



## NATURAL HEALTH CARE

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**\*\*Welcome to our clinic\*\***

### New Patient Intake Form

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (cell) \_\_\_\_\_

E-mail \_\_\_\_\_

Occupation \_\_\_\_\_ Hours per wk \_\_\_\_\_ Retired \_\_\_\_\_

Employer \_\_\_\_\_ Education \_\_\_\_\_

Are you: Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Single \_\_\_

Significant Partnership \_\_\_

Live With: Spouse \_\_\_ Partner \_\_\_ Relatives \_\_\_ Friends \_\_\_ Alone \_\_\_ Parents \_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Address \_\_\_\_\_

How did you hear about this clinic: \_\_\_\_\_

**\*Thank You For Your Time & Effort\***

Holistic health care and preventive medicine are only possible when the physician has full understanding of each patient, physically, mentally, and emotionally. Your time, thoughtfulness, and honesty in filling out the information below will greatly improve the quality of your holistic healthcare experience.

## Health History Questionnaire

Do you currently have a primary care doctor? Y N

Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently under the care of any other physician/healthcare providers?

Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialty/Reason for seeing: \_\_\_\_\_

Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialty/Reason for seeing: \_\_\_\_\_

Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialty/Reason for seeing: \_\_\_\_\_

What are your most important health problems? List in order of importance.

1. \_\_\_\_\_ Onset? \_\_\_\_\_

2. \_\_\_\_\_ Onset? \_\_\_\_\_

3. \_\_\_\_\_ Onset? \_\_\_\_\_

4. \_\_\_\_\_ Onset? \_\_\_\_\_

5. \_\_\_\_\_ Onset? \_\_\_\_\_

When was the last time you had excellent/optimal health? \_\_\_\_\_

How long do you think it will take for you to return to excellent health? \_\_\_\_\_

What is your present level of commitment to address any *underlying causes* of your signs & symptoms? Rate from 0 to 10, 10 being 100% committed.

0%    0    1    2    3    4    5    6    7    8    9    10    100%

What three expectations do you have of me personally as your health care provider?

### For All New Patient Files:

The naturopathic community is interested in furthering the goal of naturopathic medicine through scientific investigations and research. Would you consent to our use of your medical records by qualified investigators under protocols approved by an appropriate Institutional Review Board?

Your anonymity will be guaranteed. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**General**

Height \_\_\_\_\_

Weight \_\_\_\_\_

Maximal Weight \_\_\_\_\_

Weight one year ago \_\_\_\_\_

When \_\_\_\_\_

**Family History***Check those applicable*

	Father	Mother	Sibling	Child	Grandparent	Spouse
Cancer (type)	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma, Hayfever, Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Autoimmune Disease	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____	_____
Hypothyroidism	_____	_____	_____	_____	_____	_____
Depression/Anxiety	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

**For the following sections, please circle Y=yes or N=no****Childhood**

Were there any complications with your birth? Y N

What? \_\_\_\_\_

Did you have any prolonged childhood illnesses:

Scarlet Fever Y N      Diphtheria Y N      Rheumatic Fever Y N

Mumps Y N      Measles Y N      German Measles Y N

Other \_\_\_\_\_

How would you rate your health &amp; happiness as a child? (0 = worst, 10 = best)

0 1 2 3 4 5 6 7 8 9 10

As a teenager?

0 1 2 3 4 5 6 7 8 9 10

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### Immunization history

Polio Y N Tetanus shot Y N Measles/Mumps/Rubella Y N  
 Pertussis Y N Diphtheria Y N Chicken pox Y N  
 Hepatitis B Y N HIB Y N Flu shot Y N Date? \_\_\_\_\_  
 Other \_\_\_\_\_

### Hospitalization and Surgery

Please list any prior hospitalizations or surgeries you have had:

\_\_\_\_\_  
 \_\_\_\_\_

### Imaging

Please mark any imaging you have received with approximate date of service:

X-ray \_\_\_\_\_ CAT Scan \_\_\_\_\_ MRI \_\_\_\_\_ EKG \_\_\_\_\_ EEG \_\_\_\_\_  
 Ultrasound \_\_\_\_\_ DEXA \_\_\_\_\_ Bone Scan \_\_\_\_\_  
 Other \_\_\_\_\_

### Allergies

Please list any foods, drugs, or other allergens that you are aware of:

\_\_\_\_\_  
 \_\_\_\_\_

### Medications & Supplements

Please list any **prescriptions & over the counter medications** you take *consistently*.

Attach additional sheet if needed.

Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ How long? \_\_\_\_\_  
 Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ How long? \_\_\_\_\_  
 Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ How long? \_\_\_\_\_  
 Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ How long? \_\_\_\_\_  
 Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ How long? \_\_\_\_\_

Please list any **supplements** you are currently taking. Please include the **brand name**.

\_\_\_\_\_ Dose: \_\_\_\_\_ How long? \_\_\_\_\_  
 \_\_\_\_\_ Dose: \_\_\_\_\_ How long? \_\_\_\_\_  
 \_\_\_\_\_ Dose: \_\_\_\_\_ How long? \_\_\_\_\_  
 \_\_\_\_\_ Dose: \_\_\_\_\_ How long? \_\_\_\_\_  
 \_\_\_\_\_ Dose: \_\_\_\_\_ How long? \_\_\_\_\_  
 \_\_\_\_\_ Dose: \_\_\_\_\_ How long? \_\_\_\_\_

### Toxic Exposures

Have you had any past or present careers or hobbies that led to possible toxic exposures?  
 (example - hair dresser, lived on a farm, artist, cleaner, painter, dentist)

\_\_\_\_\_  
 Age: \_\_\_\_\_  
 \_\_\_\_\_  
 Age: \_\_\_\_\_

## Habits, Hobbies, and Lifestyle

What are your interests? What do you love to do? What brings you passion in your life?

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are unhealthy or self-destructive?

Please rate your stress on a scale from 1 to 10 (10 = most)

0 1 2 3 4 5 6 7 8 9 10

Please rate your energy on a scale from 1 to 10 (10 = most)

0 1 2 3 4 5 6 7 8 9 10

**Please answer Y = yes, N = no, or P = in the past**

Do You Exercise? Y N P

What Type? \_\_\_\_\_

How Often? \_\_\_\_\_

How Many Hours? \_\_\_\_\_

Do You Watch TV? Y N P Hours each day \_\_\_\_\_

Do You Read? Y N P Hours each day \_\_\_\_\_

Take regular vacations? Y N P

Date of last vacation \_\_\_\_\_

Do you have a religious or spiritual practice? Y N P

Describe \_\_\_\_\_

## Review of Symptoms

Please Circle All That Apply

Y = Current issue    N = never had    P = Past problem    S = Sometimes a problem

### General

Do you sleep well                    Y N P S  
 Do you wake rested                Y N P S  
 Average 6-8 hours sleep        Y N P S  
 Fatigue                                Y N P S  
 Enjoy your work                    Y N    S  
 Spend time outside                Y N    S  
 Do you eat three meals daily    Y N    S  
 Do you go on diets often?        Y N P S  
 Do you eat out often?            Y N P S  
 Use alcoholic beverages        Y N P S  
 How much \_\_\_\_\_  
 Been treated for alcoholism    Y N  
 Use tobacco                        Y N P S  
 How much \_\_\_\_\_  
 If in past, how many years \_\_\_\_\_  
 Use recreational drugs        Y N P S  
 Treated for drug dependence    Y N

### Skin

Rashes                                Y N P S  
 Itching                                Y N P S  
 Color Change                      Y N P S  
 Acne                                  Y N P S  
 Eczema                                Y N P S  
 Lumps                                 Y N P S  
 Hair Loss                            Y N P S  
 Other \_\_\_\_\_

### Head

Headaches                         Y N P S  
 Head Injury                        Y N P S  
 Jaw issues                         Y N P S  
 Other \_\_\_\_\_

### Neck

Lumps                                Y N P S  
 Swollen Glands                  Y N P S  
 Goiter                                Y N P S  
 Pain or Stiffness                Y N P S  
 Other \_\_\_\_\_

### Eyes

Impaired Vision                    Y N P S  
 Glasses or Contacts                Y N P S  
 Eye Pain                            Y N P S  
 Tearing                             Y N P S  
 Dryness                             Y N P S  
 Double Vision                      Y N P S  
 Glaucoma                          Y N P S  
 Cataracts                          Y N P S  
 Other \_\_\_\_\_

### Ears

Impaired hearing                  Y N P S  
 Ringing                            Y N P S  
 Earaches                          Y N P S  
 Dizziness                         Y N P S  
 Other \_\_\_\_\_

### Nose and Mouth

Frequent Colds                    Y N P S  
 Sore Tongue                        Y N P S  
 Hoarseness                        Y N P S  
 Gum Problems                      Y N P S  
 Tooth Problems                    Y N P S  
 Sinus Problems                    Y N P S  
 Other \_\_\_\_\_

### Respiratory

Cough                                Y N P S  
 Excess Sputum                    Y N P S  
 Spitting up Blood                Y N P S  
 Wheezing                          Y N P S  
 Asthma                              Y N P S  
 Bronchitis                        Y N P S  
 Pneumonia                        Y N P S  
 Pleurisy                            Y N P S  
 Emphysema                        Y N P S  
 Difficulty Breathing            Y N P S  
 Pain with Breathing            Y N P S  
 Shortness of Breath            Y N P S  
     Lying down                    Y N P S  
 Tuberculosis                      Y N P S

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**Cardiovascular**

High Blood Pressure Y N P S  
 Heart Disease Y N P S  
 Angina Y N P S  
 Chest Pain Y N P S  
 Murmurs Y N P S  
 Rheumatic Fever Y N P S  
 Swelling in ankles Y N P S  
 Palpitations, Fluttering Y N P S  
 Other \_\_\_\_\_

**Gastrointestinal**

Trouble Swallowing Y N P S  
 Heartburn Y N P S  
 Change in Thirst Y N P S  
 Change in Appetite Y N P S  
 Nausea Y N P S  
 Vomiting Y N P S  
 Vomiting Blood Y N P S  
 Bowel Movements  
     How frequent? \_\_\_\_\_  
     Is this a change Y N  
 Blood in Stool Y N P S  
 Belching or passing gas Y N P S  
 Jaundice (yellow skin) Y N P S  
 Liver Disease Y N P S  
 Gall Bladder Disease Y N P S  
 Ulcer Y N P S  
 Hemorrhoids Y N P S  
 Other \_\_\_\_\_

**Urinary**

Pain on Urination Y N P S  
 Increased Frequency Y N P S  
 Frequency at Night Y N P S  
 Inability to hold urine Y N P S  
 Frequent Infections Y N P S  
 Kidney Stones Y N P S  
 Other \_\_\_\_\_

**Sexual Orientation**

Heterosexual \_\_\_\_\_  
 Homosexual \_\_\_\_\_  
 Bisexual \_\_\_\_\_  
 Other \_\_\_\_\_

**Female Reproductive**

Age of 1<sup>st</sup> Menses \_\_\_\_\_  
 Last Menses (if menopausal) \_\_\_\_\_  
 Duration of Menses \_\_\_\_\_  
 Length of Cycle \_\_\_\_\_  
 Regular Cycles Y N S  
 Bleeding Between Periods Y N P S  
 Painful Menses Y N P S  
 Excessive Flow Y N P S  
 Vaginal problems Y N P S  
 PMS Symptoms Y N P S  
 Pain with Intercourse Y N P S  
 Menopausal Symptoms Y N P S  
 Currently Sexually Active Y N P S  
 Birth Control Y N S  
     What Type? \_\_\_\_\_  
 Sexual Difficulties Y N P S  
 Sexually Transmitted Disease Y N P S  
 Number of Pregnancies \_\_\_\_\_  
 Number of Live Births \_\_\_\_\_  
 Number of Miscarriages \_\_\_\_\_  
 Number of Abortions \_\_\_\_\_  
 Difficulty Conceiving Y N P S  
 Other \_\_\_\_\_

**Breasts**

Do You Self Examine Y N P S  
 Lumps Y N P S  
 Pain (or Tenderness) Y N P S  
 Nipple discharge Y N P S  
 Other \_\_\_\_\_

**Male Reproductive**

Hernias Y N P S  
 Testicular Masses Y N P S  
 Testicular Pain Y N P S  
 Penis problems Y N P S  
 Discharge or Sores Y N P S  
 Prostate Disease Y N P S  
 Currently Sexually Active Y N P S  
 Birth Control? Y N S  
     What Type? \_\_\_\_\_  
 Sexual Difficulties Y N P S  
 Premature Ejaculation Y N P S  
 Sexually Transmitted Disease Y N P S  
 Other \_\_\_\_\_

**Musculoskeletal**

Joint Pain or Stiffness Y N P S  
 Arthritis Y N P S  
 Broken Bones Y N P S  
 Muscle Spasms Y N P S  
 Weakness Y N P S  
 Sciatica Y N P S  
 Other \_\_\_\_\_

**Neurologic**

Fainting Y N P S  
 Seizures Y N P S  
 Paralysis Y N P S  
 Muscle Weakness Y N P S  
 Numbness/Tingling Y N P S  
 Loss of Memory Y N P S  
 Other \_\_\_\_\_

**Peripheral Vascular**

Deep Leg Pain Y N P S  
 Cold Hands and Feet Y N P S  
 Varicose Veins Y N P S  
 Thrombophlebitis Y N P S  
 Other \_\_\_\_\_

**Mental/Emotional**

Treated for emotional issue Y N P  
 Depression Y N P S  
 Mood Swings Y N P S  
 Anxiety Y N P S  
 Tension Y N P S  
 Easily Stressed Y N P S  
 Memory Problems Y N P S  
 Brain Fog Y N P S  
 Poor Concentration Y N P S  
 Other \_\_\_\_\_

**Endocrine**

Hypothyroid Y N P S  
 Heat/Cold Intolerance Y N P S  
 Excessive Thirst Y N P S  
 Excessive Hunger Y N P S  
 Other \_\_\_\_\_

**Blood**

Anemia Y N P S  
 Easy Bleeding or Bruising Y N P S  
 Previous Blood Transfusion Y N  
 Other \_\_\_\_\_

**Immune**

Reactions to immunizations Y N P S  
 Chronically swollen glands Y N P S  
 Slow wound healing Y N P S  
 Chronic fatigue syndrome Y N P S  
 Chronic infections Y N P S  
 Night sweats Y N P S

*\*Thank you for your time and  
 patience in filling out these forms.*

*\*Be sure to bring them along to your  
 visit, along with **any recent blood  
 work or relevant medical records.***

*\*I look forward to working with you  
 as together we make progress toward  
 a more healthy & optimal life...*

Yours in health,

Craig T. Fasullo, ND