Western North Carolina
NATUROPATHIC MEDICINE
Dr. Janet Opila-Lehman, ND

NEW ADULT INTAKE FORM

The following information helps me to understand your needs and how to help you reach your highest health goals. Please answer each question accurately and completely. Print all information and mark anything you have questions about.

Today's Date:_____
Client's Name:_____Phone: _____
Birthday: _____Age: _____ □ Female □ Male
Height: _____Weight: _____Weight 1 year ago: _____

Address: _____
Email: _____
Occupation: _____Employer: _____

If someone other than the client is responsible for payment, please complete the following:
Name of responsible party: _____
Relationship to patient: _____ Phone #: _____
Email: _____

Emergency Contact Person: _____ Phone: _____
Relationship: _____

When did you last go to a doctor's office, clinic, or hospital? What was the reason?
_____
Are you currently under any physician(s) care? □ Yes □ No
If yes, physician name(s): _____
For what condition(s)? _____

Last blood work? _____
X-rays, CT scans, MRI? _____
Other tests?_____

NATUROPATHIC HEALTH CARE SURVEY

On a scale of 0-10 (0-none, 10=lots) how familiar are you with naturopathic medicine? _____

What types of alternative treatment (ie Chinese Medicine, Herbs, Chiropractic, Massage, Homeopathy, etc.) have you used in the past? _____

CURRENT CONDITION

What is your most important goal for your first visit?

_____
_____

What are your other top health concerns?

1._____
2._____
3._____

Note any symptoms that are a concern to you in the following areas:
Head, Eyes, Ears: _____
Musculoskeletal: _____
Mood/Nerves: _____
Eating: _____
Digestion: _____
Skin: _____
Nails: _____
Respiratory: _____
Cardiovascular: _____
Urinary: _____
Genital: _____
Lymphatic: _____
Other: _____

MEDICAL HISTORY

Major illnesses (dates if known):

_____
_____

Surgeries (dates if known):

_____
_____

Accidents/Injuries (dates if known):

_____
_____

Immunizations (dates if known):

_____
_____

Hospitalizations (dates if known):

_____
_____

Glasses/Contacts: _____

Blood Type: ___A ___B ___AB ___O ___Rh+ ___Unknown

FEMALE HISTORY

_____Length of periods _____ Painful periods _____Heavy periods
_____Clotting _____ Other

Age at first period? _____Date of last menstrual period? _____
Hormonal Birth Control? _____Pills _____Nuva Ring _____Patch _____Other
Do you use contraception devices? _____Condom _____Diaphragm _____IUD _____Partner Vasectomy

_____Pregnancies _____ Deliveries _____ Miscarriages _____ Abortions
_____Living Children _____ Infertility _____Toxemia _____Gestational Diabetes
_____Breast Feeding _____How long _____Post Partum Depresssion

Hormonal Balance:
_____Fibrocystic Breasts _____Endometriosis_____ PMS _____Fibroids
_____Hysterectomy Do you still have your ovaries? ___Yes ___ N

Last Mammogram? _____ Normal? _____ Abnormal? _____
Breast Biopsy? _____ Normal? _____ Abnormal? _____
Last PAP smear? _____ Normal? _____ Abnormal? _____
Last Bone density test? _____ Normal ? _____ Abnormal? _____

Are you in Menopause? ___Yes ___No Age started menopause? _____Age ended? _____
_____Hot flashes _____Memory issues _____Decreased libido _____Joint Pain
_____Weight gain _____Palpitations _____Mood swings _____Vaginal dryness
_____Heavy bleeding _____Headaches _____Incontinence
Use of hormone replacement therapy? ___Yes ___No How long? _____

MALE HISTORY (men only)

Have you had a PSA done? ___ Yes ___ No Level: ___0-2 ___2-4 ___4-10 ___>10
_____ Prostrate enlargement
_____ Prostrate infection Concerns:
_____ Change in libido
_____ Impotence
_____ Difficulty obtaining an erection
_____ Nocturia (urination at night)
_____ Urgency/Hesitancy/Change in Urinary stream
_____ Loss of urine control

DENTAL HISTORY

Your last dental exam? _____
Do you have silver mercury fillings? ___Yes ___ No Do you floss regularly? ___Yes ___ No
_____Root canals
____ Implants Concerns:
_____Tooth pain
____ Bleeding gums
____ Gingivitis
_____Problems with chewing

MEDICATIONS/SUPPLEMENTS

Current Medications:

Medication	Dose	Frequency	Start Date (month/year)	Reason for Use

Nutritional Supplements (Vitamins, Minerals, Herbs, Homeopathy, Other)

Supplement/Brand	Dose	Frequency	Start Date (Month/year)	Reason for Use

Have your medications or supplements ever caused you side effects or problems? ___Yes ___ No
Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ___Yes ___No

Have you had prolonged or regular use of Tylenol? ___Yes ___ No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ___Yes ___No

Frequent antibiotics >3 times/year ___Yes ___No Long term antibiotics? ___ Yes ___ No

Use of steroids (prednisone, nasal allergy inhalers) in the past? ___Yes ___ No

Allergies to any drugs, chemicals? Your reactions?
_____
_____
_____

REVIEW of SYSTEMS			
Please mark "N" (Now) for any problems that you have now, "P" (Past) for problems you have resolved or experienced previously, and "F" (Family) if there is a significant family history such as parents, siblings, grandparents, aunts, uncles, and/or children. Please make notes including dates for specific diagnoses & family relation for family history below.			
NPF	NPF	NPF	NPF
□ □ □ Abnormal Pap smear □ □ □ Acne □ □ □ Allergies □ □ □ Anemia □ □ □ Anxiety □ □ □ Arthritis □ □ □ Asthma □ □ □ Birth defect □ □ □ Blood disease □ □ □ Blood in stool □ □ □ Breast disorders □ □ □ Bronchitis □ □ □ Cancer □ □ □ Cataracts □ □ □ Chest pain □ □ □ Colds, frequent □ □ □ Congestion □ □ □ Constipation □ □ □ Dental cavities □ □ □ Depression	□ □ □ Diabetes □ □ □ Diarrhea □ □ □ Difficulty breathing □ □ □ Diphtheria □ □ □ Drug/alcohol use □ □ □ Ear infections □ □ □ Eating disorder □ □ □ Eczema/psoriasis □ □ □ Epilepsy □ □ □ Eye pain □ □ □ Fatigue □ □ □ Fibromyalgia □ □ □ Frequency at night □ □ □ Gastrointestinal disease □ □ □ German measles (rubella) □ □ □ Glaucoma □ □ □ Gum problems □ □ □ Headaches/migraines □ □ □ Hearing loss □ □ □ Heart disease	□ □ □ Heartburn/reflux □ □ □ Hemorrhoids □ □ □Hepatitis/liver disease □ □ □ High blood pressure □ □ □ High cholesterol □ □ □ Hypoglycemia □ □ □ Infectious diseases □ □ □ Infertility □ □ □ Insomnia/sleep disorder □ □ □ Joint pain □ □ □ Kidney disease □ □ □ Lung disease □ □ □ Measles □ □ □ Menopause difficulties □ □ □ Menstrual disorder □ □ □ Mumps □ □ □ Muscle/joint pain □ □ □ Nausea/vomiting □ □ □ Neurological disorders □ □ □ Night sweats	□ □ □ Osteoporosis □ □ □ Pneumonia □ □ □ Prostate disease □ □ □ Rash □ □ □ Rheumatic/scarlet fever □ □ □ Seizures □ □ □ Sexual dysfunction □ □ □ Sexually transmitted disease □ □ □ Skin problems □ □ □ Spitting up blood □ □ □ Stroke □ □ □ Thyroid disease □ □ □ Tobacco use □ □ □ Tuberculosis □ □ □ Ulcer □ □ □ Urinary tract infection □ □ □ Vaginal infection □ □ □ Varicose veins/blood clots □ □ □ Vertigo/dizziness □ □ □ Other:_____

Notes:

_____

_____

_____

_____

LIFESTYLE

Hobbies/interests:_____

Exercise Activity	*Frequency/Week*	*Duration in minutes*
Stretching		
Cardio/Aerobics		
Strength Training		
Sports		
Other (yoga, pilates, etc)		

How would you rate your energy on a scale of 1-10? (0=least 10=most): _____
How would you rate your motivation to include exercise in your life? (1-10) _____
List any problems that limit your activity? _____

Sleep: Average # hours/night? _____How long to fall asleep?_____
Sleep Quality?_____Waking rested? _____
Major stressors affecting sleep?_____
Do you snore? _____Yes ____No Do you use any sleeping aids? ____Yes ____No

Currently smoking? ___Yes ___No How many years? _____ Packs per day? _____
Previous smoker? ___Yes ___No How many years? _____ Packs per day? _____

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits
_____None _____1-3 drinks _____4-6 _____7-10 _____ >10

Recreational drugs? _____ Yes _____No Which? _____
How often? _____

NUTRITION

Are you currently following a special diet or nutrition program? ___Yes ___No
Describe? _____
Check all that apply:
_____ Low fat _____ High protein _____ Diabetic _____ Gluten free _____ Dairy free
_____ Vegetarian _____ Vegan _____ Low carb _____ Low salt _____Other

Any food allergies? Which? _____
Describe your reactions? _____
Do you avoid any specific foods? ___Yes ___No Which? _____
Do you crave any specific foods? ___Yes ___No Which? _____
What would you like to change about the way you eat?
_____

DIET
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks:_____
Liquids:_____
Coffee cups/day: _____1 _____2-4 _____>4
Black tea cups/day: _____1 _____2-4 _____>4
Soda/day (12 oz): _____1 _____2-4 _____>4

Bowel movements/day? _____ Form? _____Color?_____
Diarrhea? _____ Constipation? _____ Do you feel you digest your food well? ___ Yes ___ No
Do you feel bloated after eating? ___Yes ___ No
Any recent foreign travel? ___ Yes ___ No Where? _____
Any wilderness camping? ___ Yes ___No Where? _____

ENVIRONMENTAL ASSESSMENT

Do any of these items negatively affect you?
_____ Monosodium glutamate (MSG) _____Aspartame (Nutrasweet) _____Caffeine _____Chocolate
_____ Bananas _____Garlic _____Onion _____Cheese _____Citrus foods _____ Preservatives
_____ Alcohol _____Red wine _____Sulfite foods (wine, dried fruit, shellfish)
_____ Other

Which of these negatively affect you?
_____ Cigarette smoke _____Perfumes/colognes _____Auto exhaust fumes _____Other

In your work environment are you exposed to:
_____ Chemicals _____Electromagnetic radiation _____ Mold

Have you ever had the following?
_____Yellow color (jaundiced) _____Gilbert's syndrome _____Liver disorder

Have you ever been knowingly exposed to?
_____ Herbicides _____Insecticides (frequent exterminators) _____Pesticides _____Organic solvents
_____ Heavy metals _____Other

How often do you wear dry cleaned clothes? _____Never _____1-3x/week _____3-5 _____>5

Have you ever lived in a damp or moldy environment? _____ Yes _____ No

Do you have any pets or farm animals? _____ Yes _____No

SOCIAL HISTORY

Psychosocial
How would you rate your vitality? (0=worse, 10=best) _____
Are you happy? _____ Yes _____ No
Do you feel your life has meaning and purpose? _____Yes _____No
Do you like the work you do? _____ Yes _____ No
Have you ever experienced major losses in your life? ____Yes ___No Describe: _____
How do you spend the majority of your time and money? _____
How would you describe your childhood? _____

Stress/Coping
How would you rate the amount of stress in your life? (0=none 10=extreme) _____
Do you feel able to cope with your stress? _____Yes _____ No
Daily stresses: _____Work _____ Family _____ Social _____Finances _____Health _____Other
Do you practice: _____Yoga _____Meditation _____Imagery _____Breathing _____Tai Chi
_____Prayer _____ Other
Have you ever sought out counseling? ____Yes _____No
Have you ever been abused, a victim of crime or experienced significant trauma? _____Yes ____No

Roles/Relationships
Marital Status: □ Single □ Married □ Partnered □ Divorced
With whom do you live? □ Spouse □ Parents □ Children □ Partner □ Friends □ Alone
Who are your resources for emotional support?
_____
Are you satisfied with your relationships? _____

Children	Gender	Age	Where living?
Grandchildren	How many?		

Religious/Spiritual belief (optional): _____

Please share any other information that you would like me to know about:
_____
_____
_____
_____

How did you hear about me?
_____

Thanks for taking the time to share this valuable about your life!

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