NATUROPATHIC NEW PATIENT INTAKE FORM

asula
back·body·balance

Patient Information

Name: Date of Birth: Age:

Sex at Birth: ☐ Male ☐ Female Gender: ☐ Male ☐ Female ☐ Trans ☐ Non-binary ☐ Prefer not to say

Pronouns: ☐ He ☐ She ☐ They ☐ Other:

Address:

City: State: Zip:

E-mail Address:

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

Occupation: Employer: How long?

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

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

Emergency Contact: Phone Number:

Primary Care Doctor: 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 main 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:

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

Dinner:

Snacks:

Do you have any food allergies, sensitivities or restrictions?

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

Alcohol: # drink per week? 1 Per day? 1 ☐ Wine ☐ Beer ☐ Liquor ☐ Other:

Caffeine: # drink per week? 1 Per day? 1 ☐ Coffee ☐ Tea ☐ Soda ☐ Other:

Water: Glasses/day

Bowel movements per day?

Do you have any concerns about weight gain or loss?

Lifestyle

Tobacco Use? ☐ Never ☐ Occasionally From ages to

Substance Use? ☐ Cannabis ☐ Other: From ages to

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, with 10 being the most fulfilled, and 1 being the least fulfilled, please rate the following areas of your life:

FRIENDSHIPS: _____ RELATIONSHIPS/ROMANCE: _____ PHYSICAL HEALTH: _____

FINANCIAL HEALTH: _____ WORK LIFE: _____ FAMILY LIFE: _____

SPIRITUAL HEALTH: _____ EMOTIONAL HEALTH: _____

On a scale of 1 – 10 (10 being very committed), how committed are you to making changes? _____

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		☐ Drug Abuse	
☐ Allergies or Asthma		☐ Heart Disease	
☐ Arthritis		☐ High Blood Pressure	
☐ Auto-Immune Disorders		☐ Obesity	
☐ Cancer		☐ Osteoporosis	
☐ Depression		☐ Thyroid Disease	
☐ Diabetes		☐ Other:	

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 past medical diagnoses? If yes, please list them:

Have you had any surgeries or hospitalizations? Please include the date:

Do you have any allergies to medication? Type of reaction?

Symptoms

Please ☑ any you PRESENTLY have (last few weeks) or those you have had PREVIOUSLY

PAST	PRESENT	
		GENERAL
☐	☐	Headaches / Migraines
☐	☐	Fever
☐	☐	Chills or sweats
☐	☐	Fainting or dizziness
☐	☐	Seizures or epilepsy
☐	☐	Insomnia
☐	☐	Fatigue
☐	☐	Hypoglycemia
☐	☐	Nervousness / Anxiety
☐	☐	Panic Attack / Phobia
☐	☐	Depression
☐	☐	Mental Disorder
☐	☐	Alcohol / Drug problems
☐	☐	Diabetes
☐	☐	Neuralgia
☐	☐	Anemia
☐	☐	Excessive Thirst
☐	☐	Unexplained weight gain / loss
		EAR, NOSE & THROAT
☐	☐	Vision Changes
☐	☐	Eye Strain / Pain
☐	☐	Glaucoma
☐	☐	Sensitivity to light
☐	☐	Hearing Problems
☐	☐	Ear infections
☐	☐	Sinus infections
☐	☐	Frequent colds
☐	☐	Nose bleeds
☐	☐	Sore throat
☐	☐	Thyroid conditions
☐	☐	Tinnitus
		CARDIOVASCULAR
☐	☐	Irregular heartbeat
☐	☐	High or low blood pressure
☐	☐	High Cholesterol
☐	☐	Coronary artery disease
☐	☐	Atherosclerosis
☐	☐	Swelling of ankles
☐	☐	Poor circulation
☐	☐	Blood clots
☐	☐	Chest pain
☐	☐	Heart palpitations
		SKIN
☐	☐	Rashes
☐	☐	Dark circles under eyes
☐	☐	Eczema
☐	☐	Itching
☐	☐	Bruise easily
☐	☐	Hair loss
☐	☐	Acne
☐	☐	Psoriasis
		MUSCLE & JOINT
☐	☐	Swollen joints
☐	☐	Muscle or joint pain
☐	☐	Muscle spasms or cramps
☐	☐	Spinal curvature
☐	☐	Osteoporosis / Osteopenia
☐	☐	Arthritis
☐	☐	Weak/numb/tingling muscle
		GASTROINTESTINAL
☐	☐	Abdominal pain
☐	☐	Gallstones
☐	☐	Bloating
☐	☐	Fatty liver disease
☐	☐	Trouble swallowing
☐	☐	Indigestion / Heartburn
☐	☐	Nausea / Vomiting
☐	☐	Disordered eating
☐	☐	Ulcers
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Appendicitis
☐	☐	Hemorrhoids
☐	☐	Hepatitis
☐	☐	Poor appetite
☐	☐	Belching or passing gas
☐	☐	Excessive hunger
☐	☐	Food allergy / sensitivity
		GENITOURINARY
☐	☐	Frequent urination
☐	☐	Night urination
☐	☐	Kidney infection or stones
☐	☐	Incontinence
☐	☐	Sexually transmitted infection
☐	☐	Low libido
		RESPIRATORY
☐	☐	Asthma
☐	☐	Allergies (Environmental)
☐	☐	Pneumonia
☐	☐	Emphysema
☐	☐	Bronchitis
☐	☐	Chronic cough
☐	☐	Shortness of Breath
		FEMALE:
☐	☐	Premenstrual syndrome
☐	☐	Painful menstrual period
☐	☐	Excessive flow
☐	☐	Bleeding between cycles
☐	☐	Irregular cycle
☐	☐	Endometriosis
☐	☐	Ovarian cysts
☐	☐	Uterine fibroids
☐	☐	Abnormal PAP
☐	☐	Vaginal discharge
☐	☐	Breast pain / tenderness
☐	☐	Lumps in breast
☐	☐	Menopausal symptoms
☐	☐	Hot flashes
		Date of last period:
		Age of first period:
		MALE:
☐	☐	Prostate issues
☐	☐	Erectile dysfunction

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

Patient Signature: _____ Date: _____