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?

Diet

What do you typically eat for:

Breakfast:

Lunch:

Dinner:

Snacks:

818 NW Marshall St · Portland OR 97209 · phone (503) 719.5335 · fax (503) 719.5334
4847 Meadows Road, Suite 153 · Lake Oswego OR 97035 · phone (971) 330.8578 · fax (971) 330.8579

Do you have any food allergies, sensitivities or restrictions?

Food Ethics: ☐ Vegan ☐ Vegetarian ☐ Kosher ☐ Other:

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?

Lifestyle

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

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

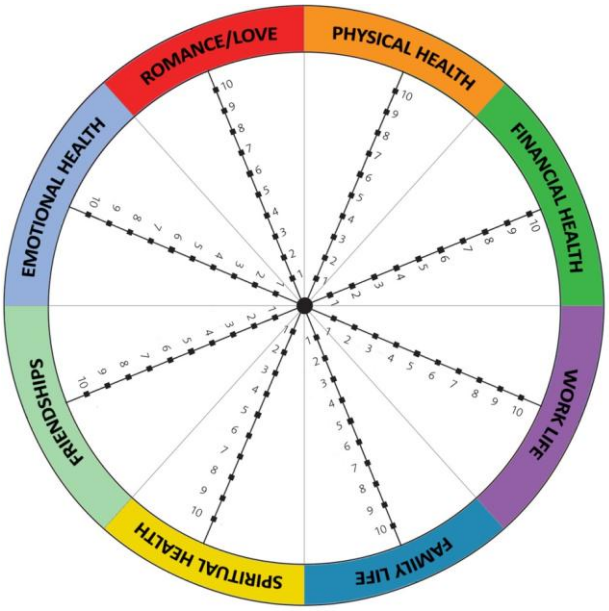
Are there times in the day that you feel best? Worst?

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.



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	

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?

Past Medical History

Have you had any surgeries? Please include the date.

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

Do you have any allergies to medications?

Type of reaction?

Symptoms

Please (CIRCLE) those you PRESENTLY have (last few weeks). <u>UNDERLINE</u> those you have had PREVIOUSLY.

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

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

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

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

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

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

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

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

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 **NATUROPATHY** **MASSAGE** **ACUPUNCTURE**