



Naturopathic Health Care, Inc.

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) | | Women | |
| 1. | 6. | Approximate date last menstrual period ended | |
| 2. | 7. | # of Pregnancies | # of Children |
| 3. | 8. | | |
| 4. | 9. | | |
| 5. | 10. | | |

| | 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

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 | |
|---|-----------------|---|-----------------|---|
| <input type="checkbox"/> Bloating/Gas | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Burning/Pain | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> GERD | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Blood or mucus in stool | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Constipation | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Hemorrhoids | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Loose stools or diarrhea | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Other | 1 | 2 | 3 | 4 |

Liver/Skin

| | Minimum Concern | | Maximum Concern | |
|--|-----------------|---|-----------------|---|
| <input type="checkbox"/> Hepatitis A, B, C | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Cirrhosis | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Eczema | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Psoriasis | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Acne | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Bladder problems | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Other | 1 | 2 | 3 | 4 |

Lungs

| | Minimum Concern | | Maximum Concern | |
|-------------------------------------|-----------------|---|-----------------|---|
| <input type="checkbox"/> Asthma | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Bronchitis | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Emphysema | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> COPD | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Cough | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Other | 1 | 2 | 3 | 4 |

Heart/Blood Vessels

| | Minimum Concern | | Maximum Concern | |
|---|-----------------|---|-----------------|---|
| <input type="checkbox"/> Angina | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Mitral valve prolapse | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Atrial flutter | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Hypertension (High Blood Pressure) | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Other | 1 | 2 | 3 | 4 |

| Head Conditions/Nerves/Muscles | Minimum Concern | | Maximum Concern | |
|--|------------------------|---|------------------------|---|
| <input type="checkbox"/> Headache | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Tremor | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Twitch | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Pain | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Multiple sclerosis | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Parkinson's | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Restless leg syndrome | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Eye, Ear, Nose, Mouth (includes teeth, tongue, lips) | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Throat | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Muscle | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Other | 1 | 2 | 3 | 4 |

| Hormone/Skeleton | Minimum Concern | | Maximum Concern | |
|-------------------------------------|------------------------|---|------------------------|---|
| <input type="checkbox"/> Thyroid | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Adrenal | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Ovarian | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Testicular | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Skeletal | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Other | 1 | 2 | 3 | 4 |

| Immune | Minimum Concern | | Maximum Concern | |
|---|------------------------|---|------------------------|---|
| <input type="checkbox"/> Recurrent infections | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Vaginitis | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Prostatitis | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Cold | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Flu | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Earache | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Leukemia | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> Cancer | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(if yes, in a few words what is it?)</i> |
| 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? |

