

# Well-Natured Naturopathic Care, LLC

21332 Provincial Blvd.  
Katy, TX 77450  
phone: 281-650-0405; fax 978-359-0405

## New Patient Intake Form

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
(Last) (First) (MI)

Date of Birth: \_\_\_\_\_ Sex: M\_\_\_\_ F\_\_\_\_ Blood Type: \_\_\_\_\_ (+ or -)

### Contact Information

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

How do you prefer to be contacted? Home Work Cell E-mail

May we leave a message? Home Work Cell E-mail

Emergency contact: \_\_\_\_\_  
(Name, relationship, day & evening telephone)

How did you hear about our clinic? \_\_\_\_\_

### Your Healthcare Providers

Primary Care Physician: \_\_\_\_\_  
(Name & Address)

Date of Last Physical Exam: \_\_\_\_\_  
(Month & Year)

Screening Test/Evaluation	Date of Most Recent
Cholesterol test	
Breast exam & self care	
Mammogram/Ultrasound	
Pelvic Exam/Pap test	
Prostate	
Colorectal Exam	
Urinalysis	
Hearing Evaluation	
Vision Test/Eye Exam	
Routine bloodwork/screen	
Other	

Are you currently under the care of a specialist? Yes No

1) \_\_\_\_\_  
(Name/Specialty/Address)

2) \_\_\_\_\_  
(Name/Specialty /Address)

3) \_\_\_\_\_  
(Name/Specialty/Address)



### Allergies/Adverse Reactions to Medications & Substances

Please describe any adverse or allergic reactions that you have had to any of the following: prescription drugs, over-the-counter-medications, recreational drugs, vaccinations, herbs, vitamins, minerals or homeopathics

Name of substance	Describe the reaction

### Environmental/Food Allergies & Sensitivities (food, pollen, mold, animals, chemicals)

Name of allergen	Describe the reaction

Please check box at right if you have ever been treated with or used any of the following:

Antibiotics for > 2 weeks	<input type="checkbox"/>	Antacids	<input type="checkbox"/>
Cortisone/other steroids	<input type="checkbox"/>	Chemotherapy/radiation	<input type="checkbox"/>
Antihistamines	<input type="checkbox"/>	Pain relievers	<input type="checkbox"/>
Arthritis drugs (Vioxx, Celebrex)	<input type="checkbox"/>	Hormone therapy	<input type="checkbox"/>
Thyroid medication	<input type="checkbox"/>	Recreational drugs	<input type="checkbox"/>
Laxatives/stool softeners	<input type="checkbox"/>	Blood thinners	<input type="checkbox"/>
Anti-depressants	<input type="checkbox"/>	Stimulants	<input type="checkbox"/>
Flu vaccine	<input type="checkbox"/>	Diuretics	<input type="checkbox"/>
Vaccine for foreign travel	<input type="checkbox"/>	Anesthesia	<input type="checkbox"/>
Sleeping pills/sedatives	<input type="checkbox"/>	Epidural	<input type="checkbox"/>

### Toxin Exposure

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes, or other toxic substances at home, at work, or while traveling?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced health problems after putting down new carpeting, painting your home, doing renovations, or having your lawn sprayed?	<input type="checkbox"/>	<input type="checkbox"/>
Are you particularly sensitive to perfume, gasoline, or other vapors?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever lived near a refinery or polluted area?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever lived in a home more than 50 years old?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have mercury dental fillings?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any dental root canal procedures?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any surgical implants or prosthesis (cosmetic or medical)	<input type="checkbox"/>	<input type="checkbox"/>
Do you live near power lines?	<input type="checkbox"/>	<input type="checkbox"/>

### Surgeries

Procedure	Year	Any complications?

### Hospitalizations/Major Injuries or Trauma

Reason/Injury	Year	Outcome

## Family History

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (good, avg. poor)	_____	_____	_____	_____	_____	_____
Deceased age	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____
<b>Check those applicable:</b>						
Allergies	_____	_____	_____	_____	_____	_____
Alcohol/drug abuse	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Arthritis (OA/RA)	_____	_____	_____	_____	_____	_____
Autoimmune Dz.	_____	_____	_____	_____	_____	_____
Alzheimer's Dz	_____	_____	_____	_____	_____	_____
Cancer (specify type)	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Thyroid Condition	_____	_____	_____	_____	_____	_____
Skin Conditions	_____	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____	_____
Neurological disease	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Syphilis	_____	_____	_____	_____	_____	_____
Gonorrhea	_____	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____	_____
Gout	_____	_____	_____	_____	_____	_____
Other (specify)	_____	_____	_____	_____	_____	_____

## Past Medical History *(Please check if you have had any of the following childhood illnesses)*

_____ Chickenpox	_____ Coxsackie	_____ Diphtheria	_____ Fifth's	_____ Measles
_____ German measles	_____ Mono	_____ Mumps	_____ Polio	_____ Rheumatic Fever
_____ Rotovirus	_____ Smallpox	_____ Typhoid	_____ TB	_____ Whooping Cough

## Medical Conditions *(for any of the following, please mark {P} for past or {C} for current)*

_____ Allergies	_____ Lung Disease
_____ Anemia	_____ Mononucleosis
_____ Asthma	_____ Pneumonia
_____ Autoimmune	_____ Seizures
_____ Cancer	_____ Substance Abuse
_____ Canker sores	_____ Stroke
_____ Chronic fatigue	_____ Syphilis
_____ Chronic infections	_____ Tonsillitis
_____ Depression	_____ Ulcers
_____ Anxiety	_____ Venereal diseases/STDs
_____ Diabetes	_____ Significant weight changes
_____ Ear infections	_____ Joint Problems
_____ Eating Disorder	_____ Other (please describe)
_____ Eczema	
_____ Fracture	
_____ Glaucoma	
_____ Heart Disease	

- Herpes
- Hepatitis
- High Blood Pressure
- HIV +/-AIDS
- Irritable Bowel Syndrome

**Current Health Factors**

Which best describes your general state of health:  Excellent  Good  Average  Fair  Poor

What time of day do you feel most energetic? \_\_\_\_\_ least energetic? \_\_\_\_\_

List 5 important events in your life from most recent to the most distant.

- 1) \_\_\_\_\_ Date: \_\_\_\_\_
- 2) \_\_\_\_\_ Date: \_\_\_\_\_
- 3) \_\_\_\_\_ Date: \_\_\_\_\_
- 4) \_\_\_\_\_ Date: \_\_\_\_\_
- 5) \_\_\_\_\_ Date: \_\_\_\_\_

Which of these events has affected you most and why? \_\_\_\_\_

Rate your current stress level with each of the following (1 = least stressful and 10 = most stressful)

- Family  Spirituality  Other relationships
- Work/School  Physical health  Sense of self-fulfillment/purpose
- Love relationship  Mental health

Are you currently under the care of a professional counselor, social worker, psychologist, religious counselor, or other type of therapist? Yes No

**Review of Systems**

Please check space to the left if you have experienced or are currently experiencing any of the following. Please mark (P) for past and (C) for current.

**Mental/Emotional**

- Abuse  Memory problems
- Anxiety/nervousness  Mental illness
- Depression  Mood swings
- Easily angered  Panic attacks
- Indecision  Phobias
- Irritability  Prolonged sadness or grief

Has there been an event or illness that you have never fully recovered from?

**Endocrine System**

- Significant change in weight  Generally feel hot
- Sluggish after eating  Generally feel cold
- Poor concentration  Hypoglycemia (low blood sugar)
- Sluggish after coffee/stimulants  Mental dullness

Rate your energy level (1= extreme fatigue, 10 = abundant energy) \_\_\_\_\_

Rate your stress level (1= relaxed, 10 = extremely stressed) \_\_\_\_\_

How many hours of sleep do you get per night, on average? \_\_\_\_\_

Do you wake feeling rested? \_\_\_\_\_

**Immune System**

- Chronic infections  Cold sores  Slow wound healing
- Frequent use of antibiotics  Swollen glands or lymph nodes  Frequent sore throat
- Frequent colds/flu  Shingles

**Neurologic**

- Paralysis  Tingling/pins & needles  Vertigo/dizziness
- Numbness  Loss of memory
- Muscle weakness  Loss of balance

**Skin, Hair & Nails**

- Rashes
- Lumps or abscesses
- Dry skin
- Hair loss
- Itching
- Excessive sweating
- Hair loss
- Night Sweats
- Hair loss
- Change in skin color
- Change in size, shape, or color of mole or freckle
- Brittle nails
- Night sweats
- Strong body odor
- Warts

Do you have a history of severe sunburns/frequent tanning? \_\_\_\_\_

**Head, Ears, Eyes, Nose, & Throat**

- Headaches
- Cataracts
- Nose bleeds
- Gum disease
- Night blindness
- Loss of smell
- Migraine
- Visual disturbances
- Ringing in ears
- Poor sense of smell
- Hoarseness
- Itchy ear canal
- Far-sightedness
- Near-sightedness
- Jaw pain/clicking
- Excessive tearing
- Earaches
- Post-nasal drip
- Teeth grinding
- Runny nose
- Dry eyes
- Impaired hearing

**Respiratory System**

- Chronic cough
- Shortness of breath when lying down
- Pain while breathing
- Chronic phlegm
- Coughing up blood
- Shortness of breath during the day
- Wheezing

**Cardiovascular System**

- Chest pain
- Hemorrhoids
- Dizzy when standing up quickly
- Varicose veins
- Fainting
- Heart palpitations
- Easy bruising or bleeding
- Heart murmurs
- Cold hands & feet
- Socks leave an imprint on your ankles
- Heaviness or pain in the legs

**Gastrointestinal System**

- Trouble swallowing
- Nausea
- Blood in stool or on tissue
- Constipation
- Stool floats in bowl
- Hard stool
- Heartburn
- Bloating
- Diarrhea/loose stool
- Itching around rectum
- Grey stool
- Change in thirst
- Gas
- Stomach cramps or pain
- Black stool
- Mucous in stool
- Undigested food in stool
- Burping

**Bowel Movement Habits:**

- Frequency (how often):  Every day  Every other day  Every week
- Color:  Dark  Brown  Green  Yellow  White  Gray
- Consistency:  Soft  Hard  Watery
- Other:  Mucus  Blood (circle: bright or dark)  Strong Odor

Have you ever traveled to a third-world country? \_\_\_\_\_

Have you ever had a parasite that you are aware of? \_\_\_\_\_

**Urological System**

- Pain on urination
- Frequent bladder infections
- Strong urine odor
- Kidney stones
- Inability to hold urine
- Kidney infections
- Awaken to urinate
- Must strain to urinate
- Pain on urination
- Increased frequency

**Male Reproductive**

- Hernia
- Discharge or sores
- Low sex drive
- Testicular mass
- Testicular pain
- Prostate condition
- Sexual difficulty
- Impotence

What is your sexual orientation?:  heterosexual  homosexual  bisexual

Are you sexually active? \_\_\_\_\_

Do you practice protected sex? \_\_\_\_\_

When was your last prostate exam? \_\_\_\_\_

**Female Reproductive**

Age of first menses \_\_\_\_\_

Age of last menses \_\_\_\_\_

How long is your cycle (in days)? \_\_\_\_\_

How would you describe your menstrual flow? \_\_\_ normal \_\_\_ light \_\_\_ heavy  
Do you use tampons? \_\_\_\_\_

How many days is your menses? \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_  
Are you currently pregnant? \_\_\_\_\_  
Are you trying to conceive? \_\_\_\_\_

What type of birth control do you use (if any)? \_\_\_\_\_  
What is your sexual orientation?: \_\_\_ heterosexual \_\_\_ homosexual \_\_\_ bisexual  
Are you sexually active? \_\_\_\_\_  
Do you practice protected sex? \_\_\_\_\_

### Gynecological Health

___ Excessive discharge	___ Abnormal pap tests	___ Pain during intercourse
___ Itching	___ Sexual difficulties	___ Menopausal symptoms
___ Abdominal pain mid-cycle	___ Sores, growths, lumps	___ Low sex drive
___ Vaginal dryness	___ Odor	___ History of miscarriages
		___ History of abortion

### Pre-menstrual and Menstrual Symptoms

___ Pain or cramping	___ Irregular cycles	___ Heavy flow
___ Flow more than 5 days	___ Flow less than 5 days	___ Light flow
___ Diarrhea	___ Bloating	___ Bleeding between periods
___ Water retention	___ Breast tenderness	___ Cravings
___ Clotting	___ Missed periods	___ Mood swings
___ Headaches	___ Low back ache	

### Breast Health

___ Fibrocystic breasts	___ Nipple discharge	___ Flaky dry skin on the nipple
___ Puckering of skin	___ Tenderness	___ Breast lump or mass

Do you perform monthly self-breast exams? Yes No  
When was your last breast exam? \_\_\_\_\_  
Do you have regular mammograms? \_\_\_\_\_  
Do you have a family history of breast cancer? \_\_\_\_\_

### Lifestyle

Have you ever been a smoker? If yes, how many packs per day and for how long?  
\_\_\_\_\_

Do you currently smoke? Yes No  
Are you exposed to or do you have a history of exposure to secondhand smoke?  
\_\_\_\_\_

How often do you drink alcohol and how much do you drink?  
\_\_\_\_\_

Do you currently use recreational drugs?  
\_\_\_\_\_

Any history of recreational drug use? \_\_\_\_\_

How often do you exercise? \_\_\_\_\_  
What type of exercise do you do? \_\_\_\_\_

What do you do to relax? \_\_\_\_\_  
Do you feel like you have a strong social support network? \_\_\_\_\_  
Describe your living situation \_\_\_\_\_  
Do you have any pets? \_\_\_\_\_  
Do you feel safe at home? Yes No  
Do you have a history of physical or sexual abuse? Yes No  
Do you have a spiritual practice? \_\_\_\_\_

### Diet

What type of water do you drink? \_\_\_\_\_  
How much water do you drink per day? \_\_\_\_\_

How many times per week do you eat dairy products? \_\_\_\_\_  
How many times per week do you eat red meat? \_\_\_\_\_  
How many times per week do you eat fish? \_\_\_\_\_  
How many times per week do you eat poultry? \_\_\_\_\_  
How many times per week do you eat fruit? \_\_\_\_\_  
How many times per week do you eat vegetables? \_\_\_\_\_

Do you eat organic food? Yes      No  
How often do you eat out? \_\_\_\_\_  
What foods do you crave? \_\_\_\_\_

How many sodas, coffees, and teas do you drink per week? \_\_\_\_\_  
Do you eat smoked foods? Yes      No  
Do you have any dietary restrictions? (vegetarian, vegan, religious, or  
allergy) \_\_\_\_\_

**Other**

How does your general state of health affect you? \_\_\_\_\_  
What do you feel needs to happen for you to get better?  
\_\_\_\_\_

What do you enjoy most in your life?  
\_\_\_\_\_

How much change are you willing to make at this time for improving your health?  
MINIMAL      SOME      COMPLETE

Is there any information about your health that you would like to add?  
\_\_\_\_\_

Thank you for taking the time to fill this out. We look forward to meeting you!