Naturopathic Health Care

Dr. Jon Dunn, Licensed Naturopathic Physician

All information is 100% confidential.
We do not release this information without your written authorization.

Patient Intake

Last Name	First Name	MI	Date
Mailing Address	Home Phone No.		Cell Phone No.
	Message Phone No.		E-Mail Address
Emergency Contact Name			Emergency Contact Phone No.

Known Allergies *(Check all that may apply. Use space to give details and description of reaction)*

- ☐ Food *(Please specify)*
- ☐ Synthetic pharmaceutical drugs
- ☐ Herbs/supplements
- ☐ Environment:
  - ☐ Pollen etc.
  - ☐ Dogs
  - ☐ Cats
  - ☐ Chemical/perfume
- ☐ Other:

Major surgeries/Approximate Dates

Major Illnesses/Approximate Dates

Family History (siblings, parents, grandparents)

- ☐ Heart Disease (Who and What?):
- ☐ Cancer (Who and What?):
- ☐ Diabetes (Who?)
- ☐ Osteoporosis (Who?)

Your Profession

Medications (including natural hormones) please list name and purpose *(i.e. atenolol - blood pressure)*

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Women

Approximate date last menstrual period ended

# of Pregnancies	# of Children

	Type and Amount	**Daily**	**Weekly**
Coffee Intake			
Alcohol			
Tobacco			
Recreational Drugs			

What brings you Joy?

Are there any significant stresses in your life at this point in time?

1
2
3
4
5

Please check the dietary statements applicable to you

☐ Vegetarian
☐ Vegetarian with milk and egg products in diet
☐ I eat most everything
☐ Sweet Tooth and ☐ Usually resist ☐ Sometimes indulge (a few times a week) ☐ Most always indulge (daily)
☐ Commercial red meat consumption ☐ Daily ☐ Several times a week ☐ Few times a month ☐ Never
☐ Organic food and beverages ☐ Always ☐ Most of the time ☐ Occasionally ☐ Never

Do you enjoy cooking? ☐ Yes ☐ No ☐ Sometimes

Do you crave any particular food or beverages? ☐ No ☐ Yes *(If yes, please specify)*

Thirst: please specify type of beverage(s) and approximate daily intake in cups (8 oz. size)

Favorite spices/condiments:

Do you generally eat *(Please check all that apply)* ☐ breakfast ☐ snack ☐ lunch ☐ snack ☐ dinner ☐ snack

Do you know your current average daily caloric intake? ☐ No ☐ Yes *(if yes, please specify):* _______________

Exercise *(type, duration, frequency)*

Are you generally rested when you wake in the morning? ☐ Yes ☐ No

Approximate bedtime is __________ Approximate rising time is _____________

Is your energy through out the day generally: ☐ Poor ☐ Good ☐ Excellent

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Please circle and rate on a scale of 1 (minimal concern) to 4 (serious concern) each condition in each category that applies to you.

Stomach/Digestion/Intestines	Minimum Concern			Maximum Concern
☐ Bloating/Gas	1	2	3	4
☐ Burning/Pain	1	2	3	4
☐ GERD	1	2	3	4
☐ Blood or mucus in stool	1	2	3	4
☐ Constipation	1	2	3	4
☐ Hemorrhoids	1	2	3	4
☐ Loose stools or diarrhea	1	2	3	4
☐ Other	1	2	3	4

Liver/Skin	Minimum Concern			Maximum Concern
☐ Hepatitis A, B, C	1	2	3	4
☐ Cirrhosis	1	2	3	4
☐ Eczema	1	2	3	4
☐ Psoriasis	1	2	3	4
☐ Acne	1	2	3	4
☐ Bladder problems	1	2	3	4
☐ Other	1	2	3	4

Lungs	Minimum Concern			Maximum Concern
☐ Asthma	1	2	3	4
☐ Bronchitis	1	2	3	4
☐ Emphysema	1	2	3	4
☐ COPD	1	2	3	4
☐ Cough	1	2	3	4
☐ Other	1	2	3	4

Heart/Blood Vessels	Minimum Concern			Maximum Concern
☐ Angina	1	2	3	4
☐ Mitral valve prolapse	1	2	3	4
☐ Atrial flutter	1	2	3	4
☐ Hypertension (High Blood Pressure)	1	2	3	4
☐ Other	1	2	3	4

Head Conditions/Nerves/Muscles

	Minimum Concern			Maximum Concern
☐ Headache	1	2	3	4
☐ Tremor	1	2	3	4
☐ Twitch	1	2	3	4
☐ Pain	1	2	3	4
☐ Multiple sclerosis	1	2	3	4
☐ Parkinson's	1	2	3	4
☐ Restless leg syndrome	1	2	3	4
☐ Eye, Ear, Nose, Mouth (includes teeth, tongue, lips)	1	2	3	4
☐ Throat	1	2	3	4
☐ Muscle	1	2	3	4
☐ Other	1	2	3	4

Hormone/Skeleton

	Minimum Concern			Maximum Concern
☐ Thyroid	1	2	3	4
☐ Adrenal	1	2	3	4
☐ Ovarian	1	2	3	4
☐ Testicular	1	2	3	4
☐ Skeletal	1	2	3	4
☐ Other	1	2	3	4

Immune

	Minimum Concern			Maximum Concern
☐ Recurrent infections	1	2	3	4
☐ Vaginitis	1	2	3	4
☐ Prostatitis	1	2	3	4
☐ Cold	1	2	3	4
☐ Flu	1	2	3	4
☐ Earache	1	2	3	4
☐ Leukemia	1	2	3	4
☐ Cancer	1	2	3	4
☐ Other	1	2	3	4

General Body Temperature:

Are you often wearing sweaters when others are wearing T-shirts? ☐ Yes ☐ No
Are you often wearing t-shirts when others are wearing sweaters? ☐ Yes ☐ No

Weight

Is weight gain too easy for you? ☐ Yes ☐ No
Is weight gain difficult for you? ☐ Yes ☐ No Approximate Weight: _________ Approximate Height:________

Birth date: ______________ **Age** _______

Do you have a particular religious affiliation? ☐ No ☐ Yes *(if yes, in a few words what is it?)*
Briefly describe your general nature
Are there any other health concerns you would like me to be aware of?
Current Health Care Providers
How did you hear about this clinic?