New Patient Intake Form

CREATIVE NATURAL HEALTH
...When You're Sick & Tired of Being Sick & Tired...

Name _____ **Date** _____

Address _____ **City** _____

State _____ **Zip** _____ **Sex** **M** ☐ **F** ☐

Phone _____ **Email** _____

We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth _____ **Social Security** _____

Emergency Contact _____ **Phone Number** _____

Relationship _____ **How did you hear about us?** _____

Occupation _____ **Employed** ☐ **Full Time** ☐ **Part Time** ☐ **Retired**

Primary or Referring Doctor _____ **Phone Number** _____

What is the single most important complaint / problem for which you are seeking treatment?

_____

Describe how it feels:

☐ Aching ☐ Burning ☐ Dull ☐ Numb ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tingling

Other _____

When did your complaint start? _____

How did it start? ☐ Suddenly ☐ Gradually ☐ Bending ☐ Pulling ☐ Lifting ☐ Fall

☐ Injured at work ☐ Injured during sports ☐ Injured in auto accident ☐ Unknown

What makes the complaint worse? _____

What makes the complaint better? _____

What is the range of the severity of this complaint? (0=Fine, 10=Crippling/Bedrest) _____

How would you describe the intensity of the complaint? (Circle one)

Mild Moderate Moderate-Severe Severe

How often do you have your complaint? (Circle one) Constant Intermittent Occasional

Is your sleep disturbed by your complaint? ☐ No ☐ Yes - How many times do you wake at night? _____

Is the complaint getting worse? ☐ No ☐ Yes – Describe: _____

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Have you had any of the following health problems? (Please check all that apply)

- ☐ Angina or chest pain
- ☐ Anxiety
- ☐ Arthritis
- ☐ Bleeding / Clotting
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fibromyalgia
- ☐ Heart Attacks / TIAs
- ☐ Hepatitis / Liver Problems
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Hypertension
- ☐ Spine Trauma
- ☐ Kidney Disease
- ☐ Lyme's Disease
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Weight Loss Resistance
- ☐ Cancer – Specify Type _____

Please circle any treatments you have tried for your complaint (you may circle more than one)

Surgery Injections Traction Physical Therapy Acupuncture

Chiropractic Orthotics Massage Creams Medication

Did any of these treatments provide relief? ☐ No ☐ Yes – Please describe: _____

_____

Please list any surgeries and/or hospitalizations:

Date	Reason
_____	_____
_____	_____
_____	_____

Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes daily? _____

Do you drink? Yes ☐ No ☐ If yes, how many drinks per week? _____

Do you exercise regularly? Yes ☐ No ☐ If yes, please describe type & how often: _____

_____

_____

List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

_____ _____ _____

_____ _____ _____

_____ _____ _____

List ALL allergies/sensitivities to medication, food, and other items here:

Item you react to: *Reaction:*

_____ _____

_____ _____

_____ _____

Have you had any of the following? (Please check all that apply)

☐ Back problems, poor posture, arthritis

☐ Recent or sudden weight loss, fever, chills, weakness, or fatigue

☐ Recent or sudden difficulty concentrating or memory issues ☐ Recent headache or dizziness

☐ Recent or sudden change in smell, vision or hearing ☐ Recent or current enlarged lymph nodes

☐ Recent unexplained skin rash or itching ☐ Recent sweating, cold or heat intolerance

☐ Recent anemia, bleeding, or sudden unexplained or excessive bruising

☐ Recent or sudden shortness of breath, coughing, chest pain/pressure/discomfort

☐ Recent burning on urination, change in bowel / bladder control or recent increase in erectile dysfunction

Do you have a secondary complaint? If yes, describe: _____

When & how did this complaint start? _____

What makes the complaint worse? _____

What makes the complaint better? _____

Describe how it feels:

☐ Aching ☐ Burning ☐ Dull ☐ Numb ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tingling

What is the severity of your complaint? (0=Fine, 10=Crippling/Bedrest) _____

What time of day is your complaint the worst? _____

Before this complaint began, had you ever experienced this type of problem before? _____

What lifestyle changes have you had to make due to this complaint? _____

_____

Please take several minutes to answer these so we can help you get better
(Please check all that apply)

1. How have others been affected by your health condition?

- ☐ No One is Affected
- ☐ They Tell Me to Do Something
- ☐ Haven't Noticed Any Problem
- ☐ People Avoid Me

2. What are you afraid this might be beginning to affect or will affect?

- ☐ Job
- ☐ Sleep
- ☐ Kids
- ☐ Time
- ☐ Future Ability
- ☐ Finances
- ☐ Marriage
- ☐ Freedom
- ☐ Self Esteem

3. Are there health conditions you are you afraid this might turn into?

- ☐ Family Health Problems
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Depression
- ☐ Cancer
- ☐ Chronic Fatigue
- ☐ Diabetes
- ☐ Need for Surgery
- ☐ Arthritis

4. How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

_____

_____

_____

_____

5. What has that cost you? (time, money, happiness, freedom, sleep promotion, etc.) Please give 3 examples:

1._____

2._____

3._____

6. What are you most concerned with regarding the problem?

_____

_____

_____

_____

7. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific:

_____

_____

_____

_____

8. What is the one thing that you would like to do again if this problem gets resolved? Please be specific:

_____

_____

_____

_____

Notes for the office:

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WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____