



# Natural Healing Family Medicine

Lori Wieser N.D.

360-402-4943



## 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 If yes, with: Men \_\_\_ Women \_\_\_ Both \_\_\_

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 \_\_\_ Diaphragm \_\_\_ 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.

	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)			

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_





**For the following, please circle:**

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

**General:**

- Do you sleep well? Y N P S
- Average 6 to 8 hours? Y N P S
- Awake rested? Y N P S
- Have a supportive relationship? Y N P S
- Have a history of abuse? Y N P S
- Experience a major trauma? Y N P S
- Treated for drug dependence? Y N P S
- Do you enjoy your work? Y N P S
- Take Vacations? Y N P S
- Spend time outside? Y N P S
- Eat three meals a day? Y N P S
- Do you go on diets often? Y N P S
- Do you eat out often? Y N P S
- Drink black/green tea? Y N P S
- Drink soda? Y N P S
- Do you eat refined sugar? Y N P S
- Do you add salt to your food? Y N P S

**Endocrine**

- Hypothyroid? Y N P S    Hyperthyroid Y N P S
- Hypoglycemic? Y N P S    Heat or cold intolerance Y N P S
- Excessive thirst? Y N P S    Hyperthyroid Y N P S
- Fatigue? Y N P S

**Endocrine Cont.**

- Diabetes? Y N P S
- Excessive hunger? Y N P S
- Seasonal Depression? Y N P S
- Difficulty Exercising? Y N P S

**Immune**

- Reaction to immunizations? Y N P S
- Chronically swollen glands? Y N P S
- Slow wound healing? Y N P S
- Chronic fatigue syndrome? Y N P S
- Night sweats? Y N P S

**Ears**

- Impaired hearing? Y N P S
- Ringing in ears? Y N P S
- Dizziness? Y N P S
- Ear Aches? Y N P S

**Eyes**

- Impaired vision? Y N P S
- Cataracts? Y N P S    Glaucoma Y N P S
- Eye pain or strain Y N P S
- Spots in vision? Y N P S
- Color blindness? Y N P S
- Tearing or dryness? Y N P S

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**Neurologic**

- Seizures? Y N P S
- Muscle weakness? Y N P S
- Loss of memory? Y N P S
- Vertigo or dizziness? Y N P S
- Paralysis? Y N P S
- Numbness or tingling? Y N P S
- Easily stressed? Y N P S
- Loss of balance? Y N P S

**Head**

- Headaches? Y N P S
- Migraines? Y N P S
- Head injury? Y N P S
- Jaw or TMJ problems? Y N P S

**Nose and Sinus**

- Frequent colds? Y N P S
- Stuffiness? Y N P S
- Sinus problems? Y N P S
- Nose bleeds? Y N P S
- Hayfever? Y N P S
- Loss of smell? Y N P S

**Neck**

- Lumps in neck? Y N P S
- Goiter? Y N P S
- Difficulty swallowing? Y N P S
- Pain or stiffness in neck? Y N P S

**Mouth and Throat**

- Frequent sore throat? Y N P S
- Copious saliva? Y N P S
- Sore tongue or lips? Y N P S
- Hoarseness? Y N P S
- Jaw clicks? Y N P S
- Teeth grinding? Y N P S
- Gum problems? Y N P S
- Dental cavities? Y N P S

**Skin**

- Rashes? Y N P S
- Acne/boils? Y N P S
- Change in skin color? Y N P S
- Lumps or bumps on skin? Y N P S
- Eczema or hives? Y N P S
- Itching? Y N P S
- Perpetual hair loss? Y N P S

**Respiratory**

- Cough? Y N P S
- Sputum? Y N P S
- Asthma? Y N P S
- Wheezing? Y N P S
- Bronchitis? Y N P S
- Coughing up blood? Y N P S
- Shortness of breath? Y N P S
- Shortness of breath when lying down? Y N P S



**Respiratory cont.**

Pain in breathing? Y N P S

Emphysema? Y N P S

Tuberculosis? Y N P S

**Gastrointestinal**

Trouble swallowing? Y N P S

Change in thirst? Y N P S

Change in appetite? Y N P S

Nausea/vomiting? Y N P S

Ulcer? Y N P S

Jaundice? Y N P S

Gall bladder disease? Y N P S

Liver disease? Y N P S

Hemorrhoids? Y N P S

Pancreatitis? Y N P S

Heartburn? Y N P S

Abdominal pain or cramps? Y N P S

Belching or passing gas? Y N P S

Constipation? Y N P S

Bowel movements: How often? \_\_\_\_\_

Is this a change? \_\_\_\_\_

Black stools? Y N P S

Blood in stools? Y N P S

**Mental/ Emotional**

Treated for emotional problem? Y N P S

Depression? Y N P S

**Mental/ Emotional Cont.**

Anxiety or nervousness? Y N P S

Poor concentration? Y N P S

Do you have mood swings? Y N P S

Considered suicide? Y N P S

Attempted suicide? Y N P S

Tension? Y N P S

Memory problems? Y N P S

**Urinary**

Increased frequency of urination? Y N P S

Inability to hold urine? Y N P S

Pain in urination? Y N P S

Frequency at night? Y N P S

Frequent UTIs? Y N P S

Kindney stones? Y N P S

**Musculoskeletal**

Joint pain or stiffness? Y N P S

Arthritis? Y N P S

Broken bones? Y N P S

Weakness? Y N P S

Muscle spasm or cramps? Y N P S

Sciatica? Y N P S

**Blood**

Easy bleeding or bruising? Y N P S

Anemia? Y N P S

Cold hands/feet? Y N P S



**Blood cont.**

Deep leg pain? Y N P S

Thrombophlebitis? Y N P S

Varicose veins? Y N P S

**Female Reproductive**

Age of first menses? \_\_\_\_\_

Age of last menses? ( if menopausal) \_\_\_\_\_

Length of cycle: \_\_\_\_\_ days

Duration of menses: \_\_\_\_\_ days

Are your cycles regular? Y N P S

Painful menses? Y N P S

Heavy or excessive flow? Y N P S

PMS? Y N P S

Symptoms: \_\_\_\_\_  
\_\_\_\_\_

Bleeding between cycles? Y N P S

Clotting? Y N P S

Endometriosis? Y N P S

Ovarian cysts? Y N P S

Vaginal odor? Y N P S Discharge? Y N P S

Date of last PAP smear? \_\_\_\_\_

Abnormal PAP? Y N P S

Cervical Dysplasia? Y N P S

Pain during intercourse? Y N P S

Herpes? Y N P S

Genital warts? Y N P S

**Female Reproductive cont.**

Gonorrhea? Y N P S

Chlamydia? Y N P S

Syphilis ? Y N P S

Currently trying to conceive? Y N P S

Difficulty conceiving? Y N P S

Any chance you may be pregnant? Y N P S

Number of pregnancies? \_\_\_\_\_

Number of live births? \_\_\_\_\_

Number of miscarriages? \_\_\_\_\_

Number of abortions? \_\_\_\_\_

Do you do self breast exams? Y N P S

Breast pain/tenderness? Y N P S

Breast lumps? Y N P S

Nipple discharge? Y N P S

Menopausal symptoms? Y N P S

**Male Reproductive**

Discharge or sores? Y N P S

Chlamydia? Y N P S

Gonorrhea? Y N P S

Genital warts? Y N P S

Herpes? Y N P S Syphilis? Y N P S Hernias? Y N P S

Testicular masses? Y N P S

Testicular pain? Y N P S

Impotence? Y N P S

Premature ejaculation? Y N P S

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