Intake form

Please read all instructions very carefully and take your time filling this out. If there is anything that you would like to elaborate on in person or have a question about, please mark it with a big star.

Name: _____ Today's Date: _____

Date of birth: _____

Gender: M ___ F ___

Home address: _____

Phone number(s) – please star which one(s) you prefer to be contacted through and which times of the day or days of the week:

Home _____ Work _____ Cell _____ Other _____

Email address: _____

Emergency contact(s) – please include name and best phone number to reach them:

_____

_____

_____

How did you hear about It's Time Natural Health?

Social Media: __ HealthProfs __ Yelp __ Instagram __ LinkedIn __ Facebook __ Just found the website
__ Radio __ Ad (Please specify where: _____)

Referral via: __ Network __ Family __ Friends __ Healthcare professional (please specify: _____)

__ Previously met the doctor

__ Other (please explain)

Y = yes X = no P = past H = still happens sometimes

General __ Weakness __ Fatigue __ Change in weight/appetite __ Fever/chills __ Night sweats __ Hot/cold intolerance __ Increased thirst __ Increased hunger __ Increased urination __ Change in sleeping habits __ Anemia __ Bleeding tendencies __ Easy bruising	Skin __ Rashes __ Lumps __ Sores __ Itching __ Dryness __ Change in moles __ Changes in hair __ Changes in nails	Head __ Head injury __ Headache __ Migraines __ Dizziness	Eyes __ Watery/itchy/red eyes __ Eye discharge __ Double vision __ Eye blurriness __ Cataracts __ Glaucoma __ Sensitivity/pain to light or vision changes *Glasses/contacts:* Yes ____ No ____ Correction (if yes):
Ears __ Pain __ Discharge __ Infections __ Hearing changes/impaired __ Tinnitus (ringing) __ Vertigo	Nose __ Chronic sinusitis __ Hay fever __ Decreased smell __ Excessive rhinorrhea/ __ congestion __ Nosebleeds __ Nasal fractures	Mouth/Throat __ Tenderness __ Lesions __ Sore throats __ Burning sensation of the tongue __ Difficult/painful swallowing or persistent hoarseness __ Tooth pain __ Bleeding gum Brush Daily? Yes __ No ___ If no, how often? Floss Daily? Yes __ No ___ If no, how often? Last dental exam:	Neck __ History of injury __ Masses __ Pain __ Stiffness
Chest __ Cough __ Chest pain __ Shortness of breath (SOB) __ Wheezing __ Sputum (explain quantity and appearance) __ History of asthma __ Bronchitis __ Hemoptysis (coughing up blood) __ Pneumonia __ Tuberculosis	Cardiac __ Chest pain __ Hypertension __ Angina __ Murmurs __ Palpitations __ Dizziness __ Fainting __ Dyspnea (difficult/labored breathing) on exertion __ Orthopnea (SOB when lying flat) __ Paroxysmal nocturnal dyspnea (SOB or coughing attacks at night) Heart attack? Yes __ No ___ Date(s): Stroke? Yes __ No ___ Date(s): EKG? Yes __ No ___ Date(s):	Vascular __ Leg/hip pain while walking __ Coolness/ discolored extremities __ Hair loss on legs __ Cyanosis (blue appearing skin) __ Leg Ulcers/non-healing wounds __ Varicose veins __ Deep vein thrombosis	Urinary __ Dysuria (painful or difficult urination) __ Urgency __ Blood in urine __ Infections __ Stones __ Difficulty initiating stream __ Incontinence Frequency of urination: Urine color (ex. Clear, cloudy, light yellow, dark yellow, red, etc.) - if it 'depends,' what is the usual color? Urine odor: Any abnormal results on urinalysis:

Explanations (optional):

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Musculoskeletal __ Weakness __ Muscle pain/stiffness __ Joint pain/stiffness __ Paralysis __ Limited movement __ Arthritis (please list what type if been diagnosed) __ Back pain __ Muscle cramps	Neuro __ Fainting __ Dizziness __ Blackouts __ Paralysis __ Stroke __ Numbness __ Tingling __ Burning __ Tremors __ Speech disorders __ Memory loss __ Mood changes __ Nervousness __ Psychiatric disorders (please list diagnoses) __ Hallucinations __ Seizures	Gastrointestinal __ Abdominal pain __ Nausea __ Vomiting __ Diarrhea __ Constipation __ Change in appetite __ Food intolerance __ Heartburn __ Hematemesis __ Excessive belching __ Excessive passing of gas __ Bloating/ __ Distention __ Change in stool color, consistency, size __ Hemorrhoids __ Rectal bleeding/pain How many bowel movements per day? If not every day, how many per week? What is the color? What is the size?	Breasts __ Lumps __ Discharge __ Pain __ Prior surgery/biopsy Do you perform self breast exams? Yes ___ No ___ How often?
Male genital __ Pain __ Lesions __ Erectile dysfunction __ Libido changes __ Testicular masses __ Testicular pain __ Testicular swelling __ Hernias __ Decreased force of urinary stream __ Sexually transmitted infections (please list diagnoses): Last prostate exam: Last digital rectal exam: Do perform self-testicular exams? Yes ___ No ___ How often?	Female genital __ Dysmenorrhea __ PMS (please explain) __ Vaginal discharge __ Itching __ Lesions __ Dyspareunia (pain during sex) __ Libido changes __ STIs (please list diagnoses) __ Post-menopausal bleeding Last pap smear? How many times have you been: __ Pregnant __ Delivered a child __ Abortion (if so, please list what type(s) and how many times): What age did you first begin your period? Last menstrual period: #/types pads/tampons per day: Age at menopause:	Intercourse How many sexual partners do you currently have? Do you use contraception? Yes ___ No ___ Sometimes ___ How often do you use contraception with intercourse? What form(s) of contraception do you use? Do you get STD tests done? When was the last time?	

Explanations (optional):

Anything I have left blank is a "No" _____ (Initials)

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*Medications/Supplements:

Name of medication/supplement	Prescribed dosage and frequency per day	How much you are actually taking per day	What condition you are taking them for

*Are there any medications or other therapies that you have stopped in the last 3 months? If so, please describe. For medications or supplements, please include dosages and frequency taken.

Please list the top 3 items you'd like to address, then any others:

1.

2.

3.

When did this start?

1.

2.

3.

What factors do you think may have contributed to its onset (drugs, supplements, foods, body positions, exercise, controlling emotions and stress, sleep, etc.)?

1.

2.

3.

Does anything make it better (drugs, supplements, foods, body positions, exercise, controlling emotions and stress, sleep, etc.)?

1.

2.

3.

Does anything make it worse (drugs, supplements, foods, body positions, exercise, emotions, stress, etc.)?

1.

2.

3.

Can you describe how it feels (sharp, throbbing, dull, achy, piercing, cramping, itching, burning, etc.)?

1.

2.

3.

Can you rate the feeling on a scale of 1-10, where 1 is minor, 10 is *really* bad?

1.

2.

3.

Please list the location of the symptoms:

1.

2.

3.

Does it radiate to anywhere in the body?

1.

2.

3.

Timing – when it happens, when it stops, how long it lasts, is it intermittent or constant, how frequently does it occur (how many times per day/week/month/year):

1.

2.

3.

Medical History
Any chronic illnesses or medical diagnoses (please specify if current or previous)?

Childhood illnesses:

Vaccinations you've received in life, or are you fully vaccinated?

When was the last time you had lab work done and with which doctor? If it is within the last year, please send them to me before your visit, along with this form.

Have you had any imaging done for the goals you are coming to me for? If so, please list the results here, and bring them with you to the visit.

Please be sure to mark **NO** if you do not have a particular condition:

Respiratory disease	Yes ____ No ____	Hypertension	Yes ____ No ____
Cancer	Yes ____ No ____	Other Cardiovascular disease	Yes ____ No ____
Diabetes	Yes ____ No ____		

For each person listed, please list:

- Age – current or when deceased
- Any health conditions they deal with or had
- What they passed away from, if applicable

Mother:
Father:
Maternal grandmother:
Maternal grandfather:
Paternal grandmother:
Paternal grandfather:
Siblings:

Have you had any surgeries or hospitalizations? If so, please list the dates.

Allergies to any foods, medications, chemicals, environmental, seasonal:

Female: Any chance that you are pregnant or intend to become pregnant soon? If so, when? This is important for me to know, as some therapies may be contraindicated.

Social History

Do you exercise? If so, what type(s), and how often? How long each time?

Energy level on a scale of 1-10 (1 being very low, 10 being outstanding!):

Employment:

How is your home life?

Are you married? Yes ____ No ____ Are you happily married? Yes ____ No ____

Do you drink alcohol? If so, how much (1 cup = 8 oz)? How often? What do you drink?

Do you smoke, or have you smoked in the past? When did you stop?

Recreational drug use? If so, what type?

Any history of abuse (physical, verbal, sexual, other)?

Please list 3 days' worth of your diet, and how that may significantly change on the weekend or any other given time. *Please give me the full ingredient list, including seasonings or seasoning blend brand names used.*

Breakfast, and time eaten	**Lunch, and time eaten**	**Dinner, and time eaten**	**Snacks or other meals, and times eaten**
Changes from the norm:			

How much water do you drink per day? Is it a specific type (ex. reverse osmosis, spring, purified alkaline, tap, etc.)?

Sodas: Yes ____ No ____ How many per day ____ How many per week ____

Coffee: Yes ____ No ____ How many cups per day ____
How much sugar and/or cream do you add?
Are there any other beverages you drink?

Do you have an aversion to heat or cold?

Are you thirsty or have a lack of thirst?

How much sun do you get per day?

Emotional History

What is your basic nature/disposition?

Do you stuff your emotions regularly?

Any significant worries or fears:

Do you struggle with depression or anxiety?

Sleep

How many hours do you get per night?
Do you wake rested?
Do you sleep well through the night?
Do you struggle with insomnia? Yes ____ No ____

- Difficulty with: Falling asleep ____ Staying asleep ____ Waking too early ____ Snoring ____ Apnea ____

What is your usual body temperature? Hot ___ Cold ____ Average ____