Graceful Healing Naturopathic PLLC
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Holly Oliver, ND

New Patient Intake Form

Patient's Name: _____ Date: _____
First Middle Last

Naturopathic healthcare is possible only when your physician completely understands the patient's spiritual, emotional, mental and physical conditions. The information you provide helps your physician understand your needs and how to help you reach your health goals. Please write legibly and answer all questions thoroughly. Feel free to mark anything you may have a question about.

Address: _____

City: _____ State: _____ Zip code: _____

Telephone numbers: home_____ cell_____ work/other _____

What is your preferred telephone number for appointment reminders and other messages? _____

Do we have permission to leave a detailed message at this preferred number? No private health information will be disclosed. (circle) Yes No

SS #: _____ Driver's license #: _____

Date of Birth: ___/___/_____ Age: _____ Gender: _____ Number of children you have: _____

Occupation: _____ Hours per week: _____

Employer and address: _____

Marital status: ☐ Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced

With whom do you live? ☐ Spouse ☐ Partner ☐ Parents ☐ Friends ☐ Children ☐ Alone ☐ Other

Emergency contact: _____ Relationship to patient: _____

Telephone numbers: home _____ cell _____ work/other _____

If someone other than patient is responsible for payment, please complete the following:

Name of responsible party: _____ SS#: _____ - _____ - _____

Relationship to patient: _____ Phone #: _____

Address: _____

Employer: _____ Work # _____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Graceful Healing Naturopathic to release information necessary to secure payment.

Signature: _____ **Date**: _____

How did you hear about Dr. Oliver? (Circle one or more of the following) website, friend, family member, insurance company, medical referral, other: _____

Have you ever been treated by a Naturopathic doctor before? Yes No

Are you currently under the care of another Health Care Provider (Medical doctor, Naturopathic doctor, Chiropractor, Massage Therapist, Acupuncturist, Physical therapist, Counselor, Psychiatrist, etc.)? Yes No
If yes, please list their name and what you were being seen for:

1) _____

2) _____

3) _____

4) _____

If not, where did you last receive medical care and what for? _____

_____

Health Concerns

Please list your health concern, in order of importance:

1) _____

2) _____

3) _____

4) _____

5) _____

When was the last time you felt truly well? _____

What do you think is wrong with your health? _____

_____

Personal Health History

Please list any hospitalizations or surgeries:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Please list any major accidents:

_____ Date: _____

_____ Date: _____

Have you ever had a concussion? (Circle one) Yes No

Please list any diagnostic imaging studies have you had (examples: Bone density scan, Mammogram, X-rays, Electrocardiogram, Electroencephalogram, CT scan, MRI, colonoscopy, sigmoidoscopy) and the reason why.

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

MEDICATIONS AND/OR SUPPLEMENTS

Do you take or use any of the following?

☐ Pain relievers (examples: aspirin, ibuprofen)
☐ Diet pills, appetite suppressants
☐ Cortisone (cream or pills)
☐ Thyroid medication
☐ Sleeping pills
☐ Laxatives
☐ Tranquilizers
☐ Antibiotics
☐ Antacids

Please list any prescription medications, over-the-counter medications, vitamins, minerals, herbs, or other supplements you are taking with the dose and a brief reason for taking them:

_____ Reason _____

_____ Reason _____

_____ Reason _____

_____ Reason _____

_____ Reason _____

_____ Reason _____

_____ Reason _____

_____ Reason _____

***** If you need additional space, please attach a separate sheet of paper.

CHILDHOOD ILLNESSES

Please circle whether you have/had any of the following conditions as a child/adolescent:

Diphtheria	Yes	No	Mumps	Yes	No
German measles	Yes	No	Rheumatic fever	Yes	No
Measles	Yes	No	Scarlet fever	Yes	No

Other: _____

PAST IMMUNIZATIONS

Please circle any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diphtheria	Yes	No	Measles/Mumps/Rubella	Yes	No
Pertussis	Yes	No	Tetanus	Yes	No
Chicken Pox	Yes	No	Polio	Yes	No

Other: _____

FAMILY HISTORY

Mark with an X or appropriate response:	Mother	Father	Brother	Sister	Grandparents	Child	Spouse
Age (if living)							
Health (G = good, P = poor)							
Age of death (if deceased)							
Cause of death (if deceased)							
Alcoholism							
Anemia							
Arthritis							
Asthma/ Hay fever/ Hives							
Cancer							
Cataracts							
Diabetes							
Epilepsy							
Gallbladder Disease							
Glaucoma							
Heart Disease							
High Blood Pressure							
Kidney Disease							
Liver Disease							
Mental Illness							
Stroke							
Thyroid Problems							
Tuberculosis							
Other major illness							

LIFESTYLE OVERVIEW

What is your occupation? _____

Do you take vacations? Yes No

Interests and hobbies: _____

Do you Smoke or chew any tobacco products? Yes No Past

If current or past use, how many years? _____ Packs, cigarettes or cans per day? _____

Are you exposed to smoking at home? Yes No Are you exposed to smoking at work? Yes No

Do you use any recreational drugs? Yes No Type(s) and frequency: _____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Yes No

If yes, please describe? _____

Do you have any allergies to drugs or other environmental allergens (examples: cats, mold, dust)? Yes No

If yes, please list and explain: _____

_____

Do you have any food allergies or intolerance? Please describe: _____

Do you have any dietary restrictions (religious, vegetarian, etc.)? Please describe: _____

_____

Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you drink any of the following? (circle all that apply) Water, Coffee, Soda, Beer/Wine/Spirits, Energy drinks, Fruit juice, Vegetable juice, other: _____

Have you ever been treated for substance abuse/ alcoholism? Yes No

Do you exercise? Yes No How many times per week and for how long? _____

What kinds of exercise? _____

Do you have a spiritual practice? (optional) Yes No

If yes, what type _____

SLEEP HABITS

How many hours do you sleep per night? _____

Do you wake rested? Yes No If No, why? _____

Number of times you usually wake at night: _____

Do you have trouble falling or staying asleep? Yes No If yes, why? _____

On a scale of 1 to 10 how do you rate your quality of sleep (please circle)?

1 2 3 4 5 6 7 8 9 10

Very Poor Excellent

ENERGY AND STRESS LEVEL

When during the day is your energy best? _____ Worst? _____

Rate your daily energy level on a scale of 1-10 (please circle):

1 2 3 4 5 6 7 8 9 10

Extremely Low Low Moderate High

Do you enjoy your work?_____ How many hours do you work each week? _____

Rate your daily stress level on a scale of 1-10 (please circle):

1 2 3 4 5 6 7 8 9 10

Extremely Low Low Moderate Extreme

What are your top stressor(s): (check all that apply)

☐ Financial ☐ Job related ☐ Marriage ☐ Health ☐ Interpersonal ☐ Unfulfilled expectations

☐ Family ☐ Spiritual ☐ Other(s): _____

What do you do to deal with stress? _____

GENERAL

Height: _____ Weight: _____ lbs. Weight one year ago: _____ lbs.
Maximum weight: _____ lbs. When? _____

REVIEW OF SYSTEMS

Please circle. Y = Yes, present condition. N = No, never had the condition. P = Problem of the past.

Head

Headache	Y	N	P	Migraine	Y	N	P				
Injury	Y	N	P	Jaw/TMJ	Y	N	P				

Ears

Ringing	Y	N	P	Impaired hearing	Y	N	P				
Earache	Y	N	P	Dizziness	Y	N	P				

Neck

Lumps	Y	N	P	Swollen Glands	Y	N	P				
Goiter	Y	N	P	Painful/Stiffness	Y	N	P				

Skin

Rashes	Y	N	P	Psoriasis	Y	N	P	Eczema/Hives	Y	N	P
Lumps	Y	N	P	Acne/Boils	Y	N	P	Color change	Y	N	P
Itching	Y	N	P	Loss of Hair	Y	N	P	Night sweat	Y	N	P

Musculoskeletal

Joint Pain	Y	N	P	Broken Bones	Y	N	P	Sciatica	Y	N	P
Arthritis	Y	N	P	Weakness	Y	N	P	Back pain	Y	N	P
Muscle Spasm	Y	N	P								

Eyes

Blurred Vision	Y	N	P	Cataracts	Y	N	P	Glasses/Contacts	Y	N	P
Eye Pain/strain	Y	N	P	Glaucoma	Y	N	P	Tearing/dryness	Y	N	P
Spots in Eyes	Y	N	P	Color blind	Y	N	P	Double Vision	Y	N	P

Nose/Sinuses

Stuffiness	Y	N	P	Loss of smell	Y	N	P	Sinus Problems	Y	N	P
Hay fever	Y	N	P	Nose Bleeds	Y	N	P	Frequent colds	Y	N	P

Mouth/Throat

Hoarseness	Y	N	P	Gum Problems	Y	N	P	Freq. Soreness	Y	N	P
Jaw Clicks	Y	N	P	Dental Cavities	Y	N	P	Sore lips/tongue	Y	N	P

Respiratory

Asthma	Y	N	P	Cough	Y	N	P	Sputum	Y	N	P
Pleurisy	Y	N	P	Pneumonia	Y	N	P	Emphysema	Y	N	P
Wheezing	Y	N	P	Bronchitis	Y	N	P	Shortness of Breath	Y	N	P
Tuberculosis	Y	N	P	Spitting up blood	Y	N	P	At Night	Y	N	P
Pain Breathing	Y	N	P	Difficult Breathing	Y	N	P	Lying Down	Y	N	P

Cardiovascular

Angina	Y	N	P	Chest pain	Y	N	P	Blood clots	Y	N	P
Murmur	Y	N	P	Heart Disease	Y	N	P	Rheumatic fever	Y	N	P
Fainting	Y	N	P	Ankle Swelling	Y	N	P	Low/High Blood Pressure	Y	N	P

Gastrointestinal

Diarrhea	Y	N	P	Constipation	Y	N	P	Change in thirst	Y	N	P
Ulcers	Y	N	P	Black Stool	Y	N	P	Coughing Blood	Y	N	P
Jaundice	Y	N	P	Hemorrhoids	Y	N	P	Gall Bladder disease	Y	N	P
Heartburn	Y	N	P	Abdominal Pain	Y	N	P	Blood in Stool	Y	N	P
Liver Disease	Y	N	P	Bloating	Y	N	P				

How Many Bowel movements per day? _____

Urinary

Incontinence	Y	N	P	Frequent Infection	Y	N	P	Painful Urination	Y	N	P
Kidney Stones	Y	N	P	Frequency at night	Y	N	P	Blood in urine	Y	N	P

Blood/Peripheral Vascular

Anemia	Y	N	P	Cold hands/feet	Y	N	P	Thrombophlebitis	Y	N	P
Leg Pain	Y	N	P	Easy bruising	Y	N	P	Varicose veins	Y	N	P

Neurological

Fainting	Y	N	P	Paralysis	Y	N	P	Numbness/tingling	Y	N	P
Seizures	Y	N	P	Loss of Memory	Y	N	P	Muscle Weakness	Y	N	P

Emotional

Mood swings	Y	N	P	Nervousness	Y	N	P	Tension/stressed	Y	N	P
Anxiety	Y	N	P	Depression	Y	N	P				

Endocrine

Hypothyroidism	Y	N	P	Excessive thirst	Y	N	P	Cold intolerance	Y	N	P
Hyperthyroidism	Y	N	P	Excessive Hunger	Y	N	P	Heat intolerance	Y	N	P

Female Reproductive

Age of first menses _____ Age of last menses (if menopausal) _____
Length of cycle _____ Duration of menses _____
Date of last annual exam _____

Painful Menses	Y	N	P	Endometriosis	Y	N	P	Ovarian Cysts	Y	N	P
Sexually active	Y	N	P	Cycles Regular	Y	N	P	Cervical dysplasia	Y	N	P
Sexual Difficulty	Y	N	P	Abnormal pap	Y	N	P	Bleeding between cycles	Y	N	P
Breast lumps	Y	N	P	Nipple discharge	Y	N	P	Do Self breast exams	Y	N	P
PMS	Y	N	P								
Birth Control	Y	N	P ⇨	If yes currently or in the past, what types? _____							

Number of pregnancies _____ Number of live births _____
Number of miscarriages _____ Number of abortions _____
Are you currently pregnant? Yes No Are you currently trying to get pregnant? Yes No

Male Reproductive

Hernias	Y P N	Testicular masses	Y P N	Discharge or sores	Y P N
Prostate issues	Y P N	Sexual difficulty	Y P N	Testicular pain	Y P N
Sexually active	Y P N	Premature ejaculation	Y P N	Sexually Transmitted infection	Y P N

Is there anything else you would like us to know in order to serve you better?

_____

_____

_____

_____

Welcome! We look forward to supporting you on your journey toward optimal wellness.