New Patient Intake Form

Patient Name: ____DOB:____________________________
Phone: (___)______________**Cell:(___)**________________**Work: (___)**________________**Fax: (___)**______________________
Address:____
City:____________________**State:**_________**Zip:**_________________**Email:**_______________@_____________________
Is it acceptable for us to contact you via e-mail? Yes/No
Is it acceptable for us to leave messages on your answering machine/voice mail? Yes/No
Marital Status: S/M/D/W Parent/Guardian (if minor)____
How did you hear about us?____
Name & Phone # of someone we may contact in an emergency:____

List in Order of importance what your problems are:

1) ____

2) ____

3) ____

4) ____

5) ____

List as best you are able, all that has been done in the past (procedures, treatments, medications, natural approaches, etc.) and up to the present time to address the problem(s) listed above:____

____

____

____

Last time you had blood work done and with what physician: ____

____

Please list other health professionals with whom you currently consult (name, specialty, location, & telephone):

1.____

2.____

3.____

4.____

Family History

	Father	**Mother**	**Siblings**	**Grandparents**	**Spouse**	**Children**
Age if living:	________	________	________	________	________	________
Age when died:	________	________	________	________	________	________
Reason for death:	________	________	________	________	________	________
Cancer type:						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N

Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease: (Fibromyalgia, Lupus, MS, etc.)	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N
Other Condition:__________	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1) ______________________________ 4) ______________________________

2) ______________________________ 5) ______________________________

3) ______________________________ 6) ______________________________

Please Note When & Why You Have Had Each of the Following:

X-Rays: ______________________ MRI/Cat Scans: ______________________

Ultrasounds: ______________________ Accidents: ______________________

TB Test: ______________________ HCV: ______________________

HIV: ______________________ Last Dental Visit: ______________________

Last Eye Exam: ______________________

Did you have the following **D**isease (**D**), Got **I**mmunized (**I**), or **N**either (**N**):

Measles: D I N **Chicken Pox**: D I N **Mumps**: D I N **Rubella**: D I N

Tetanus: D I N **Whooping Cough**: D I N **Hemophilus (Hib)**: D I N **Hepatits B**: D I N

German Measles: D I N **Any vaccination reactions:** ______________________

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Antacids: Y N P **Steroids**: Y N P **Smoking**: Y N P **Packs per day & number of years**: __________

Analgesics: Y N P **Laxatives**: Y N P **Coffee**: Y N P **Cups per day if Yes/Past**: __________

Soda Pop: Y N P **Ounces per day if Yes/Past**: __________

Alcohol: Y N P **How often & how much if Yes/Past**: ________

Any Alcohol Addiction: Y N P **Any Alcohol Treatment**: Y N P

Recreational Drugs: Y N P **Any Drug Addictions**: Y N P

Any Drug Treatment: Y N P **How much water do you drink a day? What type?**__________

List all <u>Prescriptions</u>, <u>Medications</u>, <u>Hormones</u>, <u>Vitamins</u>, <u>Herbs</u>, or <u>any other therapeutic substance</u> that you are taking and include dosage/amount <u>if known</u>:

____

____

____

Allergies

List all known Allergies (food, drugs, environment, etc.): ____

____

____

NOTE: The following pages are for health history information: Please fill out all areas that apply. If you are coming in for **URGENT/ACTE CARE,** go to bottom of last page and read/sign it.

Review of Systems:

Present Weight: ______________ **Weight one year ago**: ______________ **Height**: ______________

Maximum weight and when: __________ **Minimum weight as adult & when**: ____________________________

Ideal Weight: ____________________

REGARDING THE NEXT LONG SECTION: Please circle (**Y)** if you have the problem **NOW**, (**N)** if you've **NEVER** had the problem, (**P)** if you had the problem in the **PAST**.

Good Energy: Y N P

Fatigue: Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst? ______________________________

If you have fatigue, can you do what you need to during the day? Y N

SKIN				
Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
Cancer:	Y N P		**Perspiration:**	Y N P
HEAD				
Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
Oil/dry hair:	Y N P		**Hair loss:**	Y N P
NOSE				
Frequent Colds:	Y N P		**Nosebleeds:**	Y N P
Congestion:	Y N P		**Post Nasal Drip:**	Y N P
Polyps:	Y N P		**Seasonal Allergies:**	Y N P

EYES				
Dry/Watery:	Y N P		**Blurry Vision:**	Y N P
Double Vision	Y N P		**Cataracts:**	Y N P

Glaucoma:	Y N P		**Styes:**	Y N P
Strain:	Y N P		**Discharge:**	Y N P
Itchy:	Y N P		**Dark under Eyelid:**	Y N P
		MOUTH/THROAT		
Canker sores:	Y N P		**Cold sores:**	Y N P
Sore Throat:	Y N P		**Gum disease:**	Y N P
Dentures:	Y N P		**Cavities:**	Y N P
Loss of taste:	Y N P		**Hoarseness:**	Y N P
		NECK		
Stiffness:	Y N P		**Swollen Glands:**	Y N P
Full movement:	Y N P		**Tension:**	Y N P
		RESPIRATORY		
Cough:	Y N P		**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P		**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P		**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P		**Asthma:**	Y N P
Wheezing:	Y N P		**Painful breathing:**	Y N P
		CARDIOVASCULAR		
High Blood Pressure:	Y N P		**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P		**Murmurs:**	Y N P
Arrhythmias:	Y N P		**Palpitations:**	Y N P
Edema:	Y N P		**Chest Pain:**	Y N P
		URINARY TRACT		
Incontinence:	Y N P		**Pain w/ Urination**	Y N P
Frequent Infections:	Y N P		**Kidney Stones**	Y N P
Urgency:	Y N P		**Discharge/Blood:**	Y N P
		GASTROINTESTINAL		
Heartburn:	Y N P		**Bowel Movement Freq:**	
Indigestion:	Y N P		**Recent BM Change:**	Y N P
Bloating:	Y N P		**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P		**Hemorrhoids:**	Y N P
Vomiting:	Y N P		**Gall Bladder Disease**	Y N P
Change in Appetite:	Y N P		**Liver Disease:**	Y N P
Pancreatitis:	Y N P		**Ulcer:**	Y N P
		MALE GENITALIA		
Testicular pain/swelling:	Y N P		**Sexually Active:**	Y N P
Hernia:	Y N P		**S.T.D.:**	Y N P

Discharge:	Y N P	**Prostate Disease/Symptoms:**	Y N P
Impotency:	Y N P	**Libido:**	

FEMALE GENITALIA

Age Period Began:		**How Often Period Occurs:**	
How long period lasts:		**Heavy menstrual bleeding:**	Y N P
Menstrual cramping:	Y N P	**Menstrual Pain:**	Y N P
PMS:	Y N P	**Food/Sweet cravings:**	Y N P
Times Pregnant:		**How many births:**	
Miscarriages:		**Abortions:**	
Last Pap Smear:		**Diagnosis:**	
Any abnormal paps:	Y N P	**When was abnormal:**	
Menopausal since what age:		**Use of hormones:**	Y N P
Type of hormones used:		**Healthy libido:**	Y N P
Dry vagina:	Y N P	**Sexually Active:**	Y N P
Pain w/ Intercourse:	Y N P	**Vaginitis:**	Y N P
S.T.D.:	Y N P	**Mammography:**	Y N P
Dexa Scan:	Y N P	**If Yes, what were results:**	

Please list any birth control used and ages used: ____

____

MUSCULOSKELETAL

Weakness:	Y N P	**Arthritis:**	Y N P
Stiffness:	Y N P	**Leg Cramps:**	Y N P
Tremors:	Y N P	**Pain:**	Y N P

NERVOUS

Paralysis:	Y N P	**Sciatica:**	Y N P
Tingling/numbness:	Y N P	**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P	**Fainting:**	Y N P

Mental/Emotional

Depression:	Y N P	**Anger/irritability:**	Y N P
Suicidal:	Y N P	**High-strung/tense:**	Y N P
Anxiety:	Y N P	**Fear/Panic**	Y N P
Eating disorder:	Y N P	**Psych Hospitalization:**	Y N P

Exercise

How often do you exercise? ____________ **What type of exercise?** ______________________________

For how long? ______________________ **Hobbies:** ____

____

Sleep

How long per night? ____________ **If you wake up frequently, what is the reason?** ____________________

Nightmares: Y N P **Wake Refreshed:** Y N P **Must nap during the day:** Y N P

Sleep walk: Y N P **Grind teeth:** Y N P **Snore:** Y N P

Toxin Exposure

Have you often had to lower the regular dose of prescription, over-the-counter- medication or herbal supplements because you were too sensitive to normal doses? If yes, please explain:__________________________________

____

Do you avoid caffeine in the afternoon or all together because it can keep you up at night? If yes, please explain:______

____**Are you particularly sensitive to perfumes, gasoline, chemicals, smells, diesel, or other vapors? If yes, please explain how you are sensitive (any reactions?):**____

____

Have you ever been exposed to chemicals, heavy metals, fumes, or other toxic materials in the course of work, hobby, schooling, or daily living? When? How Long? Name them:____________________________________

____

____**Did you grow up near or have you lived near any refinery, polluted area, golf course, or, farmlands? If so, which, and for how long?**

____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? ____

Do you use pesticides, herbicides or other chemicals around your home? ______________________________

____

Have you ever had silver fillings put in your teeth? If so how many, for how long, and do you have any remaining:______

____

Have you ever had root canals, or implants in your teeth or body (what type?)__________________________

____

Have you ever been on antibiotics? If so, when, for how long, and for what?____________________________

____

____

Social Life

Enjoy job: Y N P **Hours worked per week:** __________ **Highest Level of Education:** __________________

Active spiritual practice: Y N P **Quality of significant relationship:** ____________________________

History of sexual, mental/emotional, physical abuse: Y N **P** **If so, at what age and by whom:** ______________

What is your greatest health concern: ____

How does it limit you the most: ____

How committed are you towards making valuable changes: Little Moderately Very

Typical Day's Diet

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

____

I understand that any expenses incurred with White Mountain Naturopathic Medical are my responsibility and not that of any other person or reimbursement group. I understand that I may be billed for any appointment missed or changed with less than 24 hours notice. I understand that no claims or guarantees have been made by White Mountain Naturopathic Medical personnel for future reimbursement or particular medical outcomes.

(Please give responsible guardian's signature if patient is a minor)

I have read, understand, and agree to the above policies:

Signed:____Date:______________________________

Note: All information given now or at any point in the future is entirely confidential. If we receive requests to share information with doctors, insurance groups, or health agencies, we will only do so with your permission.