NEW
Natural Elite Wellness

NATUROPATHIC INTAKE FORM

PATIENT INFORMATION **DATE** _____

Last Name _____ **First Name** _____
Middle Initial _____**Gender** ☐ **M** ☐ **F** **Date of Birth** _____**Age** _____
Address_____**Zip code**_____
Home phone (____**)**_____ **Cell phone (**____**)**_____**Work phone (**___**)**_____
May we leave a message? ☐ **Y** ☐ **N** **Preferred phone** _____ **Email**_____
Marital Status: ☐ **Single** ☐ **Married** ☐ **Partner** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** **No. of Children:**___
Occupation: **How Long** **Employer**

How did you hear about us? _____

HEALTH COMPLAINTS (please list in order of importance to you):

Complaint	Duration	Cause

Are You Currently Under the Care of a Primary Care Physician (PCP), Medical Doctor (MD), or Other Health Care Practitioner (ND, DC, DO, etc)?

Name	For What Conditions?	Treatment?

What MEDICATIONS Are You Currently Taking? (please list prescription and over-the-counter drugs you are currently taking or have taken for extended periods):

Medication	Reason	Dose & Duration	Adverse Effects

List any allergies to medications:_____
Have you taken prolonged courses of antibiotics? ☐ **Y** ☐ **N**

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What SUPPLEMENTS Are You Currently Taking? (please list all vitamins, minerals, homeopathic remedies, botanicals, herbs, teas, etc.)

Supplement	Reason	Dose & Duration	Effect

List any allergies/sensitivities/adverse reactions to supplements: _____

_____

Please list any HOSPITALIZATIONS, SURGERIES, MAJOR ACCIDENTS, AND TRAUMATIC EVENTS (physical and/or emotional):

Event	Effect	Date

PAST DIAGNOSTIC PROCEDURES:

Procedure	Date	Reason	Results
Basic Blood Work (CBC, CMP)			
Urinalysis			
Thyroid (TSH, T3, T4)			
Cholesterol			
Vit D			
Mammogram			
Pap Smear			
Prostate/Rectal (PSA/DRE)			
Colonoscopy			
CT Scan, MRI			
X-ray, Ultrasound			
Vision			
Dental			
Other:			

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Which of the Following CONDITIONS Have You Had:

	Allergies		**Asthma**		**High cholesterol**		**Jaundice**		**Hormonal imb.**
	Anxiety		**Hay Fever**		**Frequent UTI**		**Hepatitis**		**Diabetes**
	Depression		**Mono**		**Kidney Stones**		**Gastritis**		**Leukemia**
	Bipolar		**Influenza**		**Incontinence**		**Gall Stones**		**Alcoholism**
	Migraine		**Cold Sores**		**Heartburn/GERD**		**Kidney disease**		**Tuberculosis**
	Ear infection		**Sinusitis**		**Ulcer**		**Gout**		**Skin Disease**
	Tonsillitis		**High BP**		**Constipation**		**Joint pain**		**Prostatitis**
	Strep Throat		**Low BP**		**Diarrhea**		**Joint stiffness**		**Cancer**
	Pneumonia		**Chest Pain**		**Chron's Disease**		**Arthritis**		**Parasites**
	Bronchitis		**Palpitation**		**UlcerativeColitis**		**MS**		**STD/STI**
	Cough		**Rheumatic fever**		**IBS**		**Hypothyroidism**		**Bleeding**
	Wheezing		**Stroke**		**Nausea/Vomit**		**Hyperthyroidism**		**Epilepsy**

FAMILY MEDICAL HISTORY: please list any ailments your blood relatives have had:

	Mother	**Father**	**Siblings**	**Grandparents**	**Aunts/Uncles**	**Children**
Age if living						
Age at death						
Ailments						

WOMEN ONLY:

Age of First Menses:_____Date of Last Menses:_____ Menses Are Regular: ☐ Y ☐ N
Currently Pregnant: ☐ Y ☐ N #of Pregnancies: _____#of Miscarriages_____#of Abortions_____
Difficulties Conceiving? ☐ Y ☐ N Difficult Pregnancies ☐ Y ☐ N_____
Have You Reached: ☐ Pre-Menopause ☐ Menopause ☐ Post-Menopause
Past/Current Use of Birth Control Pills? ☐ Y ☐ N Duration: _____Name:_____
Other Means of Contraception:_____
Difficult Menses? ☐ Y ☐ N If Yes, please explain:_____
_____
PMS? ☐ Y ☐ N If Yes, please explain:_____
_____
Recurrent Yeast Infections: ☐ Y ☐ N Treatment:_____
Recurrent Urinary Tract Infections: ☐ Y ☐ N Treatment:_____
Hormone Replacement Therapy: ☐ Y ☐ N Type: Duration:

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DIET and NUTRITION ASSESSMENT:

As accurately as possible, please list all food and drink consumed in the last 2 days:

MEAL	DAY 1	DAY 2
Breakfast		
Lunch		
Dinner		
Snacks/Dessert		
Drink		

LIFESTYLE

How Long Do You Sleep Each Night?_____ Difficulty with sleep? ☐ Y ☐ N

Predominant/Frequent Emotions: ☐ Angry ☐ Sad ☐ Anxious ☐ Moody ☐ Happy ☐ Content

Do You Smoke? ☐ Y ☐ N _____Pack(s)/Day for _____yrs. Use Recreational Drugs? ☐ Y ☐ N

Exercise Level: ☐ None ☐ Light ☐ Moderate ☐ Daily ☐ Heavy

Type_____ How long (min/day/week)_____

ENVIRONMENTAL

Please List any Environmental/Chemical Exposures and Reactions:

Substance	Exposure	Reaction
Solvents/Coolants/Fumes		
New Paint, Carpet, Asbestos		
Second-hand Smoke		
Cleaning Agents/Perfumes		
Radiation		
Detergents/Dry cleaning		
Mold		
Pollen/Ragweed/Trees		

How can I best be of service to you? Do you have any special requests or goals in regards to your treatment that I should know of? _____

_____

_____

I, _____Certify that the above information is true and accurate to the best of my knowledge. I understand that any false health information or withholding of health information can be detrimental to my health and I hold no liability against Dr. Simona Ciobanu, ND.

<u>Notice of Pregnancy</u>: It is my understanding that if I know or suspect I may be pregnant, I will notify the doctor immediately as some natural therapies may present a risk to the pregnancy.

_____ _____

Patient or Responsible Party Signature Simona Ciobanu, ND

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