

Woodstock Natural Health Clinic



New Patient Intake Form

Welcome! Please fill this form out entirely and bring it with you to your first office visit.

Name _____ DOB _____ SSN _____

Address _____ City _____ State _____ Zip _____

Home/Cell Telephone _____ E-mail address _____

- Ok to leave message with detailed information Ok to e-mail with detailed information
- Leave message with call back number only

Work Phone _____ Cell phone _____

- Okay to leave messages with detailed information on work or cell phone
- Leave messages with call back information only

Today's Date _____ Age _____ Male / Female (circle one) Occupation _____

Employer _____ Hrs per Week _____

How did you hear about Woodstock Natural Health Clinic? _____

Emergency Contact _____ Phone _____

What are your primary health concerns? Please list in the order of their importance to you.

- 1) _____ Past treatment: _____
- 2) _____ Past treatment: _____
- 3) _____ Past treatment: _____

What are the primary expectations you have for your visit today?

- 1) _____
- 2) _____

Are you currently receiving health care? Y N

If yes, where and from whom? Please provide contact information (phone and address) if available.

If no, when was the last time you received medical care and why?

General Information:

Height _____ Weight _____ Weight 1 yr ago _____ Maximum weight _____ When _____
Blood pressure: Most recent blood pressure reading: ____/____ When was this taken? _____

Childhood Illness (Please circle any that you have had):

- Diphtheria Measles Scarlet Fever German Measles
- Mumps Rheumatic Fever Chickenpox Other: _____

Immunizations: (Please circle any that you have had. If you don't know if you've had one, place a question mark beside it):

- Diphtheria Measles/Mumps/Rubella Meningitis Polio Tetanus
- Chickenpox Hepatitis A/B/C Pertussis Flu Other: _____

Hospitalizations and Surgeries:

_____ When? _____

_____ When? _____

_____ When? _____

Diagnostic Studies:

- Electrocardiogram (EKG) X-Ray Bone Density Scan (DEXA) CT Scan
- Electroencephalogram (EEG) Mammogram MRI Other: _____

When? _____

Are you aware of having allergies or sensitivities to any of the following? If so, describe your reaction to each one:

Drugs: _____

Foods: _____

Chemicals/Perfumes: _____

Animals: _____

Which medications, either by prescription or over-the-counter, are you taking or have you taken in the past 6 months?

- Laxatives Pain Relievers H2 Blockers/Ulcer Medication Antacids
- Cortisone/Prednisone Appetite Suppressants Antidepressants Antibiotics
- Tranquilizers Thyroid medication Cholesterol-lowering medication
- Sleeping medication Other: _____

Please list, by name, any prescription medications you currently take, over-the-counter medications, and all vitamins/supplements/herbs you take regularly at this time. Include dosage, if known. Note: Please bring each of these with you to your first office visit.

- 1) _____
- 2) _____
- 3) _____

Family History:	Mother	Father	Siblings	Spouse/Partner	Children
Age (if living)	_____	_____	_____	_____	_____
Health (good/fair/poor)	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____

Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.

- | | | | | |
|------------------------------------|-----------------------------------|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Other (list below) |

Please list other significant family medical history not listed above:

Lifestyle:

Check the appropriate box:	Yes	No
Get 8 hours of sleep nightly (if no, write how much sleep you get)		
Sleep Well		
Awaken Rested		
In an intimate relationship?		
If yes, is it satisfying?		
Satisfied with friends/family?		
History of abuse		
Suffered trauma in past 3 years		
Use recreational drugs		
Treated for drug/alcohol dependence		
Drink alcohol? How many drinks per night _____ / Per week _____		
Use tobacco? If yes, how many cigarettes daily _____? How many years? _____ If you've quit, how long has it been? _____		
Enjoy your work?		
Take vacations?		
Exercise? What type? _____ How often? _____		
Watch TV? Hours daily _____		
Read? Hours daily _____		
Eat 3 meals daily?		
Go on diets?		
Drink tea? Herbal, caffeinated or both? (please circle)		
Drink coffee?		
Drink soda? Regular or diet? (pls circle)		
Add sugar/splenda/nutrasweet/salt to food?		
Microwave food?		
Eat meals out regularly (more than 3 times weekly)		
Eat prepared/processed/fast foods?		

Review of Systems

In this section, check the box if you have the symptom currently or if you have experienced it in the past 6 months. Some questions are yes/no, in which case check the box to indicate “yes.”

Mental/Emotional	
Depression	
Mood swings	
Considered/Attempted suicide	
Poor concentration	
Anxiety or nervousness	
Mental Tension	
Memory problems	

Endocrine	
Hair loss	
Brittle nails	
Excessive thirst	
General fatigue	
Fatigue after meals	
Heat intolerance	
Cold intolerance	
Excessive hunger	

Head	
Headaches	
Migraines	
Head injury	
Jaw pain/TMJ	
Pain or difficulty moving muscles	
Energy and Immune	
Chronic fatigue syndrome	
Swollen glands	
Reaction to vaccines	
Ongoing infections	
Slow wound healing	
Colds/flu more than once yearly	
Fatigue	

Neurological	
Seizures/Epilepsy	
Muscle weakness	
Loss of memory	
Vertigo/dizziness	
Paralysis	
Numbness or tingling	
Involuntary shaking or unsteadiness in hands	

Ears	
Impaired hearing	
Earaches	
Ringing	
Itching inside or outside	

Nose and Sinuses	
Frequent head colds	
Stuffiness	
Sinus pain	
Nose bleeds	
Hay fever	
Loss of smell	

Eyes	
Spots in vision	
Blurriness	
Double vision	
Eye pain/strain	
Uncomfortable tearing or dryness	
Glaucoma	

Mouth and Throat	
Frequent sore throat	
Teeth grinding	
Gum bleeding/pain/disease	
Dental cavities	
Sore tongue/lips	
Hoarseness	
Jaw clicks	

Neck	
Lumps	
Pain or stiffness	

Skin	
Rashes	
Acne	
Color changes	
Lumps or boils	
Eczema/rash	
Hives	
Generalized itching	

Urinary	
Pain with urination	
Frequency at night; If so, how often do you wake to urinate each night ___	
Frequent infections	
Unable to hold urine	
Kidney stones	
Splitting of stream	

Respiratory	
Cough	
Spitting of blood	
Asthma	
Pneumonia	
Emphysema	
Pain on breathing	
Shortness of breath at night	
Shortness of breath daily	
Shortness of breath lying down	
Lung congestion/sputum	
Wheezing	
Bronchitis	
Pleurisy	
Difficulty breathing	
Difficult taking a full deep breath	

Cardiovascular	
Heart disease	
High blood pressure	
Low blood pressure	
Blood clots	
Phlebitis	
Rheumatic fever	
Ankle swelling	
Angina/chest pain	
Heart murmurs	
Fainting	
Heart palpitations/fluttering	

Intestinal	
Trouble swallowing	
Change in thirst	
Change in appetite	
Nausea/vomiting	
Burning pain in stomach	
Jaundice	
Gallbladder disease	
Liver disease	
Hemorrhoids	

Heartburn	
Abdominal pain or cramps	
Frequent belching or excess gas	
Constipation	
Diarrhea	
Black stools	
Blood in stools	
Bowel movement (BM) daily	
How often are BMs: _____	

Musculoskeletal	
Joint pain or stiffness	
Broken bones	
Muscle spasms or cramps	
Arthritis	
Weakness	
Sciatica or pain down one leg	

Blood/Peripheral Vascular	
Easy bleeding/bruising	
Deep leg pain	
Varicose veins	
Anemia	
Cold hands	
Cold feet	

Male Reproduction (questions apply to lifetime, not just last 6 months)	
Hernias	
Prostate disease	
Are you sexually active? Yes No	
Sexual Orientation?	
Use birth control? What type _____	
Impotence	
Premature ejaculation	
Testicular masses or pain	
Discharge or sores on penis	
Chlamydia	
Gonorrhea	
Condyloma/genital warts	
Genital herpes	
Syphilis	
Impotence	

Female Reproduction/Breasts (questions apply to lifetime, not just last 6 months)	
Age at first menses (first period) _____	
Age of last menses (if menopausal) _____	
Usual length of cycle (monthly): _____	

Duration of menstruation (days of bleeding) _____	
Last menstrual period _____	
Do you think you may be pregnant?	
Irregular cycles	
Painful menses	
Heavy flow	
Light flow	
Bleeding/spotting between periods	
Clotting	
Discharge	
PMS	
Menopausal symptoms	
Endometriosis	
Ovarian cysts	
Date of last annual exam/Pap _____	
Sexually active Yes No	
Sexual Orientation _____	
Use of birth control; if so, what type _____	
Pain during intercourse	
Difficulty conceiving	
Cervical dysplasia	
Sexual difficulties	
Gonorrhea	
Genital herpes	
Chlamydia	
Condyloma/genital warts	
Syphilis	
Regular self breast exams	
Breast pain/tenderness	
Breast lumps	
Nipple discharge	
Number of pregnancies _____	
Number of live births _____	
Number of miscarriages _____	
Number of abortions _____	

Are there any other health concerns that you have which have not been covered in this questionnaire?

Signature:

Date:
