Wildwood

Naturopathic Intake Form

Date:_____/_____/_____

PATIENT INFORMATION

Name:

Date of Birth (mm/dd/yyyy): / / Gender:

Address:

City: Zip:

Phone (primary): (secondary): Employer:

E-mail:

Emergency contact: Phone: Relationship:

Medical doctor: MD Tel:

Names of other healthcare providers:

How did you hear about Wildwood:

Optimal health is only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this confidential overview will greatly assist our understanding of your healthcare needs and desires.

HEALTH INFORMATION

What is the main purpose of this appointment?

To what extent does this problem interfere with your daily activities (i.e. sleep, work, hobbies, etc.)

What other treatments have you received for this problem?

Please list any other health concerns (physical, emotional, or mental) in order of importance.

1.

2.

3.

If you are female, are you currently pregnant? Y / N

How do you rate your overall health? Poor Fair Good Excellent

How do you rate your overall energy? Poor Fair Good Excellent

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MEDICAL HISTORY

Indicate if you had any of the following childhood illnesses (check all that apply):

- ☐ Asthma
- ☐ Chickenpox
- ☐ Eczema
- ☐ Frequent ear infections or colds
- ☐ Measles
- ☐ Mumps
- ☐ Polio
- ☐ Rubella (German measles)
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Whooping cough
- ☐ Other:

Immunizations (check all that apply):

- ☐ DPT
- ☐ Flu Shot
- ☐ Smallpox
- ☐ Hemophilus Influenza B
- ☐ Tetanus Booster
- ☐ Chickenpox
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Polio
- ☐ MMR
- ☐ Other:

Please list (with approximate dates) any serious conditions, illnesses or injuries, and any hospitalizations.

Have you ever had a bad reaction to any medication? Y / N If yes, please explain

Your birth history (if known): premature forceps delivery prolonged labor C-section

Family History

Please indicate whether any of your family members have, or have had the following:

	Relative		Relative
Alcoholism		Asthma	
Diabetes		Kidney disease	
Allergies		Cancer (indicate type)	
Drug abuse		Osteoporosis	
Alzheimer's disease		Depression	
Heart disease		Stroke	
Arthritis		Other mental illness	
High blood pressure		Suicide	

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MEDICATIONS

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose/day	How long?	Medication	Dose/day	How long?
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement	Dose/day	How long?	Supplement	Dose/day	How long?
1.			5.		
2.			6.		
3.			7.		
4.			8.		

LIFESTYLE FACTORS

Please list any dietary restrictions: _____

Please list all allergies (food, environmental, or medications):

_____

_____

Do you exercise? Y / N

What type of exercise and how often?

_____

What do you do for recreation and relaxation?

_____

_____

Marital status: Single Married Divorced Partnership

Number of children: _____

Rate your stress level (circle): Low Average High Unbearable

Please **Check** ☑ any of the following that you use.

- ☐ Alcohol
- ☐ Tobacco
- ☐ Birth Control Pills
- ☐ Pain Relievers
- ☐ Caffeine
- ☐ Appetite Suppressants
- ☐ Diet Pills
- ☐ Laxatives
- ☐ Aspirin
- ☐ Antacids
- ☐ Sleeping Pills

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WOMEN'S HEALTH

Do you get regular screening tests done by another doctor (blood work, Pap)? Y / N

Date of last Pap?(month/yr) _____/_____ Have you ever had an abnormal Pap? Y / N

Age of first period? _____ Is your period regular? Y / N Date of last period? _____

Length of monthly cycle (days)? _____ Average length of period or flow (days)? _____

Do you experience PMS? Y / N Are you menopausal? Y / N. If yes, age of last period____

Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N
Current forms of contraception? _____

Have you ever had a sexually transmitted disease? Y / N

Number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____

Have you had a hysterectomy? Y / N

Have you had any of the following concerning your breasts?(circle) Pain Lumps Infections Cysts Nipple discharge

Do you experience vaginal infections? Never Rarely Frequently

Do you experience bladder infections? Never Rarely Frequently

Any other female concerns not addressed:

MEN'S HEALTH

Do you get regular screening tests done by another doctor (blood work, prostate examination)? Y / N

Date of last prostate examination?(month/yr) _____/_____

Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N

Current forms of contraception? _____

Do you have difficulty urinating completely? Y / N

How many times do you get up from your sleep to go to the bathroom at night? _____

Have you had any of the following?(circle) Testicular pain Hernia STDs Discharge Sores

Do you have any sexual problems or concerns? Y / N. If yes, explain:

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REVIEW OF SYSTEMS

Check if you are currently experiencing any of the following or write **P** if you experienced it in the past.

General Symptoms
- ☐ Headache
- ☐ Head Injury
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Weight Problems
- ☐ Numbness in Arm/Leg/Hand
- ☐ Allergy
- ☐ Convulsions

Skin
- ☐ Hives or Allergy
- ☐ Acne or Skin Eruptions
- ☐ Itching
- ☐ Bruises Easily
- ☐ Dryness
- ☐ Boils
- ☐ Varicose Veins
- ☐ Sensitive Skin
- ☐ Change in Mole

Kidneys & Reproduction
- ☐ Inability to Control Urine
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Pus in Urine
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Prostrate Trouble
- ☐ Sores on Genitals

Eyes, Ears, Nose, Throat
- ☐ Dental Decay
- ☐ Gum Trouble
- ☐ Frequent Colds
- ☐ Enlarged Thyroid
- ☐ Tonsillitis
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Enlarged Glands
- ☐ Glaucoma
- ☐ Failing Vision
- ☐ Cataracts
- ☐ Eye Pain
- ☐ Ear Discharge
- ☐ Loss of Hearing
- ☐ Ear Ache
- ☐ Nasal Drainage
- ☐ Nose Bleeds
- ☐ Nasal Obstruction
- ☐ Sinus Infection
- ☐ Hay Fever

Musculoskeletal
- ☐ Neck Pain
- ☐ Muscle Weakness
- ☐ Swollen Joints
- ☐ Leg Pain
- ☐ Foot/Hand Pain
- ☐ Arm Pain
- ☐ Hernia
- ☐ Low Back Pain
- ☐ Joint Pain/Stiffness
- ☐ Spinal Curvature

Neurological
- ☐ Nervousness/Anxiety
- ☐ Convulsions
- ☐ Tingling/Numbness
- ☐ Depression
- ☐ Paralysis
- ☐ Confusion
- ☐ Fainting
- ☐ Forgetfulness

Cardiovascular
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Previous Heart Stroke
- ☐ Hardening of the Arteries
- ☐ Swelling of the Ankles
- ☐ Poor Circulation
- ☐ Paralytic Stroke
- ☐ Irregular Heart Beat
- ☐ Shortness of Breath
- ☐ Chest Pain

Gastrointestinal
- ☐ Excessive Thirst
- ☐ Poor/Excessive Hunger
- ☐ Heartburn/Reflux
- ☐ Gas (Flatulence)/Belching
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Cramps
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon Trouble
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gallbladder Problems
- ☐ Jaundice
- ☐ Colitis

Respiratory
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Spitting Up Phlegm
- ☐ Spitting Up Blood
- ☐ Difficult Breathing

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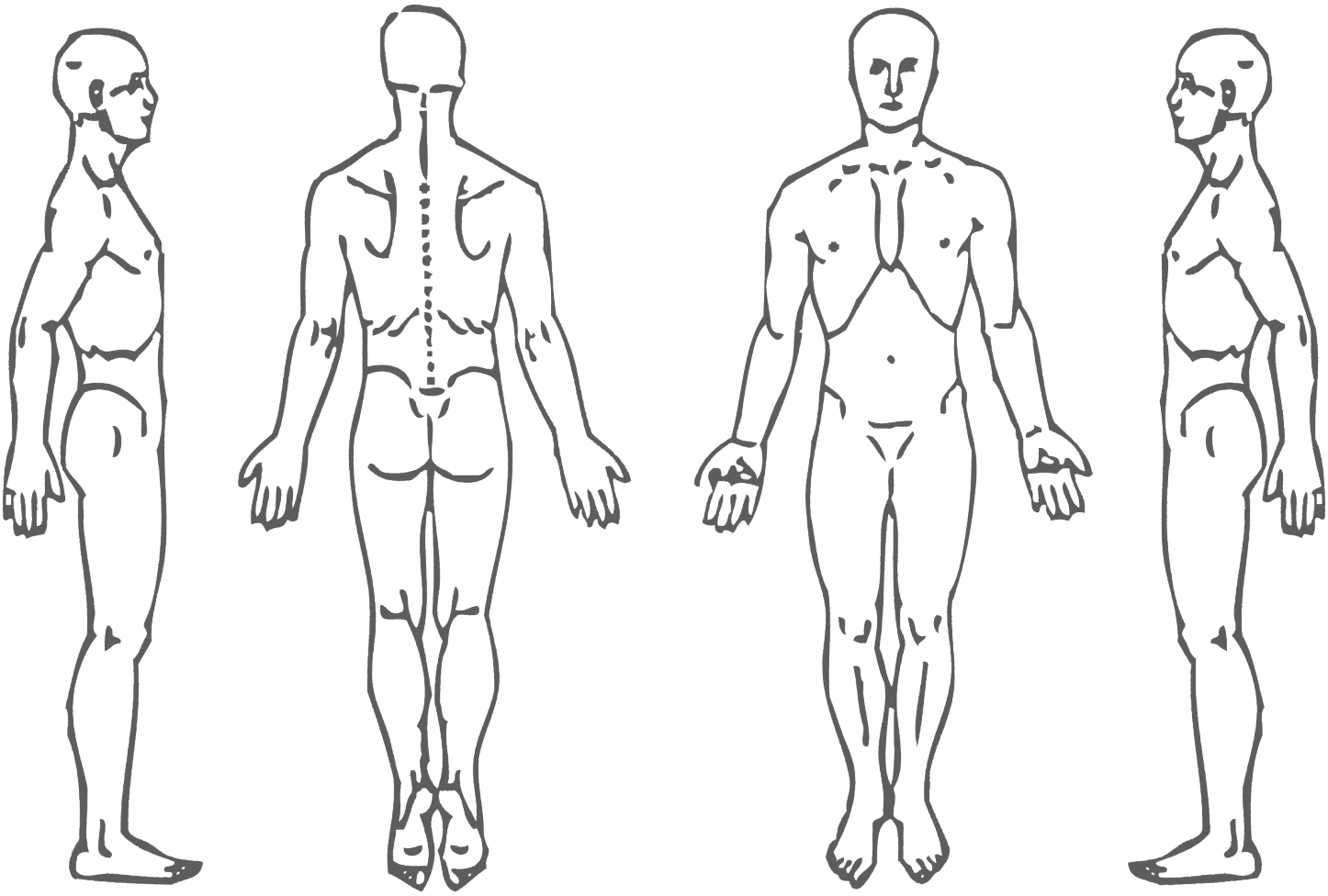
Please circle any areas of symptoms or discomfort:



What are your treatment goals and expectations?

Is there anything else that you feel has not been covered?

Thank you very much for taking the time to complete this form.

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