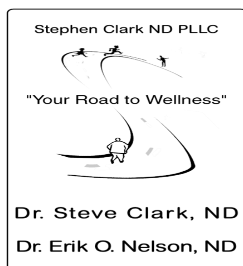
Naturopathic Intake
Dr. Erik O. Nelson, ND



Legal Name:

____

How would you like to be addressed?

____

Date of birth?

____

Mailing Address:

____

Land Address:

____

Email:

____

Phone numbers:
Home:
Cell:
Work:

____

What is your gender?

☐ **Male** ☐ **Female** ☐ **Other:**___________

Thank you for taking the time to fill out this intake form. We know it's comprehensive, but by gathering this information about your health history and goals helps give your naturopathic doctors a more complete understanding of you. We want to help you reach your optimal health.

CONCERNS:

Most important concern you would like to address?

____

Additional concerns?

____

FAMILY HISTORY:

Grandparents:
Ages:
Living/Deceased:

Parents:
Ages:
Living/Deceased:

Siblings:
Ages:
Living/Deceased:

Has any blood relatives ever had any of the following?

☐ Cancer	☐ Tuberculosis
☐ Asthma	☐ Mental illness or suicide
☐ Diabetes	☐ High blood pressure
☐ Allergies	☐ Autoimmune disease
☐ Heart attack	☐ Heart Disease
☐ Stroke	☐ Osteoporosis
☐ Other:	

If YES, check appropriate box and please indicate who below (maternal aunt, paternal grandmother, father, son, sister, etc)

MEDICAL HISTORY:

Who is your primary care physician Please include address, phone & fax number:

Please indicate the doctors or practitioners that have been involved in your care in the last three years. Provide name, date of last visit, visit reason, office number?

☐ Nephrologist	☐ Urologist
☐ Acupuncturist	☐ Chiropractor
☐ Gastroenterologist	☐ Hematologist/Oncologist
☐ Surgeon	☐ Endocrinologist
☐ Cardiologist	☐ Naturopath
☐ Gynecologist	☐ Other

List any significant prior illness, diagnosis, or injuries, including date occurred (ie hypertension March 2015):

Surgeries and hospitalizations: (Reason and date)

Please list any major accident or illness during childhood not already indicated:

Date of last physical exam:

Date of last blood work:

VACCINATION HISTORY:

Have you ever had the disease (D), been immunized (I), neither (N) or Unknown (U) for the following?

	D	I	N	U	Date
Tetanus	☐	☐	☐	☐	________
Whooping cough (pertussis)	☐	☐	☐	☐	________
Haemophilus (HiB)	☐	☐	☐	☐	________
Hepatitis A	☐	☐	☐	☐	________
Hepatitis B	☐	☐	☐	☐	________
Measles	☐	☐	☐	☐	________
Mumps	☐	☐	☐	☐	________
German Measles (rubella)	☐	☐	☐	☐	________
Chicken Pox:	☐	☐	☐	☐	________
Shingles:	☐	☐	☐	☐	________
Human Papilloma Virus (HPV)	☐	☐	☐	☐	________
Pneumococcus (PCV)	☐	☐	☐	☐	________
Polio	☐	☐	☐	☐	________
Meningococcal	☐	☐	☐	☐	________
Pneumonia	☐	☐	☐	☐	________
Influenza	☐	☐	☐	☐	________
Covid 19	☐	☐	☐	☐	________
Other vaccines:	☐	☐	☐	☐	________

Adverse reactions to vaccines?

☐ NO

☐ YES, describe:

MEDICAL IMAGING:
Date, area of body, reason:

X-ray:

MRI/CT Scan:

Ultrasound:

ALLERGIES:

☐ No known or suspected allergies
☐ Medication
☐ Food
☐ Environment

Please indicate allergy and describe reaction:

MEDICATIONS AND SUPPLEMENTS:

Current Medications and Supplements (please include ALL prescriptions, over-the-counter drugs, vitamins, herbs, etc.). Please include daily dose and reason for taking it.

SOCIAL HISTORY:

What is your current job?

Do you enjoy or job? ☐ Yes ☐ No

What are your hobbies?

Have you done any foreign travel within the last year?

☐ Yes, where? ☐ No

Please indicate your average level of energy throughout the day using the scale 1-10
(1 is the lowest, 10 is the highest)

Do you Exercise? If YES, indicate type, how many times a week, for how long?
(ie soccer, 3 days, 60 minutes)
☐ Yes, describe ☐ No

SLEEP:

How many hours of sleep do you usually get per night? .

Do you wake feeling refreshed?
☐ Always ☐ Usually ☐ Rarely ☐ NO

Do you have difficulty sleeping? ☐ Yes ☐ No
Any trouble falling asleep ☐ Yes ☐ No
Any trouble staying asleep ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No
Do you grind your teeth? ☐ Yes ☐ No
Do you have nightmares? ☐ Yes ☐ No
Do you sleepwalk? ☐ Yes ☐ No
Do you wake due to pain? ☐ Yes ☐ No

Do you use a sleep aid?
☐ Yes, Indicate: ☐ No

ALCOHOL, TOBACCO AND REACTRATIONAL DRUG USE:

Do you drink alcohol?
☐ Daily ☐ Weekly ☐ Monthly ☐ No

What type of alcohol do you prefer?
☐ liquor ☐ Wine ☐ Beer ☐ Other

How much do you drink per sitting?
Indicate amount consumed per occasion.

Do you smoke or chew Tobacco?
☐ Yes ☐ No ☐ In the past
If yes, how many cigarettes or packs per day?

If past, when did you quite smoking? Number of years of smoking and packs per day?

Do you use recreational drugs?
☐ Yes ☐ No ☐ In the past

If yes, how often?
☐ Daily ☐ Weekly ☐ Monthly ☐ Other

Specify what kind:
☐ Cannabis
☐ Barbiturates/ Benzodiazepines
☐ Solvents
☐ Psychedelic mushrooms
☐ Heroin
☐ LSD
☐ Opium
☐ Peyote
☐ Ecstasy
☐ Amphetamines
☐ Cocaine
☐ Other: ___________

Have you ever been told you have an addition or been treated for an addiction? ☐ Yes ☐ No

Does the use of alcohol or drugs impair your activities or daily living? ☐ Yes ☐No

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RELATIONSHIP STATUS:

☐ Single
☐ Separated
☐ Married
☐ Divorced
☐ Domestic partner
☐ Widowed
☐ In a relationship
☐ Other

Are you satisfied with your significant relationship?
☐ Yes ☐ No

Do you Live alone?
☐ Yes ☐ No

Do you have a support system?
☐Strong ☐ Moderate ☐ Limited

Major stressors last year?
☐ Money
☐ Job
☐ Marriage/relationship
☐ Home life
☐ Children
☐ Loss
☐ Health
☐ Other

How do you find your life? ☐ Satisfactory
☐ Too demanding ☐ Unsatisfactory ☐ Boring

REVIEW OF SYSTEMS:
Do you have, or have you had within the past year, any of the following?

General:

- ☐ Weight Change
- ☐ Appetite Change
- ☐ Fever/Chills
- ☐ Weakness
- ☐ Fatigue
- ☐ Night sweats

Eyes:

- ☐ Dryness
- ☐ Watery eyes
- ☐ Itchy eyes
- ☐ Redness
- ☐ Eye Strain
- ☐ Cataracts
- ☐ Other
- ☐ Styes
- ☐ Dark circles
- ☐ Discharge from eyes
- ☐ Contacts/glasses
- ☐ Vision problems
- ☐ Glaucoma

Date of last eye exam: ______________________

Ears, Nose, Throat:

- ☐ Ringing ears
- ☐ Change in hearing
- ☐ Ear discharge
- ☐ Ear Pain
- ☐ Vertigo
- ☐ Nose bleeds
- ☐ Polyps
- ☐ Problems smelling
- ☐ Nasal Congestion
- ☐ Nasal discharge
- ☐ Sinusitis
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Gum disease
- ☐ Mouth sores
- ☐ Swallowing problems
- ☐ Goiter
- ☐ Neck movement restricted/diminished
- ☐ Problems tasting
- ☐ Cavities

Cardiovascular:

- ☐ Murmurs
- ☐ Palpitations
- ☐ Heart attack
- ☐ arrhythmias
- ☐ Angina
- ☐ TIA/Stroke
- ☐ Chest pain
- ☐ Leg cramps
- ☐ Congestive heart
- ☐ Blue hands/feet
- ☐ Rheumatic fever
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Varicose veins
- ☐ Edema

Date of last ECG (if any):______________________

GASTROINTESTINAL:

- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Food intolerance
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Ulcers
- ☐ Rectal bleeding, burning or itching
- ☐ Gas/bloating
- ☐ Nausea
- ☐ Vomiting
- ☐ Liver disease
- ☐ Hernias
- ☐ Fatty meals aggravate
- ☐ Hemorrhoids

How often do you have a bowel movement?______

Date of last colonoscopy if any?________________

Urinary Tract:

- ☐ Incontinence
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Urgency
- ☐ Frequent urination
- ☐ Frequent infections
- ☐ Pain with urination
- ☐ Waking to urinate

Musculoskeletal:

- ☐ Muscle weakness
- ☐ Muscle aches
- ☐ Tremors
- ☐ Arthritis
- ☐ Leg cramps
- ☐ Stiffness
- ☐ Past injury
- ☐ Head injury

Skin/Integumentary:

- ☐ Positive skin exam
- ☐ Color change
- ☐ Abnormal mole
- ☐ Dry skin
- ☐ Acne
- ☐ Rash
- ☐ Hives
- ☐ Dandruff
- ☐ Oily Hair
- ☐ Hair/nail changes
- ☐ Psoriasis
- ☐ Itchy skin
- ☐ Rosacea
- ☐ Eczema
- ☐ Skin cancer
- ☐ Warts
- ☐ Dry Hair
- ☐ Hair los

Neurological:

- ☐ Paralysis
- ☐ Sciatica
- ☐ Seizures
- ☐ Weakness
- ☐ Headaches
- ☐ Migraines
- ☐ Numbness/tingling
- ☐ Tremors
- ☐ Carpal tunnel
- ☐ fainting/blackouts
- ☐ Dizziness
- ☐ Lightheadedness

Mental/Emotional:

- ☐ Anxiety
- ☐ Fear/panic
- ☐ Eating disorder
- ☐ Anger/irritability
- ☐ Feeling down
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Psychiatric hospitalization

Endocrine:

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Mood swings
- ☐ Snacking often
- ☐ Irritability
- ☐ Change in glove or shoe size
- ☐ Increased urination
- ☐ Increased thirst
- ☐ Heat/cold intolerance
- ☐ Need to eat regularly
- ☐ Hormone Therapy

Hematologic/Lymphatic:

- ☐ Anemia
- ☐ Easy bruising/bleeding
- ☐ Hemorrhoids
- ☐ Swollen Lymph nodes
- ☐ Circulation issues
- ☐ Fragile/sensitive skin
- ☐ Blood clot history
- ☐ Deep bone pain
- ☐ Reaction to insect bites
- ☐ Brittle nails

Allergic/Immunologic:

- ☐ Seasonal allergies
- ☐ Chemical sensitivity
- ☐ Dry or itchy eyes
- ☐ Asthma
- ☐ Sinusitis
- ☐ Organ transplant or donation history
- ☐ Sick often
- ☐ Rash
- ☐ Hives
- ☐ Have pets
- ☐ History environmental chemical exposure
- ☐ Family history wheat allergy or celiac disease

Is there anything else you would like the doctor to know about you?

FEMALE:

Menstrual Cycle:

Age of first menses?____________________

First day of last menses?_________________

Length of menses?______________________

Do you experience any of the following before or during your menses?

- ☐ Diarrhea
- ☐ Bloating
- ☐ Food cravings
- ☐ Mood changes
- ☐ Breast tenderness swelling
- ☐ Menstrual cramping
- ☐ Fatigue during menses
- ☐ Back/body aches
- ☐ Heavy Bleeding
- ☐

Menopause:
Age at menopause:______________________

Age your mother entered menopause:______

Was onset of menopause ☐ Within normal
☐ Total Hysterectomy ☐ Partial hysterectomy

Check all the symptoms you currently experience:

- ☐ Hot flashes
- ☐ Night sweats
- ☐ Vaginal dryness
- ☐ Decreased libido
- ☐ Brain fog or decreased memory
- ☐ Mood changes
- ☐ Incontinence
- ☐ Joint pain
- ☐ Sleep disruption
- ☐ Palpitations

Bone Density:
Date of last DEXA scan (bone scan)
Indicate if you have never had one:______________

Are you treating or supplementing for bone density? Specify:

Breast Health:

Do you have any of the following

- ☐ Breast pain
- ☐ Breast discharge
- ☐ Breast masses
- ☐ Family history

Date of last mammogram and results:

____

Gynecology and PAP History:
Date of last PAP smear and results:

____

Have you ever had an irregular PAP smear?
☐ No ☐ Yes, list date and treatment received:

____

Check all, history of pelvic disease conditions:

- ☐ Ovarian cysts
- ☐ Ovarian/uterine disease
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Pelvic inflammatory disease
- ☐ Ectopic pregnancy
- ☐ Other, describe:

Have you had any gynecological surgeries or procedures?
☐ No ☐ Yes, indicate date and type:

____

Contraception, Libido, and Sexually Transmitted Infections (STIs):

Are you currently sexually active? ☐ Yes ☐ No

Please indicate birth controls or other hormones previous or currently used:

____

Are you experiencing any of the following:

- ☐ Low libido
- ☐ Pain with intercourse
- ☐ Bleeding after intercourse

MALE:

Prostate/Urinary symptoms

☐ BPH	☐ Incomplete urination
☐ Nocturia	☐ Dribbling of urine
☐ Prostatitis	
☐ Prostate cancer	☐ Difficulty initiating urination

Date of your last PSA:______________________

Check all that apply:

☐ Testicular pain	☐ Impotency/ED
☐ Testicular swelling	☐ Decreased libido
☐ Hernias	☐ Prostate disease
☐ Penile discharge	☐ Rashes/skin changes

Contraception, Libido, and Sexually Transmitted Infections (STIs):

Are you currently sexually active ☐ Yes ☐ No

Do you experience:

☐ Low libido	☐ Difficulty achieving an erection
☐ Fertility changes	☐ Difficulty maintaining an erection

Please indicate any hormones previously or currently used:

____