Naturopathic Intake Form

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PATIENT MEDICAL PROFILE

Last Name _____ First Name _____ Today's Date _____

Nickname _____ E-Mail_____ Birthdate (d/m/y)_____ Sex_____

Home Address _____ City _____ Postal Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Method of communication: Home ☐ Cell ☐ Work ☐ or email ☐

How did you hear about Naturopathic Medicine at Mind Body Soul Integrative Clinic? _____

Would you like to receive a quarterly newsletter via e-mail? YES ☐ NO ☐

A note to our patients: Please complete this questionnaire as thoroughly as possible in order to best aid in your diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

What is your commitment level to being proactive in your health care? _____

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	**Is there a prior diagnosis of this problem? If so, what was diagnosis, when was it made and by whom?**
1.	
2.	
3.	
4.	

Please list prescription medications that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

List vitamins, minerals, herbs, homeopathic remedies you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list any severe or life-threatening allergies: _____

Explain:

Name _____ DOB: _____

Current Symptoms

General
- o Chills
- o Fatigue
- o Fever
- o Night Sweats
- o Weight Change

Eyes
- o Blurred Vision
- o Eye Drainage
- o Eye Pain
- o Glasses/contacts
- o Light Sensitivity

Ears/Nose/Throat
- o Ear pain
- o Hearing problems
- o Ringing in ears
- o Nose bleeds
- o Nasal congestion
- o Nasal ulcers
- o Runny nose
- o Bleeding gums
- o Gum disease
- o Dentures present
- o Hoarseness
- o Oral ulcers
- o Sore throat
- o Sore tongue
- o Thrush
- o Tooth pain

Cardiovascular
- o Chest pain
- o Leg pain w/ walking
- o Dizziness
- o Shortness of breath
- o Palpitations
- o Swollen feet/ankles
- o Rapid heart rate
- o Varicose veins

Respiratory
- o Cough
- o Difficulty breathing
- o Coughing up blood
- o Chest wall pain
- o Wheezing

Gastrointestinal
- o Abdominal pain
- o Indigestion
- o Sour taste in mouth
- o Poor appetite
- o Bloating
- o Difficulty swallowing
- o Clay-colored stools
- o Constipation
- o Diarrhea
- o Heartburn
- o Vomiting blood
- o Bloody stools
- o Hemorrhoids
- o Dark/tarry stools
- o Nausea
- o Vomiting
- o Painful chewing
- o Stool caliber change

Genitourinary
- o Bleeding after intercourse
- o Blood in urine
- o Change in urine stream
- o Frequent bacterial vaginosis
- o Frequent Bladder infections
- o Frequent urination
- o Genital lesions
- o Heavy periods
- o Impotence
- o Irregular periods
- o Menopausal bleeding
- o Menopausal symptoms

Genitourinary (con't.)
- o Nighttime urination
- o Painful intercourse
- o Painful menstruation
- o Painful urination
- o Sexual abuse
- o Unprotected sex
- o Urinary incontinence
- o Vaginal discharge
- o Vaginal itching

Musculoskeletal
- o Arm or leg pain
- o Back pain
- o Joint pain
- o Joint stiffness
- o Muscle aches

Skin
- o Acne
- o Concerning moles
- o Dry skin
- o Fingernail problems
- o Jaundice (Yellow skin)
- o Itching
- o Rashes
- o Warts

Breast
- o Lump
- o Skin changes
- o Breast tenderness
- o Nipple discharge
- o Regular self-breast exams

Neurological
- o Difficulty walking
- o Dizziness (fainting)
- o Fainting
- o Headaches
- o Memory loss
- o Numbness

Neurological (con't.)
- o Seizures
- o Tremor
- o Vertigo (Dizziness)
- o Weakness

Hematologic
- o Easy bruising
- o Excessive bleeding
- o Blood transfusions
- o Enlarging lymph nodes

Endocrine
- o Enlarging hands/feet
- o Hair loss
- o Heat intolerance
- o Cold intolerance
- o New hair growth
- o Hot flashes
- o Darkening skin
- o Infertility
- o Increased thirst
- o Increased hunger
- o Stretch marks
- o Sweating excessive

Allergies/Immunologic
- o Allergies
- o Hay fever
- o Frequent colds
- o HIV exposure
- o Urticaria (Hives)

Psychiatric
- o Anxiety
- o Depression
- o Stress
- o Mood Disorders
- o PMS
- o Poor concentration
- o Trouble sleeping
- o Suicidal thoughts

Name _____ DOB: _____

Past Medical History

Cardiovascular

- Abnormal Heart Rhythm
- Arterial Clot
- Carotid Artery Disease
- Congestive Heart Failure
- Coronary Artery Disease
- Deep Vein Thrombosis
- High Cholesterol
- Hypertension
- Heart Attack
- Peripheral Vascular Disease
- Superficial Vein Clot
- Phlebitis
- Heart Valve Disease

Pulmonary

- Asthma
- Bronchiectasis
- Chronic Bronchitis
- COPD
- Croup
- Cystic Fibrosis
- Pneumonia
- Pulmonary Embolism
- Pulmonary Hypertension
- Respiratory Syncytial Virus (RSV)
- Sarcoidosis
- Sleep Apnea
- TB

Gastrointestinal

- Gall Stones
- Cirrhosis
- Colon Polyps
- Crohn's Disease
- Incontinence of Feces
- GERD or Heartburn
- Hepatitis
- Irritable Bowel Syndrome (IBS)
- Pancreatitis
- Peptic Ulcer Disease
- Ulcerative Colitis

Renal

- Benign Prostatic Hypertrophy
- Chronic Renal Failure
- Endometriosis
- Bed Wetting
- Erectile Dysfunction (Impotence)
- Glomerulonephritis
- Infertility
- Kidney Stones
- Urinary Incontinence
- Frequent Bladder Infections

Musculoskeletal/Connective tissue

- Chondromalacia Patellae
- Chronic Pain
- Fibromyalgia
- Fractures
- Gout
- Juvenile Rheumatoid Arthritis
- Osgood-Schlatter Disease
- Osteoarthritis
- Osteoporosis
- Osteopenia
- Rheumatoid Arthritis
- Systemic Lupus Erythematous
- Other

Endocrine

- Addison's Disease
- Carcinoid Syndrome
- Cushing's Disease
- Diabetes I or II
- Hyperthyroidism
- Hypothyroidism
- Panhypopituitarism
- Pituitary Tumor

Neurological

- Alzheimer's Disease
- ADD/ADHD
- Autism
- Cerebral Palsy
- Stroke
- Dementia
- Degenerative Disc Disease
- Headaches
- Huntington's Disease
- Meningitis
- Mental Retardation
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Parkinson's Disease
- Sensory Neuropathy

Hematologic

- Hemolytic Anemia
- Iron Deficiency Anemia
- Pervasive Developmental Delay
- Seizures
- Transient Ischemic Attacks (TIA's)
- Pernicious Anemia
- Sickle Cell Disease
- Thallasemia

Allergy/Immune/Skin

- Allergies (food or environmental)
- Angioedema
- Chicken Pox
- Eczema
- Giardiasis
- Immune Deficiency
- Ear Infections (frequent)
- Psoriasis
- Sinusitis

Psychiatric

- Anxiety
- Anorexia Nervosa
- Bipolar Disorder
- Bulimia
- Depression Obsessive Compulsive
- Schizophrenia

Other

- Cataract
- Glaucoma
- Over weight
- _____
- _____
- _____

Name _____ DOB: _____

Other Healthcare Providers you are currently seeing (Please list all – conventional, holistic, integrative…etc.)

Dr. _____ specialty _____ Phone: _____

Dr. _____ specialty _____ Phone: _____

Dr. _____ specialty _____ Phone: _____

Dr. _____ specialty _____ Phone: _____

Date of last physical/annual exam _____ Date of last blood tests: _____

Date of last Pap/Breast Exam _____ (N/A –not applicable for men)

Have you had a Colonoscopy? _____ Year _____

Have you had a Bone Density Scan? _____ Year _____

Any X-Rays (body part)? _____ Year _____

Any CT Scans/MRI's (body part)? _____ Year _____

Surgical History (please list surgeries, dates and outcomes)

_____

_____

_____

_____

Family History

Relation	Medical Condition	Age at Death	Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			
Paternal GF			
Paternal GM			
Maternal GF			
Maternal GM			

Name _____ DOB: _____

Pregnancy/Gynecological History

Pregnancies # _____

Children # _____

Miscarriages # _____

Terminations # _____

Problems during pregnancy? _____

- o Menstrual problems
- o Hysterectomy
- o Total
- o Partial (ovaries retained)

Current Birth Control Method _____

Are you happy with current birth control method?

Age periods started _____

Age at menopause _____

Last Pap Smear (date) _____

Last Mammogram (date) _____

Social History

Occupation _____

Marital Status _____

Hobbies _____

_____

Exercise (type and frequency)

_____

_____

Children? Names and ages

_____

_____

Caffeine

Type and number of drinks per day _____

_____

Smoking

Current? In the past? Never?

How long? _____

Type? Cigarettes? Cigar? Smokeless?

How often do you use Alcohol?

- o None
- o Rare
- o Social
- o Regular
- o Occasional Binge
- o Current Alcoholic
- o Past Alcoholic
- o Used alcohol in past

Recreational Drugs

- o Frequency _____
- o Types_____
- o How long? _____

Do you Restrict any Foods?

Which? _____

_____

Dietary Habits: Briefly list what you eat and drink at a typical meal.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How do you rate your diet? Excellent good average poor terrible

What goals do you have for your visit with Dr. Jasarevic today?

Please include any other comments or health concerns that you would like to discuss:

Declaration and Consent for Naturopathic Care

I would like to take this opportunity to welcome you to our clinic. As a naturopathic doctor (ND) I will conduct a thorough case history, a physical exam and may utilize specific blood, urinary or other laboratory reports as part of the treatment work-up. I integrate supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, intravenous therapy, and lifestyle counseling to assist the body's ability to heal and improve the quality of life and health.

Statement of Acknowledgement
Printed name of patient: _____

As a patient of Dr. Emina Jasarevic, ND, I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. Slight health risks of some naturopathic treatments include, but are not limited to:

- temporary aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs or injectible therapies
- pain, fainting, bruising or injury from venipuncture or acupuncture
- muscle strains and spasms, disc injuries from spinal manipulations

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient of Dr. Jasarevic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare providers. I understand results are not guaranteed.
- I understand that a record will be kept of my visits. This record will be kept confidential and will not be released without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am responsible for payment at the time services are rendered. Dispensary items and laboratory tests must be paid for in full before leaving the office.
- I am aware that 24 hours notice must be given for all cancelled appointments or a cancellation fee will be applied, in addition to any IV's drawn up for visit.
- I understand that Dr. Jasarevic reserves the right to determine which cases fall outside of her scope of practice, in which case the appropriate referral will be recommended.
- There is a $45 charge for e-mail correspondence, as patients may need and returned phone calls lasting 5-10 minutes.

I consent to receive naturopathic treatment. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: _____ Date: _____