NATURAL HEALING FAMILY MEDICINE

LORI WIESER N.D.
NATUROPATHIC PHYSICIAN

Adult Intake Form

Last Name: ____________________First Name: ___________________Date:___________________

Address: ____

City: ____________________________State_______________________________Zip___________

Telephone (Home):________________________Telephone (Work):__________________________

Email Address: ____

Age: __________________Date of Birth: ______________________________Gender:____________

Married: ____Separated:______Divorced:____Widowed:_____Single:______Partnership:_____

Live with: Spouse_____Partner____Parents:_____Children:________Friends:____Alone:______

Do you have any children? Y / N if yes please list their ages: _______________________________

Occupation: _________________________________Hours per Week: _______________________

Employer name and address: ____

____

In an emergency contact: __________________________________Ph:______________________

How did you hear about this clinic/referred by? ____

If internet: Google____AANP website_____WANP website______Other:___________________

Emergency Contact: _____________________________Relationship:________________________

Phone: ____Address:___________________________

Have you ever consulted a Naturopathic physician before? Y / N

Are you currently receiving healthcare? Y / N, if yes where and from whom?:________________

What was the reason?____

Present Health Concerns: Please list important health concerns in their order of significance.

1.____

2.____

3.____

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4.____

5.____

What do you believe is causing your most important health concerns?_____________________

____

What goals do you have for your visit today?____

____

Do you have any contagious diseases at this time? Y / N If yes, what?_____________________

Past Medical History:

Hospitalizations/Surgeries/injuries:

____Year:_______________

____Year:_______________

____Year:_______________

____Year:_______________

Allergies: Please include mild to severe or life-threatening allergies and reactions (symptoms)

1.)Medications:____

____

____

2.)Food:____

____

____

3.)Environment:____

____

____

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General:

Height:_________________ Weight:________________ Weight 1 year ago:________________

Maximum Weight:______________________When:___________________________________

When during the day is your energy best?____________________Worst?__________________

Main interest and hobbies:____

Exercise: Y / N If so, what kind and how often: ____

Watch T.V.: Y / N If yes, how many hours?______ Read: Y / N If so, how many hours?_______

Do you have any religious or spiritual practices? Y / N If so what kind?____________________

Diet:

Breakfast:____

Lunch: ____

Dinner:____

Snacks between meals:____

How many glasses of water do you drink each day on average?:___________ What other beverages do you drink and how much per day?____

Personal Habits:

Coffee? Y/ N If yes how often and how much?____

Drink alcohol? Y / N If yes how often and how much?__________________________________

Smoke? Y / N If yes, how often and how much? _______________________________________

Recreational drugs? Y / N if yes, what, how often and how much?________________________

Sexual History:

Are you sexually active? Y / N

Are you practicing safer sex methods? Y /N What form of contraception/ Birth control are you using? (Please check all that apply) Abstinence___ Withdrawal_____ Fertility awareness method____ The sponge_____ Spermicide ______ Condom____Diaphram____Cervical cap___IUD(circle copper/periguard or merena)_____ The pill_____ The Depo shot____Nuvaring_____Implants____ The patch_____Vasectomy____ None______

If yes, is the current form working for you? Y / N, If current or past problems please describe briefly:____

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Labs and Exam History:

Date of last full physical exam:_________________ Results: □ Normal □ Other ____________________

Date of last blood work:______________________ Results: □ Normal □ Other ____________________

Date of last urine test:_______________________ Results: □ Normal □ Other ____________________

Date of last PAP **and** pelvic exam:_____________ Results: □ Normal □ Other ____________________

Date of last mammogram:___________________ Results: □ Normal □ Other ____________________

Date of last DEXA scan:_____________________ Results: □ Normal □ Other ____________________

PERSONAL and FAMILY HISTORY: Please place a “C” for current or “P” for past in the box as it applies to you or your family members.

	Self	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism									
Allergies									
Anemia									
Arthritis									
Asthma									
Cancer									
Depression									
Diabetes									
Drug Addiction									
Eczema									
Epilepsy									
Headaches									
Heart Disease									
Hepatitis									
High Blood Pressure									
Kidney Disease									
Mental Illness									
Stroke									
Tuberculosis									

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Sleep:

How many hours of sleep do you get a night on average?_______How often do you wake and for what reasons?:____

Do you have any trouble falling asleep? Y / N If yes, why?____

Do you have any trouble waking up? Y / N If yes, why?____

ENERGY AND STRESS:

How would you rate your energy on a scale of 1 – 10 with 10 being the most energy?_______________________

How would you rate your stress on a scale of 1 – 10 with 10 being the most stress?_________________________

How do you cope with stress?____

TRAVEL HISTORY: Identify any domestic or foreign travel and indicate year of travel:

Place:________________________ Year:_________ Place:___________________________Year:______________

Place:________________________ Year:_________ Place:___________________________Year:______________

Place:________________________Year:__________ Place:___________________________Year:______________

Place:________________________Year:__________ Place:___________________________Year:______________

IMMUNIZATIONS: Please place an **X** in either the Yes or No box next to each vaccination that you have been vaccinated against. If Yes, please indicate whether there were any reactions and describe in detail.

Immunization	No	Yes	Reaction Description
Hepatitis B			
Diphtheria, Tetanus, Pertussis(DPT)			
Haemophilus Influenza Type B			
Inactivated Polio			
Measles, Mumps, Rubella(MMR)			
Varicella (Chickenpox)			
Pneumococcal			
Influenza			
Rotavirus			
Human Papilloma Virus (HPV)			

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Pharmacy name:_______________________________________Pharmacy ph:(____)__________

Medication Log

Please list prescription medications +/or over the counter medications that you are currently taking, with dosages

Rx Name	Reason for Rx	Dosing	Start Date	Stop Date	

Supplement Log

Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

Supplement name	Reason for Supplement	Dosing	Start date	Stop date	

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For the following, please mark:

Y= a condition you have now, N=never had, P= a significant problem in the past, S=sometimes a problem

GENERAL					**IMMUNE**				
Do you sleep well?	Y	N	P	S	Reactions to immunizations	Y	N	P	S
Average 6 to 8 hours?	Y	N	P	S	Chronically swollen glands	Y	N	P	S
Awake rested?	Y	N	P	S	Slow wound healing	Y	N	P	S
Have a supportive relationship	Y	N	P	S	Chronic Fatigue Syndrome	Y	N	P	S
Have a history of abuse	Y	N	P	S	Night sweats	Y	N	P	S
Experience a major trauma?	Y	N	P	S	**EARS**				
Treated for drug dependence?	Y	N	P	S	Impaired hearing	Y	N	P	S
Do you enjoy your work?	Y	N	P	S	Ringing in ears	Y	N	P	S
Take vacations?	Y	N	P	S	Dizziness	Y	N	P	S
Spend time outside?	Y	N	P	S	Ear aches	Y	N	P	S
Eat three meals a day?	Y	N	P	S	**EYES**				
Do you go on diets often?	Y	N	P	S	Impaired vision	Y	N	P	S
Do you go out often	Y	N	P	S	Glaucoma	Y	N	P	S
Drink black/green tea?	Y	N	P	S	Cataracts	Y	N	P	S
Drink soda?	Y	N	P	S	Eye pain or strain	Y	N	P	S
Do you eat refined sugar?	Y	N	P	S	Spots in vision	Y	N	P	S
Do you add salt to your food?	Y	N	P	S	Color blindness	Y	N	P	S
ENDOCRINE					Tearing or dryness	Y	N	P	S
Difficulty exercising	Y	N	P	S	**MOUTH AND THROAT**				
Seasonal depression	Y	N	P	S	Frequent sore throat	Y	N	P	S
Excessive hunger	Y	N	P	S	Copious saliva	Y	N	P	S

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Diabetes	Y	N	P	S	Sore tongue or lips	Y	N	P	S
Heat or cold intolerance	Y	N	P	S	Hoarseness	Y	N	P	S
Hypoglycemic	Y	N	P	S	Jaw clicks	Y	N	P	S
Hypothyroid	Y	N	P	S	Teeth grinding	Y	N	P	S
Hyperthyroid	Y	N	P	S	Gum problems	Y	N	P	S
Excessive thirst	Y	N	P	S	Dental cavities	Y	N	P	S
Fatigue	Y	N	P	S	**SKIN**				
NEUROLOGIC					Rashes	Y	N	P	S
Seizures	Y	N	P	S	Acne/boils	Y	N	P	S
Muscle weakness	Y	N	P	S	Changes in skin color	Y	N	P	S
Loss of memory	Y	N	P	S	Lumps or bumps on skin	Y	N	P	S
Vertigo or dizziness	Y	N	P	S	Eczema or hives	Y	N	P	S
Paralysis	Y	N	P	S	Itching	Y	N	P	S
Numbness or tingling	Y	N	P	S	Perpetual hair loss	Y	N	P	S
Easily stressed	Y	N	P	S	**NOSE AND SINUS**				
Loss of balance	Y	N	P	S	Frequent colds	Y	N	P	S
HEAD					Stuffiness	Y	N	P	S
Headaches	Y	N	P	S	Sinus problems	Y	N	P	S
Migraines	Y	N	P	S	Nose bleeds	Y	N	P	S
Head injury	Y	N	P	S	Hay fever	Y	N	P	S
Jaw or TMJ problems	Y	N	P	S	Loss of smell	Y	N	P	S
RESPIRATORY					**NECK**				
Cough	Y	N	P	S	Lumps in neck	Y	N	P	S
Sputum	Y	N	P	S	Goiter	Y	N	P	S
Asthma	Y	N	P	S	Difficulty swallowing	Y	N	P	S
Wheezing	Y	N	P	S	Pain or stiffness in neck	Y	N	P	S
Bronchitis	Y	N	P	S	**BLOOD**				

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Coughing up blood	Y	N	P	S	Easy bleeding or bruising	Y	N	P	S
Shortness of breath	Y	N	P	S	Anemia	Y	N	P	S
Shortness of breath lying down	Y	N	P	S	Cold hands/feet	Y	N	P	S
Pain in breathing	Y	N	P	S	Deep leg pain	Y	N	P	S
Emphysema	Y	N	P	S	Thrombophlebitis	Y	N	P	S
Tuberculosis	Y	N	P	S	Varicose veins	Y	N	P	S
GASTROINTESTINAL					**MENTAL/EMOTIONAL**				
Trouble swallowing	Y	N	P	S	Treated for emotional problems	Y	N	P	S
Change in thirst	Y	N	P	S	Depression	Y	N	P	S
Change in appetite	Y	N	P	S	Anxiety or nervousness	Y	N	P	S
Nausea/vomiting	Y	N	P	S	Poor concentration	Y	N	P	S
Ulcer	Y	N	P	S	Do you have mood swings?	Y	N	P	S
Jaundice	Y	N	P	S	Considered suicide?	Y	N	P	S
Gall baldder disease	Y	N	P	S	Attempted suicide?	Y	N	P	S
Liver disease	Y	N	P	S	Tension	Y	N	P	S
Hemorrhoids	Y	N	P	S	Memory problems	Y	N	P	S
Pancreatitis	Y	N	P	S	**URINARY**				
Heartburn	Y	N	P	S	Increased frequency of urination	Y	N	P	S
Abdominal pain or cramps	Y	N	P	S	Inability to hold urine	Y	N	P	S
Belching or passing gas	Y	N	P	S	Pain in urination	Y	N	P	S
Constipation	Y	N	P	S	Frequency at night	Y	N	P	S
Bowel movements: How often?________________					Frequent UTI's	Y	N	P	S
Is this a change?______________________________					Kidney stones	Y	N	P	S
Black stools	Y	N	P	S	**MUSCULOSKELETAL**				
Blood in stools	Y	N	P	S	Joint pain or stiffness	Y	N	P	S
FEMALE REPRODUCTIVE					Arthritis	Y	N	P	S
Age of first menses	Y	N	P	S	Broken bones	Y	N	P	S

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Age of last menses (if menopausal)	Y	N	P	S	Weakness	Y	N	P	S
Length of cycle___________days					Muscle spasm or cramps	Y	N	P	S
Duration of menses____________days					Sciatica	Y	N	P	S
Are your cycles regular	Y	N	P	S	**MALE REPRODUCTIVE**				
Painful menses	Y	N	P	S	Discharge or soreness	Y	N	P	S
Heavy or excessive flow	Y	N	P	S	Chlamydia	Y	N	P	S
PMS	Y	N	P	S	Gonorrhea	Y	N	P	S
Symptoms___________________________________					Genital warts	Y	N	P	S
Bleeding between cycles	Y	N	P	S	Herpes	Y	N	P	S
Clotting	Y	N	P	S	Syphilis	Y	N	P	S
Endometriosis	Y	N	P	S	Hernias	Y	N	P	S
Ovarian cysts	Y	N	P	S	Testicular masses	Y	N	P	S
Gonorrhea	Y	N	P	S	Testicular pain	Y	N	P	S
Chlamydia	Y	N	P	S	Impotence	Y	N	P	S
Syphilis	Y	N	P	S	Premature ejaculation	Y	N	P	S
Vaginal odor	Y	N	P	S	**FEMALE REPRODUCTIVE CONTINUED**				
Discharge	Y	N	P	S	Number of pregnancies	Y	N	P	S
Date of last pap smear	Y	N	P	S	Number of live births	Y	N	P	S
Abnormal pap	Y	N	P	S	Number of miscarriages	Y	N	P	S
Cervical dysplasia	Y	N	P	S	Number of abortions	Y	N	P	S
Pain during intercourse	Y	N	P	S	Do you do self breast exams?	Y	N	P	S
Herpes	Y	N	P	S	Breast pain/tenderness	Y	N	P	S
Genital warts	Y	N	P	S	Breast lumps	Y	N	P	S
Currently trying to conceive	Y	N	P	S	Nipple discharge	Y	N	P	S
Difficulty conceiving	Y	N	P	S	Menopausal symptoms	Y	N	P	S
Any chance you may be pregnant	Y	N	P	S					

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