HAMPTONS NATUROPATHIC

17 Main Street, #5
PO Box 1002
Sag Harbor, NY 11963
Phone 631-353-2316/Fax 631-725-5618

ADULT INTAKE

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: (home) _____ (cell) _____ (work) _____

Email: _____ Skype name: _____

Age: _____ Date of Birth: _____ Gender: F/M/Other Education:_____

Single: ___ Married: ___ Separated: __ Divorced: ___ Widowed: ___ Partnered: _____

Live with: Spouse: ___ Partner: ____ Parents: ___ Children: ___ Alone: ___ Other:___

Occupation: _____ How long:_____

Employer: _____

Emergency Contact: _____

Relationship:_____ Phone: _____

How did you hear about us? Referral (name): _____

Google/Facebook/Flyer/Public Health talk/ND website/ Other_____

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CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient, mentally, physically and emotionally. Your time, thoughtfulness and honesty in completing this review will greatly aid me in both assessing and assisting your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What *three* expectations do you have from working with our clinic?

What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to addressing any underlying causes of your illness that relate to your lifestyle? (10 is 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you in the beneficial lifestyle changes you will be making?

What do you love to do?

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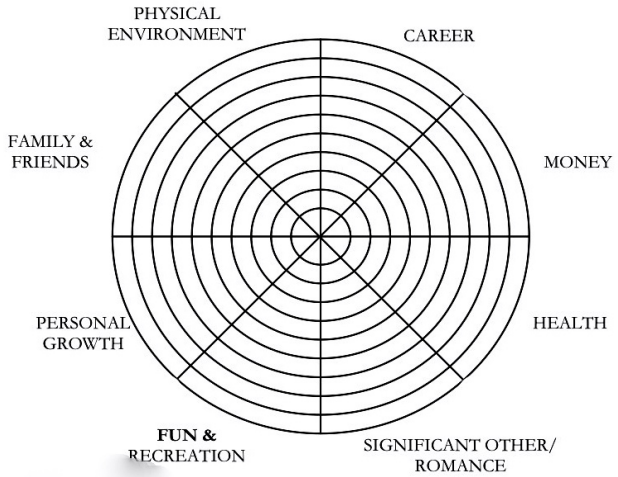
WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied with your career, shade the first six levels of the career slice.

Do the same for each area, staring from the center point radiating outward.



Are you currently receiving healthcare? Yes/No

If yes, where and from whom? _____

If no, when and where did you last receive medical or health care? _____

_____ _____

What was the reason? _____

What are your most important health problems? List as many as you can, in order of importance:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

Do you have any known contagious diseases at this time? Yes/No

If yes, what? _____

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FAMILY HISTORY

Do you or anyone in your family have a history or any of the following? (please circle and say who)

Cancer	Diabetes	Arthritis	Mental Illness
Kidney disease	Epilepsy	Anemia	Lyme Disease
Tuberculosis	Stroke	Hives	
Asthma	Hay Fever	High Blood Pressure	
Glaucoma	Heart Disease	Autism Spectrum	

Any other relevant family history? _____

What is your family heritage? _____

CHILDHOOD ILLNESSES

Please circle whether you had any of the following as a child:

Rheumatic fever	Diptheria	Measles	Scarlet Fever	Mumps
Chicken Pox	Eczema	Allergies	German Measles	

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____year_____ _____year_____

_____year_____ _____year_____

_____year_____ _____year_____

ALLERGIES

Are you hypersensitive or allergic to: If so, what are your reactions? Please indicate: Mild/Moderate/Severe

Any drugs? _____

Any foods? _____

Any environmental or chemicals?_____

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CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives	Antibiotics	Birth Control Pills	Antacids
Tranquilizers	Sleeping Pills	Hormone Replacement	Cortizone
Thyroid Medication	Pain relievers		

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking **including dosage and strength**:

1.)_____ 5.)_____

2.)_____ 6.)_____

3.)_____ 7.)_____

4.)_____ 8.)_____

GENERAL

Height:_____ Weight:_____ Weight one year ago:_____

Maximum Weight:_____ When:_____

When during the day is your energy the best? _____ Worst?_____

Main interests and hobbies:_____

Exercise: Y / N If so, what kind and how often:_____

Watch TV: Y / N If so, how many hours?_____ Read: Y / N Hours? _____

Do you have a spiritual practice? Y / N If so, what kind?_____

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FOR THE FOLLOWING, PLEASE CIRCLE:

Y=yes/condition you have now **N**= no/never had **P**= problem in the past **S**= sometimes a problem now

GENERAL

Do you sleep well?	Y	N	P	S
Average 6-8 hours?	Y	N	P	S
Awake rested?	Y	N	P	S
Have a supportive relationship?	Y	N	P	S
Have a history of abuse?	Y	N	P	S
Experienced a major trauma?	Y	N	P	S
Use recreational drugs?	Y	N	P	S
Treated for drug dependence?	Y	N	P	S
Use alcoholic beverages?	Y	N	P	S
If yes, how many drinks per week _____				
Use tobacco?	Y	N	P	S
If in the past, how many years? _____				
How many packs per day? _____				
Do you enjoy your work?	Y	N	P	S
Take vacations?	Y	N	P	S
Spend time outside?	Y	N	P	S
Eat three meals a day?	Y	N	P	S
Do you go on diets often?	Y	N	P	S
Do you eat out often?	Y	N	P	S
Do you drink coffee?	Y	N	P	S
Drink black/ green tea?	Y	N	P	S
Drink soda?	Y	N	P	S
Do you eat refined sugar?	Y	N	P	S
Do you add salt to your food?	Y	N	P	S

NEUROLOGIC

Seizures?	Y	N	P	S
Muscle weakness?	Y	N	P	S
Loss of memory?	Y	N	P	S
Vertigo or dizziness?	Y	N	P	S
Paralysis?	Y	N	P	S
Numbness or tingling?	Y	N	P	S
Easily stressed?	Y	N	P	S
Loss of balance?	Y	N	P	S

ENDOCRINE

Hypothyroid?	Y	N	P	S
Hypoglycemia?	Y	N	P	S

ENDOCRINE, CONT.

Excessive thirst?	Y	N	P	S
Fatigue?	Y	N	P	S
Heat or cold intolerance?	Y	N	P	S
Hyperthyroid?	Y	N	P	S
Diabetes?	Y	N	P	S
Excessive hunger?	Y	N	P	S
Seasonal depression?	Y	N	P	S
Difficulty exercising?	Y	N	P	S

IMMUNE

Reactions to immunizations?	Y	N	P	S
Chronically swollen glands?	Y	N	P	S
Slow wound healing?	Y	N	P	S
Chronic fatigue syndrome?	Y	N	P	S
Chronic infections?	Y	N	P	S
Night sweats?	Y	N	P	S

EARS

Impaired hearing?	Y	N	P	S
Ringing in ears?	Y	N	P	S
Dizziness?	Y	N	P	S
Ear aches?	Y	N	P	S

EYES

Impaired vision?	Y	N	P	S
Cataracts?	Y	N	P	S
Glaucoma?	Y	N	P	S
Spots in vision?	Y	N	P	S
Color blindness?	Y	N	P	S
Tearing or dryness?	Y	N	P	S
Eye pain or strain?	Y	N	P	S

HEAD

Headaches?	Y	N	P	S
Migraines?	Y	N	P	S
Head injury?	Y	N	P	S
Jaw or TMJ problems?	Y	N	P	S

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NOSE AND SINUS

Frequent colds?	Y	N	P	S
Stuffiness?	Y	N	P	S
Sinus problems?	Y	N	P	S
Nose bleeds?	Y	N	P	S
Hayfever?	Y	N	P	S
Loss of smell?	Y	N	P	S

NECK

Lumps in neck?	Y	N	P	S
Goiter?	Y	N	P	S
Difficulty swallowing?	Y	N	P	S
Pain or stiffness in neck?	Y	N	P	S

MOUTH AND THROAT

Frequent sore throat?	Y	N	P	S
Copious saliva?	Y	N	P	S
Sore tongue or lips?	Y	N	P	S
Hoarseness?	Y	N	P	S
Jaw clicks?	Y	N	P	S
Teeth grinding?	Y	N	P	S
Gum problems?	Y	N	P	S
Dental cavities?	Y	N	P	S

SKIN

Rashes?	Y	N	P	S
Acne/ boils?	Y	N	P	S
Change in skin color?	Y	N	P	S
Lumps or bumps on skin?	Y	N	P	S
Eczema or hives?	Y	N	P	S
Itching?	Y	N	P	S
Perpetual hair loss?	Y	N	P	S

RESPIRATORY

Cough?	Y	N	P	S
Sputum?	Y	N	P	S
Asthma?	Y	N	P	S
Wheezing?	Y	N	P	S
Bronchitis?	Y	N	P	S
Coughing up blood?	Y	N	P	S
Shortness of breath?	Y	N	P	S
Shortness of breath when lying down?	Y	N	P	S
Pain in breathing?	Y	N	P	S
Emphysema?	Y	N	P	S
Tuberculosis?	Y	N	P	S

GASTROINTESTINAL

Trouble swallowing?	Y	N	P	S
Change in thirst?	Y	N	P	S
Change in appetite?	Y	N	P	S
Nausea/ vomiting?	Y	N	P	S
Ulcer?	Y	N	P	S
Jaundice?	Y	N	P	S
Gall bladder disease?	Y	N	P	S
Liver disease?	Y	N	P	S
Hemorrhoids?	Y	N	P	S
Pancreatitis?	Y	N	P	S
Heartburn?	Y	N	P	S
Abdominal pain or cramps?	Y	N	P	S
Belching or passing gas?	Y	N	P	S
Constipation?	Y	N	P	S

Bowel movements: how often? _____

Is this a change? _____

Black stools?	Y	N	P	S
Blood in stools?	Y	N	P	S

MENTAL/ EMOTIONAL

Treated for emotional problem?	Y	N	P	S
Depression?	Y	N	P	S
Anxiety or nervousness?	Y	N	P	S
Poor concentration?	Y	N	P	S
Do you have mood swings?	Y	N	P	S
Considered suicide?	Y	N	P	S
Attempted suicide?	Y	N	P	S
Tension?	Y	N	P	S
Memory problems?	Y	N	P	S

URINARY

Increased frequency of urination?	Y	N	P	S
Inability to hold urine?	Y	N	P	S
Pain in urination?	Y	N	P	S
Frequency at night?	Y	N	P	S
Frequent UTI's?	Y	N	P	S
Kidney stones?	Y	N	P	S

MUSCULOSKELETAL

Joint pain or stiffness?	Y	N	P	S
Arthritis?	Y	N	P	S
Broken bones?	Y	N	P	S
Weakness?	Y	N	P	S
Muscle spasms or cramps?	Y	N	P	S
Sciatica?	Y	N	P	S

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CARDIOVASCULAR

Heart Palpitations?	Y	N	P	S
Arrythmia?	Y	N	P	S
Murmurs?	Y	N	P	S
Fainting/Dizziness?	Y	N	P	S
Anemia?	Y	N	P	S
Shortness of Breath?	Y	N	P	S
Swollen legs/ankles?	Y	N	P	S
Discoloration of fingers?	Y	N	P	S
Anemia	Y	N	P	S
Easy bleeding and bruising?	Y	N	P	S
Cold hands/ feet?	Y	N	P	S
Deep leg pain?	Y	N	P	S
Thrombophlebitis?	Y	N	P	S
Varicose veins?	Y	N	P	S

FEMALE REPRODUCTIVE

Age of first menses: _____
Age of last menses (if menopausal): _____
Length of cycle: _____ days
Duration of menses: _____ days

Are your cycles regular?	Y	N	P	S
Painful menses?	Y	N	P	S
Heavy or excessive flow?	Y	N	P	S
PMS?	Y	N	P	S

Symptoms: _____

Bleeding between cycles?	Y	N	P	S
Clotting?	Y	N	P	S
Endometriosis?	Y	N	P	S
Ovarian cysts?	Y	N	P	S
Vaginal odor?	Y	N	P	S
Vaginal discharge?	Y	N	P	S

Date of last pap smear? _____

Abnormal PAP?	Y	N	P	S
Cervical dysplasia?	Y	N	P	S
Are you sexually active?	Y	N	P	S

Sexual orientation _____
Birth control? Y/N Type: _____

Pain during intercourse?	Y	N	P	S
Gonorrhea?	Y	N	P	S
Herpes?	Y	N	P	S
Chlamydia?	Y	N	P	S

FEMALE REPRODUCTIVE, CONT.

Genital warts?	Y	N	P	S
Syphilis?	Y	N	P	S
Difficulty conceiving	Y	N	P	S

Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____

Do you do self breast exams?	Y	N	P	S
Breast pain / tenderness?	Y	N	P	S
Breast lumps?	Y	N	P	S
Nipple discharge?	Y	N	P	S
Menopausal symptoms?	Y	N	P	S

MALE REPRODUCTIVE

Are you sexually active?	Y	N	P	S

Sexual orientation: _____
Birth control? Type: _____

Discharge or sores?	Y	N	P	S
Chlamydia?	Y	N	P	S
Gonorrhea?	Y	N	P	S
Genital warts?	Y	N	P	S
Herpes?	Y	N	P	S
Syphilis?	Y	N	P	S
Hernias?	Y	N	P	S
Testicular masses?	Y	N	P	S
Testicular pain?	Y	N	P	S
Prostate disease?	Y	N	P	S
Impotence?	Y	N	P	S
Premature ejaculation?	Y	N	P	S