Flagstaff Clinic of Naturopathic Medicine

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928-774-1770

Patient Intake form

Name:_____ D.O.B._____Age:_____Sex: F____M____

Address:_____

City:_____State:_____Zip:_____home/cell phone:_____

Marital status: single:___married:___divorced:___separated:___partner:____widow:____# children:_____

Employer:_____occupation:_____work phone:_____

E-mail:_____Would you like to receive our newsletter: Y____N_____

Emergency contact:_____Emergency contact phone:_____

Primary care physician:_____PCP phone:_____

Insurance company:_____SSN:_____

Name of person insured:_____

How did you hear of us:_____

Partner/spouse name:_____

Names and ages of children:_____

Patient name:_____D.O.B.:_____

Reason for visit:
_____
_____

Your health goals:
_____
_____

Last annual physical exam:_____Last blood work:_____

Last dental exam:_____Last eye exam:_____

Weight:_____ Weight 1 year ago:_____ Max Weight:_____ When:_____

Health history (check all that apply and list self or relationship):

____alcoholism_____
____allergies_____
____anemia_____
____arthritis_____
____asthma_____
____cancer_____
____colitis_____
____diabetes_____
____drug abuse_____
____heart disease_____
____heart attack_____
____herpes_____
____high blood pressure_____
____hypoglycemia_____
____liver diseases_____
____mental illness_____
____osteoporosis_____
____stroke_____
____thyroid_____
____tuberculosis_____
other (please list):_____
_____

Do you currently have any problems with the following?

____Back Pain
____Breasts
____Breathing/Lungs
____Digestion/Bowels
____Dizziness/Fainting
____Eyes/Ears/Nose/Throat
____Genital/Pelvic
____Glandular Swelling
____Headaches/Migraine
____Heart/Circulation
____Infections
____Menopause
____Mood Changes
____Muscles/Joints
____Skin
____Sleep
____Urination

Patient name:_____D.O.B.:_____

Hospitalizations/surgeries (dates and types of illness/operation):_____
_____
_____

Known allergies (medications, food, pollens, cleaning products, vaccinations, etc):_____
_____
_____

Medications currently taking (list type and dosage):_____
_____
_____

Supplements currently taking (list type and dosage):_____
_____
_____

Do you smoke:_____Do you drink alcohol:_____Do you use recreational drugs:_____

If you use recreational drugs, what type do you use:_____

Do you drink coffee:_____Do you drink soda:_____

Do you exercise:_____What type of exercise:_____

How frequently do you exercise:_____

How much sleep a night do you get:_____Do you take naps:_____

Do you have a history of abuse:_____Do you have a history of substance abuse:_____

Please describe a poor experience with a health care practitioner you have had in the past:
_____
_____

Please describe a good experience with a health care practitioner you have had in the past:
_____
_____

Patient name:_____D.O.B.:_____

Where were you born:_____Where did you grow up as a child:_____

Do you have sensitivities to odors:_____What type of odors:_____

Do you have mercury fillings currently:_____Have you ever had mercury fillings:_____

Are you sexually active:_____Do you have a history of S.T.Ds:_____

If yes, please list S.T.D. type:_____

Female:

Last pap:_____ Do you have a history of abnormal paps:_____Age of first menses:_____

Length of menstral flow:_____PMS symptoms:_____Pain with/before flow:_____

Heavy menstrual bleeding:_____Abnormal vaginal discharge:_____Pain with intercourse_____

Menopausal since what age:_____Do you use HRT:_____If yes, what kind/dose:_____

Have you ever had an abortion:____Miscarriage:_____ Problems with infertility_____

Male:

Any urinary frequency, urgency, wakening during the night? _____

Pain or burning with urination?_____Any difficulty with urine stream?_____Any blood in your urine?____

Do you do a testicular self exam?_____ Erectile dysfunction:_____

Year of your last prostate exam:_____year of last PSA_____are you sexually active_____

Do you have a history of prostate cancer? _____Does your family_____

Thank you for taking the time to fill out this initial patient questionnaire. We sincerely look forward to working with you for your highest good.