NATUROPATHIC INTAKE FORM
ADULT PATIENTS

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 Dr. Karen Tyson:

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. _____

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:

History of adverse reactions to immunizations? Y / N If yes, please explain

_____

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	

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.		

Please list any allergies to medications:_____

LIFESTYLE FACTORS

Food:

Diet Preference: (please circle) No preference Ovo-Veg Lacto-Veg Lacto-Ovo-Veg Pescetarian

Vegan Paleo Other: _____

Typical Diet (just generally)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Water: _____

Please list any dietary restrictions: _____

Please list any food allergies: _____

Exercise:

Do you exercise regularly? Y / N

If you do exercise regularly: What type? _____

How often and duration for each type? _____

Sleep:

How many hours of sleep do you get on average nightly? _____

Do you have trouble falling asleep? Y / N If yes, what do you think impedes your ability to fall asleep?

_____

Do you have difficulty staying asleep? Y / N If yes, what do you think impedes your ability to stay asleep?

_____

Do you have trouble waking up? Y / N

Do you wake feeling rested? Y / N

Energy and Stress:

How would you rate your energy on a scale of 1 to 10 with 10 being the most energy? _____

How would you rate your stress on a scale of 1 to 10 with 10 being the most stress? _____

Work / Hobbies:

Occupation? _____

What do you do for recreation and relaxation?_____

_____

What brings you JOY?_____

_____

Psychosocial History:

Marital Status: (please circle) Single Married Divorced Separated Widowed Domestic Partnership

Number of children_____

Siblings? Y / N If yes, please list their ages: _____

Who do you live with? (please circle) Mother Father Siblings Spouse Children Other:_____

Do you feel safe in your living environment? Y / N If no, please provide details if you desire: _____

_____

Identify any foreign or domestic travel in the past 5 years:

Places	Years	Places	Years
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Toxins / Environment:

Have you regularly or have you ever been exposed to toxins or other environmental hazards (at work, home, hobbies, etc)? Y / N If yes, describe: _____

Daily Lifestyle:

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

- ☐ Alcohol
  List:_____
- ☐ Tobacco
- ☐ Pain Relievers
- ☐ Birth Control Pills
- ☐ Appetite Suppressants
- ☐ Diet Pills
- ☐ Laxatives
- ☐ Aspirin
- ☐ Antacid
- ☐ Sleeping Pills
- ☐ Antibiotics
  (Number of times in past five years):_____

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
____ Apathy/Lethargy
____ Hyperactivity
____ Restlessness

Skin
____ Hives or Allergy
____ Acne or Skin Eruptions
____ Itching
____ Bruises Easily
____ Dryness
____ Boils
____ Varicose Veins
____ Sensitive Skin
____ Change in Mole(s)
____ Dandruff
____ Numbness in Arm/Leg/Hand
____ Allergy
____ Convulsions
____ Apathy/Lethargy
____ Hyperactivity
____ Restlessness

Kidneys & Reproduction
____ Inability to Control Urine
____ Frequent Urination
____ Painful Urination
____ Blood in Urine
____ Pus in Urine
____ Kidney Stones
____ Prostate Trouble
____ Sores on Genitals
____ Genital Itch
____ Sores on Genitals

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

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

Neurological
____ Nervousness
____ Convulsions
____ Tingling/Numbness
____ Paralysis
____ Confusion
____ Fainting
____ Forgetfulness

Emotions
____ Mood Swings
____ Anxiety/Fear
____ Nervousness
____ Anger/Irritability
____ Aggressiveness
____ Depression

Cardiovascular
___ Low Blood Pressure
___ High Blood Pressure
___ Previous Heart Stroke
___ Hardening of the Arteries
___ Swelling of the Feet / Ankles
___ Poor Circulation
___ Paralytic Stroke
___ Irregular Heartbeat
___ Shortness of Breath
___ Chest Pain
___ Rapid Pounding Heart

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/Bronchitis
___ Chronic Cough
___ Spitting up Phlegm
___ Spitting up Blood
___ Difficulty Breathing
___ Shortness of Breath

Mind
___ Poor Memory
___ Poor Comprehension
___ Poor Concentration
___ Poor Physical Coordination
___ Difficulty Making Decisions
___ Binge Eating/Drinking

WOMEN'S HEALTH

Are you currently pregnant? Y/N

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 form(s) 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 form(s) 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:_____

_____

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.

Dr. Karen Tyson, ND
860-810-6646 | passifloraholistichealth@gmail.com | www.passifloraholistichealth.com