

# Herb-n-Welless™ Naturopathic Patient Intake Form

No information will be provided to any other individual or group without your express permission. E-mail will only be used by our office to inform you of our office events and to distribute our upcoming newsletter; it will not be distributed for any other use.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

(C) \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

\_\_\_\_\_ (Full name) (Relation) (Telephone) Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Number of children & their ages: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_

Telephone:(\_\_\_\_) \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Have you been treated by a Naturopathic Doctor? Other health practitioners? Name: \_\_\_\_\_

\_\_\_\_\_ Name: \_\_\_\_\_

When? \_\_\_\_\_ When? \_\_\_\_\_

Please list in order of importance your primary health concerns/ reason for your visit. Please indicate any treatments that you have tried previously to address your health issues and how effective you found these treatments.

Please list all medications you have taken, Pharmaceutical, Herbal, Vitamins and Supplements, including Dosages: Now In the Past Please list any allergies you have and what kind of reaction occurs: Please list all hospitalizations you have had: Type of illness or operation/procedure: Date Any ongoing concerns?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you rate your energy level at? (1-10, 10 being highest) \_\_\_\_\_

Do you wake-up feeling refreshed? Y\_\_ if N\_\_ , give details.

\_\_\_\_\_

Please check all that are applicable to you & your family and note who:

- Alcoholism  Glaucoma/Cataracts  Allergies  Gout  Arthritis  
 Heart Disease  Autoimmune diseases  Heart murmurs  Anorexia/Bulimia  
 High blood pressure  Asthma  Hypothyroid  Hyperthyroid  Cancer  
 Crohn's or Colitis  Kidney disease  Depression  Liver disease  
 Diabetes  Mental illness  Eczema  Stroke or aneurysm  
 GERD/hiatal hernia  Ulcers  Other: Please list; \_\_\_\_\_