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Captain Cook HI 96704
541-513-1978

Patient Intake

Personal Information

*Name	*DOB	Gender M F
	*Email	

*Address	***Primary** Phone
	Mobile Phone

*Emergency Contact

Name Relationship to you Phone

Note: Naturopathic, Holistic, and Preventative health care are only possible when the doctor has a complete picture of the patient, physically, mentally and emotionally. Please complete theis questionnaire as thoroughly as possible. This record is confidential and may be released only with your written authorization. Thank you.

Have you seen a doctor that practices natural or integrative medicine before? Y/N
If so, what type of natural medicine oriented clinicians have you visited?

____Naturopathic Doctor ____Holistic MD/DO ____Acupuncturist ____Chiropractor ____Homeopath ____Other:

How did you find us?
____Doctor Referral ____Patient Referral ____web search ____YouTube Video

If you were referred, please let us know by whom:

Do you have questions about Naturopathic Medicine?

What are your health goals?

Do you have health insurance? Y/N
If Yes, HMO or PPO? Who is your insurance carrier?

Please list other heath care providers you are currently working with:

Name	Specialty	Contact Info
Primary Care 1.		
2.		
3.		
4.		
Please add any additional info below		

Current Heath Concerns

Please list by order of importance to you. (Attach another list if necessary)	How long has this been a problem?	Have you sought diagnosis or treatment for this issue before? If yes, please describe when and where

Has anything changed or gotten worse?

Please state your travel history and place of birth.

Personal & Family Health History

Date of last physical exam?	Date of last Dexa Scan (bone density scan)?
Date of most recent blood work?	Date of last colonoscopy?
Mother: ❑ Living ❑ Deceased Age: Cause if deceased:	Sibling: Y/N Number living: Number deceased: Gender: Age(s): Cause(s) if deceased: 1. 2. 3. 4.
Father: ❑ Living ❑ Deceased Age: Cause if deceased:	

Blood Type_____

Past Medical History

Please list any hospitalizations, and any major past illnesses or injuries (e.g. broken bones, surgeries etc.)

Personal & Family Diagnosed Health Conditions	YES	Who? Indicate self or a specific family member	Notes:
ADD/ADHD	❑		
Alcohol/drug addiction	❑		
Anemia	❑		
Alzheimer's/Dementia	❑		
Arthritis (Osteo or Rheumatoid?)	❑		
Asthma	❑		
Autoimmune diseases	❑		
Birth defects	❑		
Blood disorder	❑		
Cancer	❑		What kind? Age diagnosed?
Cardiovascular Disease	❑		
Depression	❑		
Diabetes Type 2	❑		
Diverticulosis	❑		
Eating Disorder	❑		
Eczema	❑		
Epilepsy/Seizure Disorder	❑		
Fibromyalgia	❑		
Gallstones/Gall Bladder Disease	❑		
Gout	❑		
High Cholesterol	❑		
HIV/Aids	❑		
Hypertension	❑		
Inflammatory Bowel Disease	❑		
Kidney Disease	❑		
Learning Disability	❑		
Liver Disease - If Y, specify:	❑		
Mental illness – If Y, specify:	❑		
Neurologic disorder	❑		
Osteopenia/Osteoporosis	❑		
Stomach or Duodenal Ulcers	❑		
Stroke	❑		
Thyroid disease	❑		
Other:	❑		

Prescribed Medications [and over the counter medications] – attach a separate list if necessary

Medication Name	Dose	When started?	Why?
1.			
2.			
3.			
4.			
5.			
6			
7			

Drug or Other Allergies?

Any known medication allergies? Y/N

If Yes, which medications:

What allergic reaction symptoms do you experience?

Supplements – please list all vitamins/botanicals, homeopathics, etc.

Please include vendor if the product is a proprietary blend/combo product – attach a separate list if necessary.

Product name	Dose	When started	Why
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Lifestyle and Social History

Diet

Do you follow any special diet type or restrictions?	Are there foods you crave strongly?
What foods make you feel poorly? Explain:	What foods make you feel the best? Explain:

How would you describe your relationship with food?

Number of meals a day:

Number of snacks a day:

Who typically cooks your food?

Where do you typically purchase you food?

Please list typical foods consumed daily – specify typical times of day for each:

Breakfast	
Lunch	
Dinner	
Snacks	
Sweets	
Water	How much? Tap? filtered, bottled? Are you generally thirsty?

Foods you avoid?

Primary sources of protein?

List the foods you ate with in the last 24 hours

Breakfast:

Lunch:

Dinner:

Please check the appropriate box below to indicate the frequency of consumption:

	Daily	Weekly	Monthly	Occasionally (1-2x per mo)	Rarely (1-2x per yr)	Never
Sugar						
Artificial sweeteners						
Fast food						
Fried food						
Processed food						
Flour/baked goods						
Caffeine						
Soda?						
Alcohol?						

Notes/details:

Habits

Do you smoke cigarettes? Y/N	Packs per day?	Duration of habit?
	Past Use?	If so, how long ago did you quit?
Do you use recreation drugs? Y/N	If Y, what type?	
	How often?	
	Past Use?	If so, how long ago did you quit?
Have you ever been treated For drug/alcohol addiction? Y/N	If Y, describe:	How long ago?

Exercise

Do you exercise regularly? Y/N	How often?	For how long?
What type of exercise(s) do you do?		

Sleep

How many hours of sleep do you get regularly each night?	Time you go to bed?

Do you fall asleep easily? Y/N	Do you sleep soundly? Y/N	Time you get up?
Do you wake rested? Y/N	What is your AM mood like?	

Notes:

Occupation

What is your occupation?	Do you like your work? Y/N
Number of hours worked per week:	Do you like your work environment? Y/N If no, please explain:

Stress Level

Rate 1-10 (1 = Very Low, 10 = High)	Source(s) of stress:

What do you do to cope with stress?

Sense of Well-being

Rate your sense of wellbeing from 1-10 (1 = Very Low, 10 = High)	How would you define your emotional state?

What do you do to regularly support your health and well-being?

What challenges do you face with your efforts to maintain health?

Where do you feel you could use more support?

Do you cry a lot?

How do you express anger?

Do you have a history of suppressing desire or emotion?

Do you consider that your complaint dates from any particular incident, aspect or disease? Y N
Please describe however trivial or irrelevant they may seem.

PURE Naturopathic Healthcare

PURE Naturopathic Healthcare is a cash-based practice that accepts cash, check or credit card payment. Payment is required on the day services are rendered. We do not file insurance claims but we will provide you with a "super-bill" that contains the diagnosis and procedure codes required for insurance reimbursement. Pure Health assumes no responsibility for services not reimbursed by your insurance company.

I have read, understand, and agree to the above policies:

_____

Please Print Your Name

_____

Signature Date