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Homecoming Naturopathic Medicine

ADULT NEW PATIENT INTAKE FORM

Date: mm / dd / yyyy

Name:________________________ Date of birth: mm / dd / yyyy

Address:________________________

Phone numbers
Home________________ Cell________________

Gender: ________________

Occupation
Current: ________________ Occupations in the past: ________________

Emergency contact
Name: ________________ Phone number: ________________ Relation: ________________

Family doctor
Name: ________________ Address: ________________
Phone number: ________________

Other health care providers
Name: ________________ Specialty: ________________ Phone number: ________________

How did you hear about the ND? ________________

Please describe your primary health concerns

____

____

____

____

Which therapies have you already tried? Have they helped?

____

____

____

Please list any other health concerns you may have

____

____

____

Personal medical history

Height__________ Weight___________

Please list any significant illnesses you currently have or have had in the past, dates, and how they were diagnosed

____

____

____

____

Are you currently pregnant? ☐ No ☐Yes How far along? ________________

Have you ever been hospitalized? ☐ No ☐Yes: __________________________

Have you ever had any surgeries? ☐ No ☐Yes: __________________________

What medications do you take (including over the counter and birth control)?

____

____

What supplements/vitamins do you take?

____

____

Do you have any allergies and/or sensitivities (including food, environmental, and medical)?

☐ No ☐Yes: __________________________

Do you get regular screening tests done with another doctor? ☐ No ☐Yes

Family medical history

Please indicate which conditions are present in your family, and which family member has the conditions in relation to you (eg. father, sister, maternal grandmother, etc)

☐ Check here if you do not know your family history

✓		✓	
	Alcoholism/addiction		Heart disease
	Allergies		High blood pressure
	Anemia		High cholesterol
	Arthritis		Kidney disease
	Asthma		Liver disease
	Cancer		Osteoporosis
	Diabetes		Stroke
	Eczema/psoriasis		Tuberculosis
	Epilepsy		Depression/other mental illness
	Headaches/migraines		

Any other conditions that have not been listed? ______________________________

Lifestyle

Do you exercise regularly? ☐ No ☐Yes What do you do? ______________________

What are you hobbies and pastimes?

____

Do you smoke tobacco? ☐ No ☐Yes How much? ____

Do you use recreational drugs? ☐ No ☐Yes Which ones? ____

Do you consume alcohol? ☐ No ☐Yes How often and how much? ________________________________

Are you sexually active? ☐ No ☐Yes

Please describe the stress levels in your life, and how you cope with stress

____

____

____

Please describe your home life

____

____

____

Have you experienced any significant physical and/or emotional trauma, grief, or loss recently or in the past?

____

____

____

Review of body systems

Please place a check mark ✓ beside any issues you currently experience, or a ***P*** *beside issues that you have had in the past*

General	**Skin and hair**	**Head**
☐Unintentional weight loss ☐Unexplained weight gain ☐Fatigue ☐Weakness ☐Poor sleep/insomnia ☐Sweating and/or night sweats	☐Rashes/hives ☐Acne ☐Discoloration ☐Dryness ☐Eczema ☐Psoriasis ☐Itching ☐Temperature changes ☐Moles ☐Thinning/losing head hair ☐Thinking/losing body hair	☐Headaches ☐Head injury ☐Dizziness
Emotional ☐Depression ☐Anxiety ☐Mood swings ☐Fears/phobias ☐Substance abuse ☐Eating disorder		**Ears** ☐Impaired hearing ☐Earache ☐Discharge ☐Frequent ear infections ☐Ringing
Eyes ☐Impaired vision ☐Glasses/contacts ☐Eye pain ☐Redness ☐Itchiness	**Nose and sinus** ☐Impaired sense of smell ☐Frequent colds/ sinus infections ☐Congestion ☐Itching ☐Discharge	**Mouth and throat** ☐Frequent sore throat ☐Tonsillitis or laryngitis ☐Hoarseness ☐Canker sores ☐Cold sores

Eyes continued

- ☐Discharge
- ☐Dry eyes
- ☐Blurring/double vision
- ☐Glaucoma
- ☐Cataracts

Nose continued

- ☐Nose bleeds
- ☐Post-nasal drip
- ☐Polyps or deviated septum

Mouth and throat continued

- ☐Loss of taste
- ☐Dental/gum issues
- ☐Jaw pain
- ☐Goiter
- ☐Swollen glands

Gastrointestinal

- ☐Change in appetite
- ☐Change in thirst
- ☐Trouble swallowing
- ☐Heartburn
- ☐Indigestion
- ☐Abdominal pain
- ☐Nausea/vomiting
- ☐Belching
- ☐Ulcers
- ☐Excessive gas
- ☐Bloating
- ☐Constipation
- ☐Diarrhea
- ☐Changes in stool quality
- ☐Changes in stool frequency
- ☐Liver disease
- ☐Gall bladder disease
- ☐Worms/parasites
- ☐Hernias
- ☐Prolapse
- ☐Rectal bleeding
- ☐Polyps

Cardiovascular

- ☐Chest pain/angina
- ☐Heart disease
- ☐Palpitations/fluttering
- ☐Heart attack
- ☐Stroke
- ☐High blood pressure
- ☐Heart murmurs
- ☐Rheumatic fever

Respiratory

- ☐Asthma
- ☐Wheezing
- ☐Sleep apnea
- ☐Cough
- ☐Phlegm
- ☐Bronchitis
- ☐Pneumonia
- ☐Shortness of breath
- ☐Emphysema
- ☐Coughing up blood
- ☐Tuberculosis

Female reproductive

Age of first period _________
Length of cycle _____________
Length of period ___________

- ☐Irregular cycle
- ☐Very short or very long cycle
- ☐No periods
- ☐Bleeding between periods
- ☐Heave periods
- ☐Scanty periods
- ☐Painful periods
- ☐PMS
- ☐Breast tenderness
- ☐Ovarian cysts
- ☐Uterine fibroids
- ☐Vaginal discharge
- ☐Vaginal itching
- ☐STIs
- ☐Yeast infections
- ☐Infertility/trouble conceiving
- ☐Trouble lactating/breastfeeding
- ☐Menopause
- ☐Pregnancies _________
- ☐Abortions ________
- ☐Miscarriages _________

Breast

- ☐Lumps
- ☐Pain
- ☐Nipple discharge

Endocrine

- ☐Heat/cold intolerance
- ☐Thyroid problems
- ☐Changes in thirst/hunger
- ☐Diabetes
- ☐Blood sugar problems
- ☐Hormonal problems

Urinary

- ☐Pain on urination
- ☐Difficult urination
- ☐Frequent urination
- ☐Waking up to urinate
- ☐Frequent infections
- ☐Blood in the urine
- ☐Urgency
- ☐Incontinence
- ☐Kidney stones
- ☐Kidney disease

Male reproductive

- ☐Hernia
- ☐Testicular mass
- ☐Testicular pain
- ☐Sexual difficulties
- ☐Discharge
- ☐Sores/rashes
- ☐STIs
- ☐Infertility

Peripheral circulation

- ☐Deep leg pain
- ☐Cold hands/feet
- ☐Varicose veins
- ☐Swollen hands/ankles/feet
- ☐Extremity numbness/coldness
- ☐Extremity ulcers
- ☐Anemia
- ☐Easy bruising

Neurological

- ☐Fainting
- ☐Seizures
- ☐Paralysis
- ☐Numbness
- ☐Tingling
- ☐Memory loss
- ☐Balance/gait problems
- ☐Difficulty with movement

Musculoskeletal

- ☐Joint pain/swelling
- ☐Stiffness
- ☐Muscle weakness
- ☐Muscle pain
- ☐Muscle spasms/cramps
- ☐Back pain
- ☐Broken bones