



Dr. Kelly Brown, N.D.
Naturopathic Doctor



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Naturopathic Medical Intake Form

All information included here will be absolutely confidential. If you have any questions please ask. Thank you.

Name _____ Age _____ M F Today's Date _____

Birthdate (D/M/Y) _____

Home Address _____ Postal Code _____

Occupation _____ Employer _____

Work Phone _____ Home Phone _____ Cell Phone _____

Extended Health Insurance Provider: _____ Group/Plan# _____ Contract/ID# _____

Names of Other Healthcare Providers:

Medical Doctors _____ Naturopathic Physician _____

Chiropractor _____ Others _____

How did you hear about our clinic? _____

Your Main Health Concern

Why are you coming to our clinic today?

What are your most important health problems? List in order of importance:

- 1.
- 2.
- 3.

Please list all the vitamin/mineral/herbal supplements you are taking:

Supplement	Dose	How long you have been taking this supplement?
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Please list all current medications:

Medication Dose

How long have you been taking this med?

Please list any Past medications:

Your Past Medical History (Please list any major illnesses or surgeries):

Family Medical History

Age, Health Problems, If Deceased, Cause of Death, and Age at Death

Father

Mother

Brother/Sisters

Children

Social History

How many cigarettes do you smoke a day? _____

How much alcohol do you drink per week? _____

Do you take any recreational drugs? _____

Are you exposed to any toxins or chemicals in your home or work (mold, chemicals, etc)? _____

Have you been vaccinated? _____ Which vaccinations? _____

How often do you exercise? What type of exercise do you do? _____

Diet

Are you or have you ever been on a restricted diet? If so, what kind? _____

How much water do you drink/day? _____

How frequently do you move your bowels? _____ per day/week

Please check if the following symptoms are a CURRENT or RECURRING PROBLEM.

General

- Fatigue
- Change in appetite
- Change in thirst
- Cravings
- Weight gain
- Weight loss
- Poor sleep
- Chills or fever
- Night sweats
- Sweat easily
- Allergies
- Cancer
- Diabetes

Skin and Hair

- Dryness
- Rash
- Itching
- Eczema
- Psoriasis
- Acne
- Recent moles
- Hives/allergic reactions
- Loss of hair
- Thinning hair
- Dandruff
- Other skin problem(s)

Eyes Ears Nose & Throat

- Eye pain
- Eye strain
- Blurry vision
- Impaired vision
- Cataracts
- Ear aches
- Ear infections
- Ringing in ears
- Vertigo or dizziness
- Sinus infections
- Nasal obstruction
- Post nasal drip
- Nosebleeds
- Loss of smell/taste
- Sores in mouth
- Mercury fillings
- Jaw pain or clicks
- Recurrent sore throat
- Tonsillitis

- Enlarged glands
- Enlarged thyroid
- Facial pain/tics
- Headaches

Cardiovascular

- Chest pain
- Palpitations
- High blood pressure
- Low blood pressure
- Heart attack
- Congestive heart failure
- Irregular heartbeat
- Pacemaker
- Artificial heart valve
- Stroke
- Fainting
- Varicose veins
- Deep leg pain
- Cold hands or feet
- Swelling of limbs
- Anemia
- Easy Bruising

Respiratory

- Difficulty breathing
- Shortness of breath
- Chronic cough
- Bronchitis
- Emphysema
- Asthma
- Wheezing
- Coughing blood
- Phlegm in throat

Muscle Bone & Joints

- Neck pain
- Back pain
- Arthritis
- Bursitis
- Joint pain or stiffness
- Artificial joint
- Muscle pain
- Muscle weakness

Gastrointestinal

- Nausea
- Vomiting
- Vomiting blood

- Reflux or heartburn
- Constant hunger
- Ulcer
- Indigestion
- Abdominal pain or cramping
- Bloating
- Gall stones
- Liver disease
- Jaundice
- Intestinal parasites
- Gas
- Constipation
- Diarrhea
- Chronic laxative use
- Rectal burning/pain
- Hemorrhoids
- Blood in stool

Neurological

- Anxiety
- Depression
- Irritability
- Emotional problems
- Loss of balance
- Poor memory
- Dizziness
- Seizures/Epilepsy
- Concussion
- Lack of coordination
- Extremity numbness
- Extremity tingling
- Paralysis

Infections

- Strep throat
- Mononucleosis
- Tuberculosis
- Hepatitis
- HIV/AIDS
- Sexually transmitted disease

Urinary

- Frequent urination
- Urgency to urinate
- Incontinence
- Pain on urination
- Waking at night to urinate
- Urinary tract infection
- Blood in urine
- Kidney stones

Male Reproductive

- Prostate problem
- Impotence
- Sores on genitals
- Discharge
- Testicular Mass
- Testicular pain
- Infertility/low sperm count
- Hernia

Female Reproductive

- Irregular periods
 - Heavy
 - Light
 - Clots
- Painful periods
- PMS
- Sore breasts with menses
- Infertility
- Vaginal sores
- Vaginal discharge

Date of last Pap _____
 Irregular? _____
 If yes, date? _____
 Age of first menses _____

Menopausal Y/N

Age of last menses _____

Currently pregnant?
 Y/N

Currently Breastfeeding?
 Y/N

Do you practice
 birth control?
 Y/N
 Type _____

Number of:

- Pregnancies _____
- Abortions _____
- Miscarriages _____
- Births _____

Breasts

- Lumps
 - Tenderness
 - Nipple discharge
- Do you do breast self-exams?
 Y/N

There are some slight risks to treatment by Naturopathic Medicine. These include but are not limited to

- Potential allergic reaction to supplements or herbs
- Some aggravation of pre-existing symptoms as part of healing when using homeopathic remedies

I understand that the Naturopathic Doctor will answer any questions that I have to the best of their ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to treatment by my naturopath. I understand this consent form to cover the entire course of my treatment. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Patient Name: (please print) _____

Signature of Patient or Guardian: _____

Date: _____

Diet Diary

Breakfast

Lunch

Dinner

Snacks

Notes