ROOTS FOR HEALTH
NATUROPATHIC MEDICINE

Patient Intake Form

Patient Name: ______________________________________ DOB: ______________

Healthcare Team

Present Primary Care Provider (Name, Credentials, Phone):
____

Other Healthcare Providers:
____

Last Physical Exam: Date: _____________ Doctor: ___________________________________
Last Blood Work: Date: _____________ Doctor: ___________________________________

Present Health Concerns

What is the main reason for your visit today? Please describe in detail, including the date of onset and any factors that may have contributed to its onset or continuation.
____
____
____

Is this concern getting: ☐ Better ☐ Worse ☐ Same

List types of treatments (including home care) and who treated you for this condition:
____
____
____

List other health concerns and dates of onset in order of importance:
1.____ 2.____
3.____ 4.____
5.____ 6.____
7.____ 8.____

Past Medical History

General childhood health: ☐ Good ☐ Fair ☐ Poor

Childhood Illnesses:
☐ Scarlet Fever ☐ Rheumatic Fever ☐ German Measles ☐ Chicken Pox
☐ Whooping Cough ☐ Diphtheria ☐ Asthma ☐ Mumps
☐ Mono ☐ Other: ____

Hospitalizations and Surgeries (type, year):
____
____

Serious Illnesses and Injuries (type, cause, year):
____
____

List Medications (prescription, non-prescription and supplements, including dosages):
1.____ 2.____
3.____ 4.____
5.____ 6.____

Known Allergies:
Drugs: ___________________________________ Foods: _____________________________________
Animals: _________________________________ Other: _____________________________________

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Past Medical History (cont.)

Current	Past		Current	Past	
☐	☐	Allergies	☐	☐	Stroke
☐	☐	Arthritis	☐	☐	Ulcers
☐	☐	Gout	☐	☐	Herpes
☐	☐	Alcoholism	☐	☐	Candida
☐	☐	Bleeding Disorder	☐	☐	Rheumatism
☐	☐	Cancer	☐	☐	Hypoglycemia
☐	☐	Heart murmur	☐	☐	Sinus Problems
☐	☐	Asthma	☐	☐	High Blood Pressure
☐	☐	Kidney Disease	☐	☐	Pneumonia
☐	☐	Liver Disease	☐	☐	Thyroid Problems
☐	☐	Diabetes	☐	☐	Tonsillitis
☐	☐	Anemia	☐	☐	HIV/AIDS
☐	☐	Hepatitis	☐	☐	Tuberculosis
☐	☐	Eczema	☐	☐	Venereal Disease

Family Health History

☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Bleeding Disorder ☐ Seizures ☐ Allergies ☐ Sickle Cell Anemia
☐ Asthma ☐ Osteoporosis ☐ Stroke ☐ Congenital Heart Defects

Lifestyle and Habits

Rank each on a scale of 1 to 10 (10 being optimal):

Energy: ______ Nutrition: ______ Digestion: ______ Sleep: ______ Exercise: ______
Weight: ______ Work: ______ Family: ______ Well-Being: ______

How many hours a day do you:

Sleep: ______ Relax: ________ *In what way?* ______________________________
Work: ______ Exercise: ______ *In what way?* ______________________________

Do you smoke? ☐ Yes ☐ No
Have you ever smoked? ☐ Yes ☐ No
If yes, for how long? ____________________ *How much per day?* ____________________
Do you use recreational or illicit drugs? ☐ Yes ☐ No
If yes, what type? ____________________ *How often?* ____________________
How much coffee, tea or soda do you drink per day? ____________ Per week? ____________
How much alcohol do you drink per day? ____________ Per week? ____________

Nutrition

Number of meals per day: ____________________
Foods restricted from diet, and for how long?
____
____
Describe any bad reactions you get from food:
____
____

Do you crave: Sugar? ☐ Yes ☐ No Starches? ☐ Yes ☐ No
Chocolate? ☐ Yes ☐ No Salt? ☐ Yes ☐ No
Fatty foods? ☐ Yes ☐ No Other: ______________________________
How much water do you drink per day? ____________________ Is it filtered? ☐ Yes ☐ No

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Review of Systems

Please indicate symptoms that you have experienced in the last six months, or that have recurred throughout your life.

General
☐ Weight Change
☐ Fever/Chills
☐ Weakness
☐ Fatigue
☐ Sweating/Night Sweats
☐ Fainting
☐ Dizziness
☐ Forgetfulness
☐ Hair/Nail Changes

Skin
☐ Itching
☐ Rashes
☐ Bruise Easily
☐ Hives
☐ Athlete's Foot
☐ Eczema/Psoriasis
☐ Change in Moles
☐ Sores that Won't Heal

Muscle/Joint/Bone
☐ Pain
☐ Numbness
☐ Swelling
☐ Bursitis/Tendonitis
☐ Broken Bones
☐ Sprains/Strains
☐ Spasms/Cramps
☐ Headaches/Head Injuries
☐ Low Back, Hip, Leg Pain
☐ Neck/Shoulder/Arm Pain
☐ Jaw Pain/TMJ
☐ Arthritis

Eyes
☐ Glasses/Contacts
☐ Blurring
☐ Pain
☐ Double Vision
☐ Discharge
☐ Floaters
☐ Glaucoma
☐ Cataracts

Ears
☐ Ringing
☐ Earache/Discharge
☐ Loss of Hearing

Nose
☐ Sinusitis
☐ Bleeding
☐ Discharge
☐ Obstruction
☐ Postnasal Drip
☐ Nasal Polyps

Mouth/Throat
☐ Sores
☐ Bleeding Gums
☐ Teeth
☐ Hoarseness
☐ Difficulty Swallowing
☐ Taste

Pulmonary
☐ Shortness of Breath
☐ Wheezing
☐ Chronic Cough
☐ Coughing Blood
☐ Sputum

Cardiovascular
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Irregular Heartbeat
☐ Murmurs
☐ Calf Pain with Walking
☐ Edema
☐ Palpitations
☐ Chest Pain
☐ Varicose Veins

Gastrointestinal
☐ Poor Appetite
☐ Constipation/Diarrhea
☐ Indigestion/Heartburn
☐ Gas/Bloating
☐ Bowel Changes
☐ Excessive Hunger
☐ Excessive Thirst
☐ Nausea/Vomiting
☐ Hemorrhoids
☐ Blood in Stool
☐ Hernia
☐ Anal Discomfort

Genitourinary
☐ Low Back Pain
☐ Painful Urination
☐ Blood in Urine
☐ Frequent/Urgent Urination
☐ Loss of Bladder Control
☐ Nighttime Urination
☐ Recurrent Infections

Male Only
☐ Breast Lumps
☐ Erection Difficulties
☐ Lump/Pain in Testicles
☐ Penis Discharge
☐ Sores on Penis
☐ Infertility

Sexual History
☐ Syphilis
☐ Gonorrhea
☐ Chlamydia
☐ Sores/Discharge
☐ Herpes
☐ Sexual/Physical Abuse

Female Only
☐ Breast Lumps
☐ Nipple Discharge
☐ Bleeding after Menopause
☐ Hot Flashes
☐ Painful Intercourse
☐ Hysterectomy
☐ Infertility
☐ Miscarriage
☐ Fibroids
☐ Vaginal Infections
☐ Abnormal PAP Smears
☐ LMP ________

Endocrine
☐ Goiter
☐ Heat/Cold Intolerance
☐ Excessive Thirst/Hunger
☐ Hormone Therapy

Allergies
☐ Drug/Vaccination Allergy
☐ Asthma
☐ Eczema
☐ Rhinitis
☐ Hay Fever
☐ Hives
☐ Post-Nasal Drip
☐ Itchy/Watery Nose/Eyes

Blood/Lymph
☐ Anemia
☐ Transfusions
☐ Bleeding Tendency
☐ Lymph Node Enlargement
☐ Lymph Node Pain

Neurological
☐ Fainting
☐ Convulsions
☐ Sensations
☐ Gait/Coordination
☐ Speech
☐ Numbness/Tingling
☐ Paralysis/Weakness

Psychological
☐ Memory Loss
☐ Mood
☐ Sleep Pattern
☐ Anxiety/Depression
☐ Phobias
☐ Drug/Alcohol Abuse

Other
☐ ____________
☐ ____________
☐ ____________
☐ ____________
☐ ____________