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**Naturopathic Patient Intake Form**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone # (home/cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_ Female \_\_\_\_\_\_\_\_\_ Male \_\_\_\_\_\_\_\_\_

Married \_\_\_\_\_\_\_ Separated \_\_\_\_\_\_\_ Divorced \_\_\_\_\_\_\_ Widowed \_\_\_\_\_\_\_ Single \_\_\_\_\_\_ Partnership \_\_\_\_\_\_

Occupation/Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours per week \_\_\_\_\_\_\_\_\_

Health insurance company name, address, & phone #:

Policy ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you call your insurance to verify coverage? Yes / No

I certify that I, and/or my dependent(s) have coverage with the above named insurance company and assign directly to Dr. Mercer all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agencies for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

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

(Print Patient/Guardian Name) (Signature of Patient/Guardian) (Date)

Emergency contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your most important health problems?

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please List other healthcare providers or clinics you receive care from:**

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialists: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Typical Food Intake**

Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drinks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalizations, Surgeries, Diagnostic Studies**

List previous hospitalizations and/or surgeries and date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

X-rays, CAT scans, or other studies you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Immunizations**

Polio Y N Pertussis Y N

Tetanus shot Y N Diphtheria Y N

Measles/Mumps/Rubella Y N Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**

Are you hypersensitive or allergic to...

Any drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any environmentals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications / Supplements**

Please list any prescription medications or over the counter medications you are taking.

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

Please list any vitamins, minerals, or nutritional supplements you are taking.

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

**FAMILY HISTORY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family History** | **Father** | **Mother** | **Brother** | **Sister** | **Spouse** | **Child** |
| Age (if living) |  |  |  |  |  |  |
| Health ( G=good P=poor) |  |  |  |  |  |  |
| Age at death (if deceased) |  |  |  |  |  |  |

**Check (√ ) those applicable**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Diabetes |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |
| Memory Loss |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |
| Asthma / Hayfever / Hives |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |
| Auto-immune Disease |  |  |  |  |  |  |
| Cause of Death |  |  |  |  |  |  |

**REVIEW OF SYSTEMS**

**FOR THE FOLLOWING, PLEASE CHECK**

**Y = Current Condition N = Never P = Condition in the Past**

**Y N P**

**Muscle/Joint/Neurologic**

Arthritis

Bursitis

Foot trouble

Hernia

Low back pain

Neck pain, stiffness

Numbness/tingling

Neuralgia

Muscle weakness

Broken bones

Sciatica

Spinal curvature

Muscle spasm

 Muscle cramp

Epilepsy

Multiple Sclerosis

**General**

Allergies

Chills

Fever

Heat or cold intolerance

Nightsweats

Convulsions

Tremors

Dizziness

Fainting

Fatigue

Loss of sleep

Loss of weight

Anxiety

Depression

Memory problems

Considered suicide

Excessive thirst

Excessive hunger

Chronic infections

Swollen glands

Loss of balance

Sleep well

Awaken rested

High stress level

Alcoholism

Anemia

Cancer

Cold Sores

Diabetes

Gout

Smoke cigarettes

packs per day: \_\_\_\_\_\_

how many yrs: \_\_\_\_\_\_

Drink coffee

cups/day? \_\_\_\_\_\_\_

Drink alcohol

Drinks/day? \_\_\_\_\_\_

Recreational drugs

Treated for addiction

Exercise?

How often? \_\_\_\_\_\_

**Y N P**

**Cardiovascular**

Hardening of arteries

High blood pressure

Low blood pressure

Chest pain

Poor circulation

Palpitations

Swelling of ankles

Blood clots

Easy bruising

Deep leg pain

Arteriosclerosis

Heart Disease

Pacemaker

Stroke

Murmurs

**Eye, Ear, Nose and Throat**

Asthma

Colds

Headaches

Jaw/TMJ problems

Earache

Ear discharge

Ear noise/ringing

Enlarged glands

Enlarged thyroid

Eye pain/strain

Impaired vision

Dry eyes

Tearing eyes

Cataracts

Glaucoma

Gum problems

Dental Cavities

Hay fever

Hoarseness

Nasal obstruction

Near sightedness

Nose bleeds

Sinus problems

Sore throat

Tonsillitis

Lumps on neck

Goiter

**Respiratory**

Chest pain

Cough

Difficult breathing

Shortness of breath

Coughing up blood

Coughing up phlegm

Wheezing

Bronchitis

Emphysema

Pleurisy

Pneumonia

**Y N P**

**Genitourinary**

Bed-wetting

Blood in urine

Frequent urination

Frequent infections

Painful urination

Inability to hold urine

Inability to urinate

Ulcers

**Skin**

Boils/Acne

Bruise easily

Dryness

Hives or allergy

Itching

Skin eruptions(rash)

Varicose veins

Lumps

Eczema

**Gastrointestinal**

Belching

Gas

Heartburn

Trouble swallowing

Constipation

Diarrhea

Difficult digestion

Bloated abdomen

Excessive hunger

Gallbladder trouble

Hemorrhoids

Gallbladder disease

Jaundice

Liver disease

Nausea

Abdominal pain

Poor appetite

Vomiting

Black stools

Blood in stool

Appendicitis

Colitis

Bowel movements: how often?

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

**Y N P**

**Men only**

Hernias

Testicular pain

Venereal disease

Sexually active

Testicular mass

Prostate disease

Discharge or sores

Impotence

**Women only**

Age of first menses: \_\_\_\_\_\_\_

Age of last menses: \_\_\_\_\_\_\_

PMS

Painful menses

Excess menstrual flow

Abnormal PAP

Irregular cycle

Lumps in breast

Breast pain

Nipple discharge

Vaginal discharge

Menopausal symptoms

Infertility

Sexually active

Venereal disease

Miscarriage

Birth control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies: \_\_\_\_\_\_

Number of live births: \_\_\_\_\_\_\_\_

Are you pregnant?

Yes No