Western N.C. NATUROPATHIC MEDICINE

Dr. Janet OPILA-LEHMAN, ND.
966 Tunnel Rd, Asheville, NC. 28805
Ph: 828-424-0078 Fax: 828-298-4444
WA ND License: 60658783 NPI#: 1821298431
www.WNCNaturopathicMedicine.com

NATUROPATHIC PHYSICAL MEDICINE - INTAKE FORM

Thank you for taking the time to fill out this form as completely as possible before your or your child's visit.

Client's name: ____Date: ___________________

Address:____

City: ____ State:_______________ Zip: _______________

Email: ____

Telephone (Home):_________________________________ (Cell):___________________________________

Age: ______________________ Date of birth: _____________________ Gender: F M

Diagnosis: ___________________________Current height: ______Ft. ______Inches Weight: ________Lbs.

* *

If client is a child, please continue this section…

Mom's Name: ____

Daytime telephone: _________________________Email: ____

Dad's Name: ____

Daytime telephone: _________________________Email: ____

Parents are: Married ______ Divorced ______ Separated ______ Single ______

With whom does your child live? ____

Parents, how would you prefer to be contacted? home work email

May we leave a message? home work email

Child's school/daycare: ____

Siblings and ages: ____

Emergency contact:_____________________________________Relationship: ________________________

* *

Name of current Medical Provider: ____

Ok to contact? ___Yes ___ No Email: ___________________________Phone: ___________________________

Address? ____

When was your or your child's last visit to the doctor's office? __________What was the reason? ________________

CURRENT TREATMENTS

Type of Treatment	Service Provider or Clinician And Contact Information	How many hours per week is this treatment provided?	Start Date of Treatment	Do you feel that this treatment is beneficial? Please explain.
Special Education Placement			Start Date:	
Speech Therapy			Start Date:	
Occupational Therapy			Start Date:	
Physical Therapy			Start Date:	
ABA Program			Start Date:	
Neurofeedback			Start Date:	
Other:			Start Date:	

Tell me about yourself or your child…

Strengths:_____

What are your or your child's most important health concerns?

1)_____

2)_____

3)_____

4)_____

When did you first notice your or your child's problems? _____

What did you notice first?_____

Was the onset? _____ sudden _____ gradual

Was there any event or action that you think might have contributed to your or your child's symptoms?

_____

What are your goals pertaining to your or your child's health, both short- and long-term?

_____

_____

DEVELOPMENTAL HISTORY: Please describe each stage as - early, average or late.

1. Motor development (sitting, crawling, walking): _____

2. Speech and Language: _____

3. Self-help skills (dressing, brushing teeth, bathing, self-feeding): _____

4. Age of being Bowel trained: _____Age of being Bladder trained: _____

5. Handedness: _____Right _____ Left

6. Writing skills: ___ Good ___ Average ___ Poor

7. Athletic abilities (climbing, gymnastics, sports): ___ Good ___ Average ___ Poor

8. Do you or your child have an excess of accidents compared to other people? ___Yes ___ No

SCHOOL: Current grade in school: _____

1. Overall level of intelligence compared to others the same age? _____
2. School schedule? _____
3. Any know learning disabilities? _____
4. Do you or your child enjoy school? _____
5. Strengths? _____
6. Weaknesses? _____
7. Any issues at school? _____
8. Any extracurricular activities? List: _____
9. Does your child make friends easily? _____

MEDICAL HISTORY

Hospitalizations/surgeries/special tests

Please list any surgical procedures, hospitalizations, X-Rays, CAT scans, MRIs, EKGs, EEGs, hearing tests, vision tests, speech/language tests, or psychological evaluations your child has had done in the past couple years.

Test	*Date*	*Result*

Any blood/urine stool tests done? _____Yes _____ No (Please bring in copies of results)

MEDICATIONS/SUPPLEMENTS

***Current Medications**:*

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

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

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

Have medications or supplements ever caused side effects or problems? _____Yes _____ No
Describe: _____

Allergies

Are you or your child allergic or hypersensitive to any medications, supplements or environmental or chemical agents?

Describe: _____

Immunizations

MMR _____	DPT _____	Chicken pox _____	Small pox _____
Measles _____	Diphtheria _____	H. influenza _____	Hepatitis B _____
Mumps _____	Rubella _____	Tetanus _____	Polio _____
Pertussis_____	Other _____		

Adverse reactions? ___Yes ___No Describe:_____

HEALTH HISTORY (please check any that apply)

NOW	PAST		NOW	PAST	
_____	_____	Acne	_____	_____	Hearing loss
_____	_____	Allergies	_____	_____	Heart murmur
_____	_____	Anemia	_____	_____	Heat intolerant
_____	_____	Asthma	_____	_____	High fever
_____	_____	Bed wetting	_____	_____	Hives
_____	_____	Birth defects	_____	_____	Insomnia
_____	_____	Bleeding gums	_____	_____	Jaundice
_____	_____	Blood in stools	_____	_____	Joint pains
_____	_____	Calf Cramps	_____	_____	Learning disorder
_____	_____	Chicken pox	_____	_____	Measles
_____	_____	Chronic rashes	_____	_____	Mononucleosis
_____	_____	Colic	_____	_____	Mumps
_____	_____	Cold Hands/Feet	_____	_____	Nightmares
_____	_____	Congestion	_____	_____	Nosebleeds
_____	_____	Constipation	_____	_____	Numbness in arms/legs
_____	_____	Cough/Wheeze	_____	_____	Oily skin
_____	_____	Cradle cap	_____	_____	Pneumonia
_____	_____	Croup	_____	_____	Psoriasis
_____	_____	Depression	_____	_____	Rashes
_____	_____	Diarrhea	_____	_____	Rheumatic fever
_____	_____	Dizzy spells	_____	_____	Ringing in ears
_____	_____	Dry Skin	_____	_____	Rough skin
_____	_____	Earaches	_____	_____	Rubella
_____	_____	Ear infections	_____	_____	Scarlet fever
_____	_____	Easy bruising	_____	_____	Seizures
_____	_____	Eczema	_____	_____	Sore throats
_____	_____	Epilepsy/seizures	_____	_____	Stomachaches
_____	_____	Fatigue	_____	_____	Strep throat
_____	_____	Flat feet	_____	_____	Stuffy nose
_____	_____	Frequent colds	_____	_____	Thrush
_____	_____	Frequent fever	_____	_____	Tonsillitis
_____	_____	Frequent headaches	_____	_____	Tremors
_____	_____	Frequent urination	_____	_____	Urinary tract infections
_____	_____	Hair loss	_____	_____	Vomiting spells
_____	_____	Headaches	_____	_____	Wheezing
			_____	_____	Whooping cough
			Other: _____		

SIGNS & SYMPTOMS: (Please check any that apply)

NOW	PAST		NOW	PAST		NOW	PAST	
_____	_____	Aggressiveness	_____	_____	Anal Itching	_____	_____	Anxieties
_____	_____	Bad Breath	_____	_____	Blinking	_____	_____	Breath Holding

_____ _____ Dark Circles under Eyes _____ _____ Eating difficulties _____ _____Fidgeting

_____ _____ Food Cravings

_____ _____ Grinding Teeth _____ _____ Head Banging _____ _____ Hyperactive

_____ _____ Impulsiveness _____ _____ Itching _____ _____ Lack of Focus

_____ _____ Low Self-Esteem _____ _____ Mood Swings _____ _____ Nail Biting

_____ _____ OCD _____ _____ Poor Coordination _____ _____ Rocking

_____ _____ Reflux _____ _____ Self-Mutilation _____ _____ Sensitive to Crowds

_____ _____ Sensitive to Noises/Lights _____ _____ Sensory Processing difficulties

Skin-Picking _____ _____ Social Problems

_____ _____ Stiffness _____ _____ Strong Body Odor _____ _____ Tantrums

_____ _____ Tics _____ _____ Toe Walker _____ _____ White Spots on Nail

SENSORY SYSTEMS

(Please circle any issues that are you or your child experience/demonstrates.)

_____**Visual**: poor eye contact poor acuity visual perception issues
sensitive to lights responds better to lights: muted, bright
Last tested? _____

_____ **Hearing:** sensitive to noises covers ears music: soothes, aggravates
Last tested? _____

_____ **Vestibular** (balance system): often looses balance and falls clumsy dizzy

_____ **Proprioceptive/Touch**: sensitive to light or heavy touch irritated by clothes/sheets uses a weighted vest/blanket

_____ **Taste/Textures**: sensitive to _____ nausea & vomiting to _____
avoids foods _____ picky eater routine eater small or large appetite

MOTOR SYSTEMS

EXERCISE

Exercise Activity	*Frequency/Week*	*Duration in minutes*
Bike riding		
Swimming		
Dance		
Sports		
Other		

Hobbies/interests:_____
_____

ENERGY

How would you rate your or your child's focus/attention on a scale of 1-10? (0=least, 10=most): _____
How would you rate your or your child's activity level on a scale of 1-10? (0=none, 10=constant):_____
How would you rate your or your child's energy level during the day? (0=no energy, 10=overenergized): _____
List any problems that you think affect your or your child's energy: _____

SLEEP

Sleep: Average # hours/night? _____How long to fall asleep?_____
Waking during the night? ___Yes ___No How often? _____
Waking rested? _____
Do you have to be waken or wake your child in the morning? ___Yes ___No
Do your or your child snore? _____Yes ____No Do your or your child use any sleeping aids? ____Yes ____No

Please include any other information about your or your child that you would like to share:

_____
_____
_____
_____

Thanks for taking the time to share this valuable information.
Dr. Janet Opila-Lehman, ND