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Pr No. 0360813

Patient Intake Form

Patient Name: ______________________ **DOB:** __________

List in Order of importance what your problems are:

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

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

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:	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

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**), Get **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

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and include dosage if known:

____

____

____

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	**Sexual Orientation:**	Hetero Homo Bi

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 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: ____

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		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

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? ____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _______________

____

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

Are you particularly sensitive to perfumes, gasoline or other vapors? ____

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

____

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

Consent Regarding Personal Information

Your identity will be protected at all times and a record will be kept of the health services provided. Patients may look at their medical record at any time and can request a copy. We try to be as open and transparent as possible about the way we handle your personal information. All staff members who deal with your personal information are aware of the sensitive nature of the disclosed information and are trained in the appropriate use and protection of it. Only necessary information is collected from you and we only share your information with your consent.

By signing the consent section herein contained, you have agreed that you have given your informed consent to the collection, use and / or disclosure of your personal information as outlined above.

Patient Consent

I,...(patient name) agree that Dr. Benita Perch , (Naturopath) may collect, use and disclose personal information as set out above regarding the practices privacy policies. I also consent to diagnostic and therapeutic procedures for the treatment for my present condition(s), and understand that I am free to withdraw consent and to discontinue participation in these procedures at any time.

I have read, fully understand and agree to the outlined fees and policies and understand that the fees may change without prior notice.

Signature:.. Date:..

Guardian Signature (Patients under the age of sixteen) ....