NATUROPATHIC NEW PATIENT INTAKE FORM

asula
back·body·balance

Patient Information

Name:

Birthday: Age: Sex: ☐ M ☐ F

Address:

City: State: Zip:

E-mail Address:

Primary Phone: Phone Type: ☐ Home ☐ Mobile ☐ Work

Occupation: Employer: How long?

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Live With: ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone ☐ Pets

Emergency Contact Phone Number:

Do you have Health Insurance? *If **"YES"** present insurance card to front desk...* ☐ YES ☐ NO

Whom may we thank for referring you to our office?

Concerns

What is your major complaint?

Other complaints?

What are your overall health goals?

How long has it been since you really felt good?

Lifestyle

Alcohol: Wine # of glasses/day/week? Liquor # ounces/day/wk? Beer # glasses/day/wk?

Caffeine: Coffee cups/day? Teas cups/day? Soda cans/day?

Water: Glasses/day Bottled, filtered or tap?

Bowel movements per day? Any bowel concerns? ☑ Constipated

Do you have any concerns about weight gain or loss?

Tobacco Use? ☐ Never ☐ Occasionally ☐ Ages to . How many packs per day?

Other tobacco? ☐ Never ☐ Occasionally ☐ Ages to . # per day?

Were you exposed to second hand smoke or pollution?

Chemicals used at work or during hobbies:

Exercise: Type? Frequency?

How much sleep do you get each night on average?

What time do you go to sleep?

What time do you wake up?

What are your main sources of stress?

How is your energy level? ☐ Very low ☐ Low ☐ Average ☐ Excellent ☐ Highs & Lows

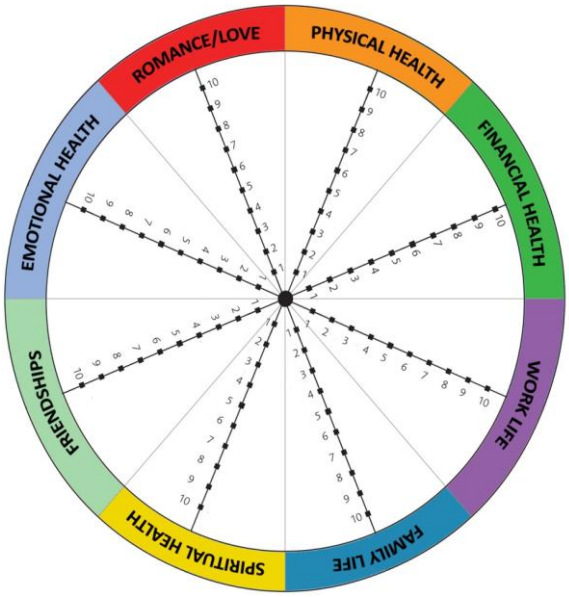
Are there times in the day that you feel best? Worst?

How do you deal with stress? What do you do to relax? Hobbies?

On a scale of 1-10, please rate each area of your life in terms of happiness.

In each section circle the number from 1-10 that best represents your happiness rating.

A score of 10 would mean you are very happy with this area, conversely, a score of 1 would indicate you are very unhappy with this area of your life.



Past Medical History

Who is your Primary Care Provider (PCP)?

When was your last visit with your PCP? What was your visit regarding?

Have you had any surgeries? Please include the date.

What are your past medical diagnoses?

Have you been hospitalized? If so, when and what for?

Do you have any allergies to medications?

Type of reaction?

Medicine & Supplements

Are you presently taking any medications? If yes, please list:

MEDICATION NAME	DOSE	REASON STARTED?

Are you presently taking any vitamins or supplements? If yes, please list:

SUPPLEMENT NAME	DOSE	REASON STARTED?

Family History

Please ☑ If a family member currently has, or has had, any of the following conditions listed below.

	CONDITION NAME	WHO?		CONDITION NAME	WHO?
☐	Alcoholism		☐	Diabetes	
☐	Allergies		☐	Drug Abuse	
☐	Asthma		☐	Heart Disease	
☐	Arthritis		☐	High Blood Pressure	
☐	Auto-Immune Disorders		☐	Obesity	
☐	Cancer		☐	Osteoporosis	
☐	Depression		☐	Thyroid Disease	

Symptoms

Please (CIRCLE) those you PRESENTLY have (last few weeks).

GENERAL
Headache
Fever
Chills or Sweats
Fainting or Dizziness
Seizures or Epilepsy
Sleeping Difficulties
Fatigue or Feel Run-Down
Hypoglycemia
Nervousness / Anxiety
Panic Attack / Phobias
Depression
Mental Disorder
Alcohol / Drug Problems
Diabetes
Neuralgia
Anemia
Memory Loss

CARDIOVASCULAR
Irregular Heartbeat
High / Low Blood Pressure
High Cholesterol
Pacemaker
Coronary Artery Disease
Atherosclerosis
Swelling of Ankles
Poor Circulation
Blood Clots

EAR, NOSE & THROAT
Eye Strain / Pain
Blurred Vision
Glaucoma
Sensitivity to Light
Hearing Problems
Ear Infections
Sinus Infections
Frequent Colds
Nose Bleeds
Sore Throat
Thyroid Conditions

SKIN
Rashes
Skin Eruptions
Eczema
Itching
Bruise Easily
Dark Circles Under Eyes
Moles
Varicose Veins
Hair Loss

RESPIRATORY
Asthma
Pneumonia
Emphysema
Tuberculosis
Bronchitis
Chronic Cough
Spitting Blood/Phlegm
Chest Pain
Difficulty Breathing
Shortness of Breath

GASTROINTESTINAL
Trouble Swallowing
Bad Breath / Body Odor
Indigestion / Heartburn
Nausea
Poor Appetite
Belching or Passing Gas
Excessive Hunger
Cravings
Eating Disorder
Vomiting Blood
Pain Over Stomach
Ulcers
Distension of Abdomen
Constipation
Diarrhea
Appendicitis
Tiredness After Meals
Hemorrhoids
Parasites
Hepatitis
Gall Bladder Trouble
Bloating After Meals
Liver Troubles
Hard / Compact Stools

GENITOURINARY
Frequent Urination
Night Urination
Blood/Pus in Urine
Kidney Infection or Stones
Bed Wetting /Incontinence
Prostrate Trouble
Hernia
STD
Sexual Dysfunction

MUSCLE & JOINT
Stiff Neck
Backache
Arthritis
Swollen Joints / Bursitis
Tendonitis
Muscle or Joint Pain
Muscle Spasms or Cramps
Foot Trouble
Spinal Curvature
Osteoporosis

WOMENS ONLY
PMS
Painful Menstrual Period
Excessive Flow
Bleeding Between Cycles
Irregular Cycle
Cramps or Backache
Endometriosis
Ovarian Cysts
Uterine Fibroids
Abnormal PAP
Vaginal Discharge
Breast Pain / Tenderness
Lumps in Breast
Menopausal Symptoms
Hot Flashes

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Signature: _____ Date: _____

THE FOLLOWING TREATMENTS ARE OFFERED AT ASULA, PLEASE (CIRCLE) *ANY OF INTEREST TO YOU.*

CHIROPRACTIC **ACUPUNCTURE** **MASSAGE** **NATUROPATHY** **AYURVEDA** **HORMONE BALANCING** **THERAPEUTIC EXERCISES**

♥ WELCOME TO OUR CLINIC ♥