouble falling back asleep? (Y N)

What time do you awake?____

How many colds or flus did you get last year? _____

Have problems at work, home, friends? (Y N)

Have trouble relaxing or enjoying your spare time? (Y N)

Rate your current stress level on a scale 0-10 (10=highest) 0 1 2 3 4 5 6 7 8 9 10

Rate your current energy 0-10 (10=highest) 0 1 2 3 4 5 6 7 8 9 10

What do you do to manage your stress?_____

Identify the major causes of stress (such as changes in your job, work, residence or finance)_____

_____

Do you have a spiritual practice? If so, what?_____

Medical History

ALLERGIES (Medications, Food, Environment): _____

_____. What happens when you have an allergy attack? _____

_____

Past SURGERIES/HOSPITALIZATIONS /INJURIES (include surgery for tonsils, appendix, gall bladder, cosmetic and hysterectomy):

Surgery:_____ Date: _____

Name of Hospital: Outcome:

Surgery:_____ Date: _____

Name of Hospital: Outcome:

Other Hospitalization:_____ Date: _____

Treatment: Outcome:

Other Hospitalization:_____ Date: _____

Treatment: Outcome:

Injury:_____ Date: _____

Treatment: Outcome:

Injury:_____ Date: _____

Treatment: Outcome:

Please List MEDICATIONS (OTC & prescribed) you are taking: if prescribed

Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:

Please List SUPPLEMENTS/HERBS You Are Taking:

Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			
Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			
Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			
Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:	_____	_____	_____	_____	_____	_____
Age when died:	_____	_____	_____	_____	_____	_____
Reason for death:	_____	_____	_____	_____	_____	_____
Cancer history yes/no:	_____	_____	_____	_____	_____	_____
High blood pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart attack/stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N
Skin disorders:	Y N	Y N	Y N	Y N	Y N	Y N
Neurologic disorders:	Y N	Y N	Y N	Y N	Y N	Y N
Digestive disorders:	Y N	Y N	Y N	Y N	Y N	Y N
Other:	_____	_____	_____	_____	_____	_____

Tests & Imaging (plz check box if yes and provide date)

☐ Radiographs _____ ☐EKG_____ ☐ EBT Heart Scan_____

☐Full Physical Exam_____ ☐Cardiac Stress_____ ☐ CT Scan: _____

☐Upper Endoscopy_____ ☐Upper GI Series_____ ☐ MRI _____

☐ Ultrasound_____ ☐TB test_____

Last time you had blood work done and with what health care provider: _____

Did you have the following Disease (D); have prior vaccination (V), or neither (N):

Measles:	**D V N**	**Chicken Pox:**	**D V N**	**Mumps:**	**D V N**	**Rubella:**	**D V N**
Tetanus:	**D V N**	**Whooping Cough:**	**D V N**	**Hemophilus (Hib):**	**D V N**	**Hepatitis B:**	**D V N**
German measles:	**D V N**	**Polio :**	**D V N**	**Yellow fever:**	**D V N**	**HPV:**	**D V N**

Flu: D V N **Pneumonia: D V N** **Other: _____** **Any history of Lyme disease: Yes No** **Dengue fever: Yes No**

Any adverse vaccination reactions? _____

List Yes (Y), No (N) or Past (P) regarding use of the following:

Antacids: Y N P **Steroids: Y N P** **Marijuana: Y N P** **Green tea: Y N P** **Black tea: Y N P**

Analgesics Y N P **Laxatives: Y N P** **Coffee: Y N P** **Cups coffee per day if yes/past:** _____

Soda Pop Y N P **Ounces pop per day if yes/past:** _____

Herbal tea: Y N P **Eating disorder: Y N P** **Drug addiction: Y N P** **Any drug rehab treatment: Y N P**

Any alcohol addiction: Y N P **Any alcohol rehab treatment: Y N P**

Food (please circle either "Y" or "N")

Feel your diet is adequate (Y N)	**Eat at irregular intervals (Y N)**	**Add sugar to food or drink (Y N)**
Eat in a hurried atmosphere (Y N)	**Vegetarian (Y N)**	**Vegan (Y N)**
Eat between meals (Y N)	**Drink water with meals (Y N)**	**Restrict fat (Y N)**
Eat out often (Y N)	**Follow a special diet (Y N)**	**Restrict salt (Y N)**
Avoid certain foods (Y N)	**Skip breakfast (Y N)**	**Eat whether hungry or not (Y N)**
Number of meals per day ____	**Graze (small frequent meals) (Y N)**	**Use canola oil (Y N)**
Regularly drink tap water (Y N)	**Regularly salt your food (Y N)**	**Eat quickly and forget to chew (Y N)**

Eat foods with artificial ingredients (Y N) **Restrict specific foods: (dairy, wheat, egg, soy, corn, gluten) (Y N)**

Exercise

Days per week_____ Length in minutes _____ Type of exercise_____

Ideal Weight:_____ Blood Type: _____ Rh factor:_____ Water intake, daily:_____ounces

Review of Systems

REGARDING THE NEXT LONG SECTION: Please circle (Y) is you have the problem NOW, (N) if you've NEVER had the problem, (P) if you had the problem in the PAST:

Good Energy: Y N P Fatigue: Y N P

If you have fatigue, when in morning, afternoon, evening is the worst? _____

If you have fatigue, can you do what you need to during the day? Y N

SKIN

Rash:	**Y N P**	**Color Change:**	**Y N P**
Hives:	**Y N P**	**Lump:**	**Y N P**
Psoriasis/Eczema:	**Y N P**	**Itchy:**	**Y N P**
Dry:	**Y N P**	**Warts/Moles:**	**Y N P**
Cancer:	**Y N P**	**Perspiration:**	**Y N P**

HEAD

Headache:	**Y N P**	**Migraine:**	**Y N P**
Dandruff:	**Y N P**	**Head Injury:**	**Y N P**
Oily/dry hair:	**Y N P**	**Hair loss:**	**Y N P**
Ear infections:	**Y N P**	**Hearing loss:**	**Y N P**

NOSE

Frequent Colds:	**Y N P**	**Nosebleeds:**	**Y N P**
Congestion:	**Y N P**	**Post Nasal Drip:**	**Y N P**
Polyps:	**Y N P**	**Seasonal Allergies:**	**Y N P**

EYES

Dry/Watery:	**Y N P**	**Blurry Vision:**	**Y N P**
Double Vision:	**Y N P**	**Cataracts:**	**Y N P**
Glaucoma:	**Y N P**	**Styes:**	**Y N P**
Strain:	**Y N P**	**Discharge:**	**Y N P**
Itchy:	**Y N P**	**Dark under Eyelid:**	**Y N P**

MOUTH/THROAT

Canker/Cold sores:	**Y N P**	**Mercury Fillings – amount** _____	
Sore Throat	**Y N P**	**Gum Disease:**	**Y N P**
Dentures:	**Y N P**	**Cavities:**	**Y N P**
Loss of Taste:	**Y N P**	**Hoarseness:**	**Y N P**

NECK

Stiffness:	Y N P	Swollen Glands:	Y N P
Full movement:	Y N P	Tension:	Y N P

RESPIRATORY

Cough:	Y N P	TB:	Y N P
Shortness of breath w/exertion:	Y N P	Bronchitis:	Y N P
Shortness of breath sitting:	Y N P	Pneumonia:	Y N P
Shortness of breath lying down:	Y N P	Asthma:	Y N P
Wheezing:	Y N P	Painful breathing:	Y N P

CARDIOVASCULAR

High Blood Pressure:	Y N P	Rheumatic Fever:	Y N P
Low Blood Pressure:	Y N P	Murmurs:	Y N P
Arrhythmias:	Y N P	Palpitations:	Y N P
Edema:	Y N P	Chest Pain:	Y N P

URINARY TRACT

Incontinence:	Y N P	Pain w/Urination:	Y N P
Frequent Infections:	Y N P	Kidney Stones:	Y N P
Urgency:	Y N P	Discharge/Blood:	Y N P
Frequent Urination:	Y N P	Night Time Urination:	Y N P

MUSCULOSKELETAL

Weakness:	Y N P	Arthritis:	Y N P
Stiffness:	Y N P	Leg Cramps:	Y N P
Tremors:	Y N P	Pain:	Y N P

NERVOUS

Paralysis:	Y N P	Sciatica:	Y N P
Tingling/numbness:	Y N P	Carpal tunnel Syndrome:	Y N P
Seizures:	Y N P	Fainting:	Y N P

MENTAL/EMOTIONAL

Depression:	Y N P	Anger/Irritability:	Y N P
Suicidal:	Y N P	High-strung/tense:	Y N P
Anxiety:	Y N P	Fear/Panic:	Y N P
Eating Disorder:	Y N P	Psych Hospitalization:	Y N P

Please list all your current care providers:
Primary Care Physician: _____ Dentist: _____

Others: (Specialist MD/DOs, acupuncture, massage, PT, etc.) _____
_____
_____

Male Reproduction

Have you had a PSA done? ☐Yes ☐ No PSA Level: ☐0-2 ☐ 2-4 ☐ 4-10 ☐ > 10
☐prostate enlargement ☐prostate infection ☐change in libido ☐ impotence
☐difficulty obtaining an erection ☐difficulty maintaining an erection
☐nocturia (urination at night). How many times at night? ____
☐urgency/hesitancy/change in urinary stream ☐ loss of control of urine
☐hernia ☐testicular masses ☐testicular pain ☐sexually active ☐discharge or sores
☐Birth control What type? _____ ☐ STD prevention What type? _____
(optional question) Sexual preference: ☐Heterosexual ☐Homosexual ☐Bisexual

Female Reproduction (Y P N = yes past no) Are you post menopausal? Y P N hormones? Y P N
Age menses began_____ # of days of menstrual flow _____Date of last period_____
Length of complete cycle _____ Date of last pap _____ ☐Normal ☐Abnormal

Excessive flow Y P N	Cycles regular Y P N	Bleeding between periods Y P N
Cramps Y P N	Abnormal vaginal discharge Y P N	Are you sexually active? Y P N
PMS Y P N	Breast lumps Y P N	Pain during intercourse? Y P N

Difficulty conceiving? Y P N Menopausal symptoms? Y P N Satisfied with sex life? Y P N
# of pregnancies: _____ # of live births _____ # of abortions _____ # of miscarriage _____
Birth control? Y P N What type? _____ Regular self breast exam? Y P N
Breast pain Y P N Breast tenderness Y P N Nipple discharge Y P N

Do you have a history of: ☐Yeast infection ☐Gonorrhea ☐Syphilis ☐Herpes ☐Chlamydia
☐HPV ☐Bacterial vaginosis ☐Ovarian Cysts ☐Uterine Fibroids ☐Endometriosis
(optional questions) What is your sex? _____ gender?_____ sexual orientation?_____

ALL PATIENTS: Anything that was *not* asked that you would like to communicate? _____
_____
_____
_____
_____
_____

Thank you for all your time. I look forward to analyzing all of the information in your case and working together to help you get healthier, feel better and live the life you want.

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