SCNM
SOUTHWEST COLLEGE OF NATUROPATHIC MEDICINE & HEALTH SCIENCES
MEDICAL CENTER

PATIENT INTAKE FORM

Legal Name:

How do you like to be addressed?

Date of Birth:

CONCERNS

Thank you for taking the time to fill out this intake form. We know it's comprehensive, but by gathering this information about your health history and goals helps give your naturopathic doctors a more complete understanding of you. We want to help you reach your optimal health.

Most important concern you would like to address?

Additional concerns?

FAMILY HISTORY

Has any blood relatives ever had any of the following?

¨ Cancer	¨ Tuberculosis
¨ Asthma	¨ Mental Illness or suicide
¨ Diabetes	¨ High Blood Pressure
¨ Allergies	¨ Autoimmune Disease
¨ Heart Attack	¨ Heart Disease
¨ Stroke	¨ Osteoporosis
¨ Other	

If YES, check appropriate box and please indicate who below (maternal aunt, paternal grandmother, father, son, sister, etc)

MEDICAL HISTORY

Who is your Primary Care Physician? Please include address, phone number, and fax number.

Please indicate the doctors or practitioners that have been involved in your care in the last three years. Provide name, date of last visit, visit reason, and office number?

¨ Nephrologist	¨ Urologist
¨ Acupuncturist	¨ Chiropractor
¨ Gastroenterologist	¨ Hematologist/Oncologist
¨ Surgeon	¨ Endocrinologist
¨ Cardiologist	¨ Naturopathic Physician
¨ Gynecologist	¨ Other

List any significant prior illnesses, diagnoses, or injuries, including date occurred (ie. hypertension, March 2015)

List all surgeries and hospitalizations, including reason and date occurred?

Please list any major accident or illness during childhood not already indicated?

Date of last physical exam?

Date of last blood work?

Medical Imaging

X-ray: Provide date, area of body, and reason?

MRI/CAT Scan: Provide date, area of body, and reason?

Ultrasound: Provide date, area of body, and reason?

Vaccination History

Have you ever had the disease (D), been immunized (I), neither (N) or unknown (U) for the following?

	D	I	N	U	Date
Tetanus	o	o	o	o	
Whooping cough (Pertussis)	o	o	o	o	
Hemophilus (HiB)	o	o	o	o	
Hepatitis A	o	o	o	o	
Hepatitis B	o	o	o	o	
Measles	o	o	o	o	
Mumps	o	o	o	o	
German Measles (Rubella)	o	o	o	o	
Chicken Pox	o	o	o	o	
Shingles	o	o	o	o	
Human papilloma virus (HPV)	o	o	o	o	
Pneumococcal Conjugated Vaccine (PCV)	o	o	o	o	
Polio	o	o	o	o	
Meningococcal	o	o	o	o	
Pneumonia	o	o	o	o	
Influenza	o	o	o	o	
Other Vaccines	o	o	o	o	

Any adverse reactions to any vaccinations?

- ¨ No
- ¨ Yes, describe:

Medications / Supplements

Current Medications and Supplements (please include ALL prescriptions, over-the-counter drugs, vitamins, herbs, etc.). Please include daily dose and reason for taking it.

Allergies

Please indicate allergies?

- ¨ No known or suspected allergies
- ¨ Medication
- ¨ Foods
- ¨ Environmental

Please indicate allergy and describe reaction:

SOCIAL HISTORY

What is your current job?

Do you enjoy your job? ¨ Yes ¨ No

What are your hobbies?

Have you done any foreign travel within the last year?
¨ Yes, indicate where ¨ No

Please indicate your average level of energy throughout the day using the scale 1-10 (1 is the lowest and 10 is the highest)

Do you exercise? If YES, indicate type of exercise, how many days per week, and for how long? (i.e. bicycling, 3 days, 60 minutes)
¨ Yes, describe ¨ No

Sleep

How many hours of sleep do you usually get per night?

Do you wake feeling refreshed?
¨ Always ¨ Usually ¨ Rarely ¨ Never

Do you have difficulty sleeping?	¨ Yes	¨ No
Any trouble falling asleep?	¨ Yes	¨ No
Any trouble staying asleep?	¨ Yes	¨ No
Do you snore?	¨ Yes	¨ No
Do you grind your teeth?	¨ Yes	¨ No
Do you have nightmares?	¨ Yes	¨ No
Do you sleepwalk?	¨ Yes	¨ No

Do you need a sleep-aid?
¨ Yes, indicate what ¨ No

Alcohol, Tobacco, and Recreational Drug Use

Do you drink alcohol?
¨ Daily ¨ Weekly ¨ Monthly ¨ No

What type of alcohol do you prefer?
¨ Liquor ¨ Wine ¨ Rarely ¨ Never

How much do you drink per sitting? Indicate amount consumed per occasion.

Do you smoke tobacco?
¨ Yes ¨ No ¨ In the past

If yes, how many cigarettes or packs per day?

If past, when did you quit smoking, number of years smoking, and packs per day?

Do you use recreational drugs?
¨ Yes ¨ No ¨ In the past

If yes, how often?
¨ Daily ¨ Weekly ¨ Monthly ¨ Other

If Yes or in the past, what kind?

¨ Cannabis	¨ Barbiturates/benzodiazepines
¨ Solvents	¨ Psychedelic mushrooms
¨ Heroin	¨ LSD
¨ Opium	¨ Peyote
¨ Ecstacy	¨ Amphetamines
¨ Cocaine	¨ Other

Have you ever been told you have an addiction or been treated for an addiction?
¨ Yes ¨ No

Does the use of alcohol or drugs impair your activities of daily living?
¨ Yes ¨ No

Diet

Do you follow a special diet (ie South Beach, Paleo, Vegan, Blood-type, etc.)?
¨ Yes, indicate type ¨ No

How many ounces of water do you drink each day?

How many meals do you eat a day?

Do you drink energy drinks?
¨ Daily ¨ Weekly ¨ Monthly ¨ No

Please indicate what kind of energy drink and how much:

Do you drink soda, juice or sports drinks?
¨ Daily ¨ Weekly ¨ Monthly ¨ No

Please indicate what kind of soda, juice or sports and how much:

How many 8oz cups of coffee do you drink daily?

Relationship

Relationship status?

¨ Single	¨ Separated
¨ Married	¨ Divorced
¨ Domestic partner	¨ Widowed
¨ In a relationship	¨ Other

Are you satisfied with your significant relationships?
¨ Yes ¨ No

Do you find your life?

¨ Satisfactory
¨ Unsatisfactory
¨ Boring
¨ Too demanding

Do you live alone?
¨ Yes ¨ No

Do you have a support system?
¨ Strong ¨ Moderate ¨ Limited

Major stressors in the last year?

¨ Money
¨ Job
¨ Marriage/relationship
¨ Home life
¨ Children
¨ Loss
¨ Other

Do you have a history of abuse? Check all that apply.

¨ Mental abuse
¨ Physical abuse
¨ Sexual abuse
¨ Emotional abuse

If yes, by whom and at what age?

How would you define your childhood memories?

¨ Mostly happy
¨ Normal
¨ Mostly painful
¨ Denies recollection

REVIEW OF SYSTEMS

Do you have, or have you had within the past year, any of the following?

General

- ¨ weight change
- ¨ appetite change
- ¨ fever/chills
- ¨ weakness
- ¨ fatigue
- ¨ night sweats

Skin

- ¨ positive skin exam
- ¨ color change
- ¨ abnormal mole
- ¨ dry skin
- ¨ acne
- ¨ rash
- ¨ hives
- ¨ hair/nail changes
- ¨ psoriasis
- ¨ itchy skin
- ¨ rosacea
- ¨ eczema
- ¨ skin cancer
- ¨ warts

Head

- ¨ migraines
- ¨ headaches
- ¨ dizziness
- ¨ lightheadedness
- ¨ head injury
- ¨ dandruff
- ¨ oily hair
- ¨ dry hair
- ¨ hair loss

Eyes

- ¨ dryness
- ¨ watery eyes
- ¨ itching eyes
- ¨ redness of the eye
- ¨ eye strain
- ¨ cataracts
- ¨ Date of last eye exam:

  _____ ___ _____ _____
- ¨ styes
- ¨ dark circles around eyes
- ¨ discharge of the eye
- ¨ contacts/glasses
- ¨ problems with vision
- ¨ glaucoma

Ears

- ¨ ringing
- ¨ change in hearing
- ¨ discharge
- ¨ recurrent infections
- ¨ pain
- ¨ vertigo

Nose

- ¨ nose bleeds
- ¨ polyps
- ¨ allergies
- ¨ frequent colds
- ¨ problems smelling
- ¨ postnasal discharge
- ¨ nasal congestion
- ¨ nasal discharge
- ¨ sinusitis

Mouth/Throat/Neck

- ¨ cavities
- ¨ dentures
- ¨ sores
- ¨ gum disease
- ¨ sore throat
- ¨ problems tasting
- ¨ swollen glands
- ¨ problems swallowing
- ¨ hoarseness
- ¨ goiter
- ¨ diminished neck movement

Respiratory

- ¨ asthma
- ¨ tuberculosis
- ¨ bronchitis
- ¨ cough
- ¨ wheezing
- ¨ emphysema
- ¨ pneumonia
- ¨ Date of last chest x-ray (if any):

  _____ ___ _____ _____
- ¨ shortness of breath with exertion
- ¨ shortness of breath with sitting
- ¨ shortness of breath with lying down
- ¨ pain with breathing

Cardiovascular

- ¨ murmurs
- ¨ palpitations
- ¨ heart attack
- ¨ arrhythmias
- ¨ angina
- ¨ TIA/stroke(s)
- ¨ chest pain
- ¨ leg cramps
- ¨ Date of last ECG (if any):

  _____ ___ _____ _____
- ¨ congestive heart failure
- ¨ blue hands/feet
- ¨ rheumatic fever
- ¨ low blood pressure
- ¨ high blood pressure
- ¨ varicose veins
- ¨ edema

Gastrointestinal

- ¨ indigestion
- ¨ diarrhea
- ¨ constipation
- ¨ food intolerance
- ¨ abdominal pain
- ¨ heartburn
- ¨ ulcers
- ¨ hemorrhoids
- ¨ How often do you have a bowel movement?

  _____ ___ _____ _____
- ¨ Date of last colonoscopy (if any):

  _____ ___ _____ _____
- ¨ gas/bloating
- ¨ nausea
- ¨ vomiting
- ¨ liver disease
- ¨ hernias
- ¨ fatty meals bothering
- ¨ rectal bleeding/burning/itching

Urinary Tract

- ¨ incontinence
- ¨ kidney stones
- ¨ blood in urine
- ¨ urgency
- ¨ frequent urination
- ¨ frequent infections
- ¨ pain with urination
- ¨ waking to urinate

Musculoskeletal

- ¨ muscle weakness
- ¨ muscle aches
- ¨ tremors
- ¨ arthritis
- ¨ leg cramps
- ¨ stiffness
- ¨ past injury

Neurological

- ¨ paralysis
- ¨ sciatica
- ¨ seizures
- ¨ weakness
- ¨ numbness/tingling
- ¨ tremors
- ¨ carpal tunnel
- ¨ fainting/blackouts

Endocrine

- ¨ diabetes
- ¨ thyroid disease
- ¨ anemia
- ¨ mood swings
- ¨ snacking often
- ¨ irritability
- ¨ hormone therapy
- ¨ increased urination
- ¨ increased thirst
- ¨ hot/cold intolerance
- ¨ needing to eat regularly
- ¨ easy bruising/bleeding
- ¨ change in glove/shoe size

Mental/Emotional

- ¨ anxiety
- ¨ fear/panic
- ¨ eating disorder
- ¨ anger/irritability
- ¨ feeling down/depressed
- ¨ suicidal thoughts
- ¨ psychiatric hospitalization

FEMALE SECTION

(Only females complete this section)

Menstrual Cycle

Age of first menses?

First day of last menses?

Length of menses?

Color of blood?

Clots in menses?

¨ Yes ¨ No

Number of pads/tampons used on your heaviest day?

Number of pads/tampons used on your lightest day?

Do you experience any of the following before or during your menses?

- ¨ diarrhea
- ¨ bloating
- ¨ food cravings
- ¨ mood changes
- ¨ headaches
- ¨ heavy bleeding
- ¨ menstrual cramping
- ¨ fatigue during menses
- ¨ backache during menses
- ¨ breast tenderness/swelling

Menopause

Surgically induced menopause:

¨ Total hysterectomy ¨ Partial hysterectomy

Age at menopause:

Age your mother entered menopause:

Check all the symptoms you experience:

- ¨ hot flashes
- ¨ night sweats
- ¨ vaginal dryness
- ¨ decreased libido
- ¨ palpitations
- ¨ mood changes
- ¨ incontinence
- ¨ joint pain
- ¨ sleep disruption
- ¨ brain fog or decreased memory

Date of last DEXA scan (bone scan):
Indicate if you never had one.

Breast Health

Do you do breast self-exams monthly?

¨ Yes ¨ No

Do you know how to perform a self breast exam?

¨ Yes ¨ No

Do you have any of the following?

- ¨ breast pain
- ¨ breast discharge
- ¨ breast masses

Date of last mammogram and results:

Gynecology and PAP History

Date of last PAP smear and results:

Have you ever had an irregular PAP smear?

¨ No ¨ Yes, list date and treatment received:

Check all pelvic disease conditions that you have a history of:

- ¨ ovarian cysts
- ¨ fibroids
- ¨ endometriosis
- ¨ ectopic pregnancy
- ¨ ovarian/uterine disease
- ¨ pelvic inflammatory disease
- ¨ other

Have you had any gynecological surgeries or procedures?

¨ No ¨ Yes, indicate date and type:

Check all the pelvic symptoms you currently experience:

- ¨ vaginal itching
- ¨ vaginal odor
- ¨ pelvic pain
- ¨ abnormal discharge
- ¨ rashes or skin changes
- ¨ pain with intercourse

Do you have difficulty with PAP/pelvic exams? Indicate:

- ¨ Emotionally distressing
- ¨ Physically painful or difficult
- ¨ No difficulty with pap/pelvic exams

Pregnancy History

Number of pregnancies:

Number of miscarriages:

Number of abortions:

Any complications with pregnancy? ¨ Yes ¨ No

Any difficulty with conceiving? ¨ Yes ¨ No

Number of vaginal births:

Number of C-Sections:

Number of VBACs (vaginal birth after cesarean):

Contraception, Libido, and Sexually Transmitted Infections (STIs)

Are you currently sexually active? ¨ Yes ¨ No

Current number of sexual partners (if any):

Please indicate birth controls or other hormones previously or currently used:

Do you have sex with?

¨ Males ¨ Both males and females
¨ Females ¨ Other

Do you experience any of the following?

¨ low libido ¨ bleeding after intercourse
¨ pain with intercourse

Do you have a history of STIs?

¨ No ¨ Yes, indicate type:

How do you protect yourself from STIs?

MALE SECTION

(Only males complete this section)

Prostate / urinary symptoms?

¨ BPH ¨ incomplete urination
¨ nocturia ¨ dribbling of urine
¨ prostatitis ¨ difficulty initiating urination
¨ prostate cancer

Do you perform monthly testicular exams? ¨ Yes ¨ No

Date of your last PSA?

Date of your last prostate exam (digital rectal exam)?

Check all the pelvic symptoms you currently experience:

¨ testicular pain ¨ impotency
¨ testicular swelling ¨ decreased libido
¨ hernia ¨ prostate disease
¨ penial discharge ¨ rashes or skin changes

Contraception, Libido, and Sexually Transmitted Infections (STIs)

Are you currently sexually active? ¨ Yes ¨ No

Current number of sexual partners (if any):

Do you have sex with?

¨ Males ¨ Both males and females
¨ Females ¨ Other

Do you experience any of the following?

¨ low libido ¨ difficulty achieving an erection
¨ fertility challenges ¨ difficulty maintaining erection

Do you have a history of STIs?

¨ No ¨ Yes, indicate type:

How do you protect yourself from STIs?

Please indicate any hormones previously or currently used:

Additional Information

Is there anything else you would like your doctor to know about you?