Desert Naturopathic Health

Dear Patient,

Thank you for your interest in naturopathic care and the opportunity to work with you. Naturopathic medicine is an approach to care that provides an array of treatment options. More importantly, I believe naturopathic medicine offers a distinctly different way to thinking about health.

The following pages are the start of our comprehensive discussion to learn about you. This form is somewhat long, but I appreciate your time to thoughtfully answer these questions.

The first office visit is where we gather the largest amount of information. Accordingly, this visit can last 1 - 1 ½ hours. In order for me to prepare for this visit, I kindly request that this form be mailed or faxed to Desert Naturopathic Health at least 2 days prior to your first appointment. Additionally, if you have recent laboratory work or pertinent medical records, please bring these to the visit.

Thank you again for your interest in working with me. I look forward to meeting you.

Sincerely,

Jason W. Jensen, NMD

Naturopathic Physician

Desert Naturopathic Health, LLC 20045 N 19th Ave Suite 166 Glendale, AZ 85027
Phone: (602) 888-1201 Fax: (602) 288-0124
www.DesertNaturalHealth.com

Name: _____ (Last, First, MI) DOB: _____

NEW PATIENT INTAKE FORM

Today's Date: _____

All questions contained in this questionnaire are optional, strictly confidential and will become part of your medical record.

Name: _____ (Last, First, MI) Sex: _____ Age: _____ DOB: _____

Address: _____ City: _____ State:_____ Zip:_____

Main Contact Phone (list type): _____ Other Phone: _____

Email Address: _____ May we contact you via email? Yes No

Emergency contact: _____ Relationship: _____ Phone: _____

Employer: _____ Occupation: _____

Marital Status: _____ # Children: _____

Primary care physician (PCP): _____ Phone #: _____

Address: City: State: Zip: _____

Date of last PCP visit: _____ Reason: _____

Insurance: _____ Ins ID#: _____ Group Number: _____

Ins. Number: _____(Please provide a copy of your insurance card)

Referred by: _____

Reason for today's visit: (in order of importance)

1. _____
2. _____
3. _____
4. _____

Please list any medical problems that other physicians have diagnosed:

_____

_____

Medication allergies (including reaction when taken):

_____

_____

Name: _____ (Last, First, MI) DOB: _____

Please list ALL **medicines**, prescribed and over the counter (OTC), **including vitamins, herbs, homeopathics, etc**

Medicine	Strength	Times/Day	Reason	Prescriber

Surgeries/Hospitalizations

Year	Reason	Hospital

Childhood Illness (Please circle)

Year	Reason	Hospital
Chicken Pox	Measles	Mumps
Rheumatic Fever	Diphtheria	Pertussis
Other:		

Immunizations (Please circle)

Polio	Pertussis	Tetanus
Diphtheria	Measles/Mumps/Rubella (MMR)	Varicella zoster (Chicken Pox)
Hepatitis B	Flu	Shingles
Other:		

Family Health History

Family Member	Age	Significant Health Problems
Father		
Mother		
Sibling 1 – Male/Female (circle)		
Sibling 2 – Male/Female (circle)		
Grandmother – Maternal		
Grandfather – Maternal		
Grandmother – Paternal		
Grandfather – Paternal		

Name: _____ (Last, First, MI) DOB: _____

Health Habits

Exercise (check one)

_____ Sedentary (no exercise)

_____ Mild Exercise (eg. Climb stairs, walk three blocks, golf)

_____ Occasional vigorous exercise (eg. Work or recreation, less than 4x/week for 30 min each time)

_____ Regular vigorous exercise (eg. Work or recreation, at least 4x/week for 30 min each time)

After exercise, how do you feel? (Energized, Fatigued, Same)? _____

Diet

Number of meals eaten in a typical day: _____

Please provide examples of:

Typical Breakfast & Time of Meal:_____

Typical Lunch & Time of Meal:_____

Typical Dinner & Time of Meal:_____

Typical Snacks: _____

Caffeine (check all that apply)

_____ None

_____ Coffee Number of cups per day _____

_____ Tea Number of cups per day _____ Usual type of tea: _____

_____ Soda Number of cans per day _____

Drug Use:

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

Are you concerned about the amount of alcohol you drink? Yes No

Have you considered stopping? Yes No Do you drive after drinking? Yes No

Are you prone to binge drinking? Yes No

Do you use tobacco? Yes No

Cigarettes/packs per day? _____ Chew per day? _____ Cigars/day? _____

Do you currently use recreational or street drugs? Yes No

If yes, which kinds and how often? _____

Name: _____ (Last, First, MI) DOB: _____

Sexual History

Are you sexually active? Yes No Preference? Heterosexual Homosexual Bisexual

Are you trying for a pregnancy? Yes No If no, type of contraception method used? _____

Any discomfort with intercourse? Yes No

Mental Health

Is stress a major issue for you? Yes No Do you cry frequently? Yes No

Do you feel depressed? Yes No Have you ever attempted suicide? Yes No

Do you panic (anxiety) when stressed? Yes No Have you ever been to a counselor? Yes No

Have you ever thought about hurting yourself or others? Yes No

Exposures History

Have you worked in manufacturing or processing of: _____ Metals _____ Plastics _____Petroleum ____ Glass _____Ceramics _____Paper _____Electronics _____Batteries _____Fiberglass _____Textiles

For how long? _____

Have you had recent exposure to: _____ Chemical Fertilizers _____Pesticides _____Herbicides _____Mold _____Paints _____ Wood Preservatives _____Chemical Dyes _____Cigarette Smoke _____Gasoline _____Nail Salons
Have you lived or worked near: _____ Coal burning plant _____Metal Mine _____Nickel Refinery _____Golf course _____Major Freeway _____Nuclear Plant _____Orchard or Farm

What is your source of drinking water at home (circle one)? Direct from tap Filtered from Tap Well Reverse Osmosis Bottled Water Other: _____

Are you overly sensitive to perfumes, cigarette smoke, gasoline etc.? Y N P

Approximately how many rounds of Antiobiotics have you taken TOTAL in the past? (circle one)

0 1-5 6-10 11-15 16-20 20 or more

Do you take hormones or oral contraceptive pills? Y N P

Do you or did you have water pipes in your home from before 1978? Y N P

Have you used pressure treated lumber before 2003 for building projects, such as decks or playsets? Y N P

Do you have metal fillings in your teeth? Y N P Do you work in a dental office? Y N P

Do you eat seafood more than 3 times per month? Y N P Wild Alaskan/Atlantic/Farmed

Do your symptoms diminish or disappear if you are AWAY from your home or work? Y N P

Which symptoms? _____

Name: _____ (Last, First, MI) DOB: _____

Review of Systems

Weight

Current Weight _____ Weight one month ago: _____ Weight one year ago: _____

Maximum Weight and when: _____ Minimum weight as adult and when: _____

Height

Your current height: _____

REGARDING THE NEXT SECTION: Please circle (Y) if you have the problem CURRENTLY, (N) if you NEVER have had the problem, and (P) if you had the problem in the PAST.

Energy

Good Energy:	Y	N	P				
Fatigue:	Y	N	P				

If you have fatigue, when does it affect you most? What time of day? _____

Skin

Rash:	Y	N	P	Color change:	Y	N	P
Hives:	Y	N	P	Lump:	Y	N	P
Psoriasis:	Y	N	P	Itchy:	Y	N	P
Eczema:	Y	N	P	Warts/Moles:	Y	N	P
Dry:	Y	N	P	Perspiration:	Y	N	P
Cancer:	Y	N	P				

Head

Headache:	Y	N	P	Migraine:	Y	N	P
Dandruff:	Y	N	P	Head injury:	Y	N	P
Oily hair:	Y	N	P	Hair loss:	Y	N	P
Dry hair:	Y	N	P				

Nose

Colds:	Y	N	P	Nosebleeds:	Y	N	P
Congestion:	Y	N	P	Post nasal drip:	Y	N	P
Polyps:	Y	N	P	Seasonal allergies:	Y	N	P

Name: _____ (Last, First, MI) DOB: _____

Eyes

Dry eyes:	Y	N	P	Itchy eyes:	Y	N	P
Watery eyes:	Y	N	P	Blurry vision:	Y	N	P
Double vision:	Y	N	P	Cataracts:	Y	N	P
Glaucoma:	Y	N	P	Discharge:	Y	N	P
Eye strain:	Y	N	P	Dark under eyelids:	Y	N	P

Mouth/Throat

Canker sores:	Y	N	P	Cold sores:	Y	N	P
Sore throat:	Y	N	P	Gum disease:	Y	N	P
Dentures:	Y	N	P	Cavities:	Y	N	P
Loss of taste:	Y	N	P	Hoarseness:	Y	N	P
Difficult swallowing:	Y	N	P	Sore throat:	Y	N	P

Neck

Stiffness:	Y	N	P	Tension:	Y	N	P
Swollen glands:	Y	N	P				

Respiratory

Cough:	Y	N	P	Wheezing:	Y	N	P
Shortness of breath				TB:	Y	N	P
w/exertion:	Y	N	P	Bronchitis:	Y	N	P
Shortness of breath				Asthma:	Y	N	P
w/sitting:	Y	N	P	Painful Breathing:	Y	N	P
Shortness of breath							
w/lying down:	Y	N	P				

Cardiovascular

High blood pressure:	Y	N	P	Rheumatic fever:	Y	N	P
Low blood pressure:	Y	N	P	Murmurs:	Y	N	P
Arrhythmias:	Y	N	P	Palpitations:	Y	N	P
Edema:	Y	N	P	Chest pain:	Y	N	P

Name: _____ (Last, First, MI) DOB: _____

Gastrointestinal

Heartburn:	Y	N	P	Freq of Bowel movements: _____/day			
Indigestion:	Y	N	P	Recent BM change:	Y	N	P
Bloating:	Y	N	P	Diarrhea:	Y	N	P
Nausea:	Y	N	P	Constipation:	Y	N	P
Vomiting:	Y	N	P	Hemorrhoids:	Y	N	P
Change in Appetite:	Y	N	P	Liver/Gall Bladder Dz:	Y	N	P
Pancreatitis:	Y	N	P	Ulcer:	Y	N	P

Musculoskeletal

Weakness:	Y	N	P	Arthritis:	Y	N	P
Stiffness:	Y	N	P	Leg cramps:	Y	N	P
Tremors:	Y	N	P	Pain:	Y	N	P

Nervous

Paralysis:	Y	N	P	Sciatica:	Y	N	P
Tingling/numbness:	Y	N	P	Carpal tunnel:	Y	N	P
Seizures:	Y	N	P	Fainting:	Y	N	P

Mental/Emotional

Depression:	Y	N	P	Anger/Irritable:	Y	N	P
Suicidal:	Y	N	P	Tense:	Y	N	P
Anxiety:	Y	N	P	Fear/panic:	Y	N	P
Eating disorder:	Y	N	P	Psych hospitalization:	Y	N	P

Urinary Tract

Incontinence:	Y	N	P	Pain w/urination:	Y	N	P
Freq. infections:	Y	N	P	Kidney stones:	Y	N	P
Urgency:	Y	N	P	Discharge/blood:	Y	N	P

Name: _____ (Last, First, MI) DOB: _____

Male

Testicular Pain:	Y	N	P	Testicular Swelling:	Y	N	P
Discharge:	Y	N	P	STD:	Y	N	P
Hernia:	Y	N	P	Prostate Disease:	Y	N	P

Last Prostate Exam (DRE): _____ Abnormal DRE? Y N P

1. Do you have a decrease in libido (sex drive)? Y N
2. Do you have a lack of energy? Y N
3. Do you have a decrease in strength and/or endurance? Y N
4. Have you lost height? Y N
5. Have you noticed a decreased "enjoyment of life"? Y N
6. Are you sad and/or grumpy? Y N
7. Are your erections less strong? Y N
8. Have you noticed a recent deterioration in your ability to play sports? Y N
9. Are you falling asleep after dinner? Y N
10. Has there been a recent deterioration in your work performance? Y N

Female

Age of first menses: _____				How often menses occurs: _____ days			
How long menses lasts: _____				Heavy bleeding:	Y	N	P
Menstrual cramps:	Y	N	P	Menstrual pain:	Y	N	P
PMS:	Y	N	P	Food cravings:	Y	N	P
Number pregnancies: _____				Healthy libido:	Y	N	P
Number of births: _____				Vaginitis:	Y	N	P
Number of miscarriages: _____				Mammography:	Y	N	P
Last pap smear: _____				Vaginal dryness:	Y	N	P
Abnormal pap:	Y	N	P	Pain w/intercourse:	Y	N	P
Menopause since what age: _____				STD:	Y	N	P
Hormone replacement:	Y	N	P				

Hysterectomy (Date): _____ Ovaries intact? Y N Reason for Hysterectomy: _____

Ovarian Cyst: _____ Cancer _____ Uterine Fibroids: _____

Please list any birth control usage including what ages used:

_____

Name: _____ (Last, First, MI) DOB: _____

Sleep

What time do you typically go to bed? _____ What time do you wake up? _____

How long per night? _____ If you wake, for what reason? _____

What time(s) do you frequently wake? _____

Nightmares:	Y	N	P	Wake refreshed:	Y	N	P
Sleep walk:	Y	N	P	Grind teeth:	Y	N	P
Must nap during day:	Y	N	P	Snore:	Y	N	P

Please include any other concerns that you have that have not been addressed in this questionnaire:

_____

_____

_____

_____

_____

_____

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_____

_____

_____

Thank you for taking the time to fill out this questionnaire thoughtfully and carefully.