EAST BAY NATUROPATHIC CLINIC
402 Colusa Ave. • El Cerrito, CA 94530 • 510.559.3640

ADULT INTAKE

Name ____ Date of birth ________________
Preferred Name _______________________________________ Age _____ Gender ____________
Address ____________________________________ City, St, Zip ____________________________
Home phone ______________ Work phone ______________ Cell phone ______________________
Email address _________________________________

Emergency Contact ______________________________ relationship ________________________
Contact phone number(s) ____

Occupation ___________________ Hours per week __________Education ________________
Marital status: ☐ single ☐ partnered ☐ married ☐ separated ☐ widowed ☐ divorced ☐ other _____________
Live with: ☐ alone ☐ friends ☐ partner ☐ spouse ☐ children ☐ other ______________________________
Number of children and ages __________________________ pets ___________________________

How did you hear about this clinic? ____
Are you interested in receiving newsletters and updates via email? ☐ Y ☐ N

Are you currently receiving healthcare? ☐Y ☐N If yes, please list healthcare providers___________________
____
If no, what was the date of your last physical exam/healthcare ____________________________________

Please list any medical diagnoses you have received:
_____________________ ____________________________ ________________________
_____________________ ____________________________ ________________________

Please list ALL current prescription and over-the-counter medicines, supplements, vitamins, herbs or remedies you are taking with dose information (if needed please use back of form or attach list):
__________________________ ______________________ _________________________
__________________________ ______________________ _________________________
__________________________ ______________________ _________________________

Are you hypersensitive or allergic to any medications/foods/other?________________________________
____
Please list all hospitalizations, surgeries (including elective), and imaging (x-rays, CAT scans, MRIs, EKGs, etc) with the approximate date:
__________________________ _______________________ _________________________
__________________________ _______________________ _________________________

Do you have any known contagious diseases at this time? ☐ no ☐ yes, what? _________________________
Are you currently pregnant or breast feeding at this time? ☐ no ☐ yes

Successful health care and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

What is the reason for today's visit?

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What are your specific goals for this visit?

What expectations do you have for me as your healthcare provider?

Please list additional health concerns or problems in order of importance:

What are your long-term goals in working with a Naturopathic Doctor?

What is your present level of commitment to address the underlying causes of your signs and symptoms?

No current commitment 0 1 2 3 4 5 6 7 8 9 10 Very committed

GENERAL HEALTH

Height ___________________ Weight ______________________ Weight one year ago _______________________
Maximum lifetime weight __________________________ When ____
Do you exercise? □ Y □ N if yes, what do you do?____
____ How many times per week?______________________
Do you sleep well? □ Always □ Usually □ Rarely □ Never Do you wake rested? □ Y □ N □ Sometimes
How many hours sleep each night __________________From ______________pm/am to ______________am/pm
Do you know your blood type ? □A □ B □ AB □ O □Rh neg. □ Rh pos. □ Don't know
Have you ever had a blood or plasma transfusion? □ Y □ N if yes, when _____________________________
Have you ever been in a serious accident? □ Y □ N Do you have supportive relationships? □ Y □ N
Hours per day on computer/TV? ___________ Do you enjoy your work (if applicable)? □ Y □ N
Do you spend time outside? □ Y □ N Hours per week ______________________ Do you take vacations? □ Y □ N
Do you have a religious or spiritual practice? □ Y □ N if yes, what kind ___________________________________
What do you love to do? ____
____
How would you describe your overall satisfaction with your life? ____
____

INTAKE

What is your typical food intake?
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Beverages: ____
Do you: eat three meals a day most days? □ Y □ N often go on diets? □ Y □ N eat out often? □ Y □ N
Do you drink: coffee? □ Y □N black/green tea? □ Y □ N soda? □ Y □ N energy drinks? □ Y □ N
Do you: consume refined sugar? □ Y □ N consume artificial sweeteners? □ Y □ N salt your food? □ Y □ N
Are you: vegetarian? □ Y □ N vegan? □ Y □ N Do you avoid other foods? ______________________________
Do you: consume alcohol? □ Y □ N use recreational drugs? □ Y □ N past history of intravenous use? □ Y □ N
Do you use tobacco? □ Y □ N ____________packs per day / If past use, how many years ______________________

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Family History (if known)
Please list any family members by relationship with known or diagnosed conditions including any of the following: cancer, diabetes, autoimmune conditions, cardiovascular issues (including stroke, heart attack, hypertension), gastrointestinal or kidney disease, addiction, or mental illness. If parents or siblings are deceased please list age of death.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Other relevant family history ______________________________
List ethnicity if known ______________________________

CHILDHOOD
Please list significant childhood health information:______________________________
____
Do you receive vaccines? □ Y □ N What vaccines have you received? ______________________________
____

REVIEW OF SYSTEMS
Please mark the following: **C** for a current condition **P** for a **significant** condition in the past
If dual symptoms are listed (ex: high/low blood pressure) please circle applicable symptom

headache	C	P	migraines	C	P	head injury	C	P
seizures	C	P	muscle weakness	C	P	loss of memory	C	P
numbness/tingling	C	P	tremors	C	P	vertigo or dizziness	C	P
loss of consciousness	C	P	paralysis	C	P	loss of balance	C	P
Eye pain or strain	C	P	double vision	C	P	impaired vision	C	P
cataracts	C	P	glaucoma	C	P	change in vision	C	P
Eye itching or burning	C	P	Eye tearing or dryness	C	P	spots in vision	C	P
ringing in ears	C	P	hearing loss	C	P	ear pain/aches	C	P
discharge from ear	C	P	loss of smell	C	P	frequent nosebleeds	C	P
hay fever/allergies	C	P	freq. head colds	C	P	sinusitis	C	P
nasal congestion	C	P	runny nose	C	P	strange odors/taste	C	P
lumps in neck	C	P	hoarseness	C	P	sore tongue or lips	C	P
freq. sore throat	C	P	snoring	C	P	teeth grinding	C	P
pain or stiff neck	C	P	excessive saliva	C	P	jaw pain/TMJ	C	P
gum problems	C	P	cavities/toothache	C	P	bad breath	C	P
cough	C	P	asthma	C	P	pneumonia	C	P
sputum	C	P	wheezing	C	P	pleurisy	C	P
coughing blood	C	P	bronchitis	C	P	difficulty breathing	C	P
emphysema	C	P	tuberculosis	C	P	pain on breathing	C	P
shortness of breath	C	P	shortness of breath while lying down	C	P	pneumonia	C	P
heart disease	C	P	palpitations	C	P	cold hands/feet	C	P
heart murmur	C	P	rheumatic fever	C	P	anemia	C	P
blood clots	C	P	ankle swelling	C	P	thrombophlebitis	C	P
phlebitis	C	P	varicose veins	C	P	easy bleeding/bruising	C	P
high/low blood pressure	C	P	chest pain /tightness	C	P	deep leg pain	C	P

Doctor's Notes:

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Review of systems cont.

change in thirst	C	P	constipation	C	P	diarrhea/loose stool	C	P
change in appetite	C	P	bloating	C	P	greater than 3 BM /day	C	P
nausea/vomiting	C	P	belching/gas	C	P	hemorrhoids	C	P
Ulcer	C	P	abdominal pain	C	P	black stool	C	P
Jaundice	C	P	heartburn	C	P	blood in stool	C	P
liver disease	C	P	pancreatitis	C	P	rectal pain or itching	C	P
trouble swallowing	C	P	gall bladder disease	C	P	change in bowel movements	C	P
frequent urination	C	P	dark urine	C	P	kidney stones	C	P
frequent UTI	C	P	cloudy urine	C	P	blood in urine	C	P
inability to hold urine	C	P	waking at night to urinate	C	P	pain or burning with urination	C	P
Arthritis	C	P	eczema or hives	C	P	psoriasis	C	P
pain in bones	C	P	change in skin color	C	P	ulcerations	C	P
broken bones	C	P	rashes	C	P	dry skin/brittle nails	C	P
dislocations/sprains	C	P	acne/boils	C	P	dandruff	C	P
Osteoporosis	C	P	itching	C	P	skin growths	C	P
muscle spasm/cramping	C	P	hair loss	C	P	growths that change in size, color, or itch	C	P
Hypothyroid	C	P	fatigue	C	P	seasonal depression	C	P
Hyperthyroid	C	P	hypoglycemia	C	P	difficulty exercising	C	P
Diabetes	C	P	excessive thirst/hunger	C	P	heat or cold intolerance	C	P
Depression	C	P	anger/temper	C	P	easily stressed	C	P
Anxiety	C	P	loneliness	C	P	considered suicide	C	P
Tension	C	P	poor concentration	C	P	attempted suicide	C	P
panic attacks	C	P	mood swings	C	P	treatment for mental emotional problems	C	P
Immunizations	C	P	night sweats	C	P	frequent illness	C	P
swollen glands	C	P	chronic infections	C	P	catch colds easily	C	P
reaction to immunizations	C	P	slow wound healing	C	P	autoimmune disorder	C	P

Doctor's Notes

REPRODUCTIVE HEALTH

Are you currently sexually active (within the past six months)? ☐ Y ☐ N sexual orientation___________________

Do you use protection from sexually transmitted infections? ☐ Y ☐ N if yes, what?________________

Have you had any of the following? chlamydia gonorrhea genital warts/HPV herpes syphilis

Have you had a change in libido? ☐ Y ☐ N Have you ever had trouble conceiving? ☐ Y ☐ N

Please complete any applicable information:

Male:

discharge or sores	C	P	hernia	C	P	testicular pain	C	P
impotence	C	P	prostate disease	C	P	testicular masses	C	P
pain with ejaculation	C	P	premature ejaculation	C	P	varicose veins in scrotum	C	P

Do you perform regular testicular self-exams? Y N

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Female:

heavy flow	C	P	vaginal discharge	C	P	yeast infections	C	P
clotting	C	P	vaginal odor	C	P	nipple discharge	C	P
endometriosis	C	P	ovarian cysts	C	P	breast pain/tenderness	C	P
bleeding between cycles	C	P	menopausal symptoms	C	P	pain during intercourse	C	P

What was the age of your first menses?____________ Age of last menses (if menopausal)________________________
When was the first day of your last menses?_______________ How many days does your menses last?__________
How many days in between menstrual periods? ___________ Are your cycles regular? □ Y □ N
Do you have PMS? □ Y □ N If yes, what are your symptoms?____
Do you have painful menses? □ Y □ N If yes, what are the symptoms?____
What was the date of your last pap smear? _________ Date of your last mammogram/thermal imaging?_________
Have you ever had an abnormal pap? □ Y □ N If yes, when? ____
Do you do regular self-breast exams? □ Y □ N Date of last mammogram/thermal imaging:___________________
Number of pregnancies __________ Number of children ________________ Type of delivery vaginal caesarean
Please list all birth control used in the past: ____

Thank you for your time and effort in completing this comprehensive intake. We look forward to providing you with the best possible care. Please bring this form to your first visit or fax it beforehand to 510-559-3224. If there is anything else that you would like to add, please use the remainder of this page.