

**Jessica Shoemaker, BS, ND**  
**Alternative Healthcare Consultant**  
*The Family Wellness Center at Briarsdale*

**Naturopathic Medical Intake Form--Adult**

Name _____	Date of First Visit _____
Address _____	
City _____	State _____ Zip Code _____
Telephone # (home) _____	(work) _____
Age _____	Date of Birth _____ Gender: female ____ male ____
Email _____	

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

Live with: Spouse \_\_\_\_ Partner \_\_\_\_ Parents \_\_\_\_ Children \_\_\_\_ Friends \_\_\_\_ Alone \_\_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_ Retired \_\_\_\_\_

Employer \_\_\_\_\_ S.S.# \_\_\_\_\_

(Work address) \_\_\_\_\_

Health insurance co. name and address \_\_\_\_\_

Telephone number ( ) \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Policy holder's name \_\_\_\_\_ Employer \_\_\_\_\_

Identification/Social Security # \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Has any other family member already been a patient at the clinic? \_\_\_\_\_

Next of Kin or other to reach in an emergency \_\_\_\_\_

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

Address \_\_\_\_\_

**PLEASE FILL OUT BOTH SIDES OF EACH PAGE**

**HEALTH HISTORY QUESTIONNAIRE**

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PROVIDER HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Are you currently receiving healthcare? Y N

If yes, where and from whom? \_\_\_\_\_  
\_\_\_\_\_

If no, when and where did you last receive medical or health care?  
\_\_\_\_\_

What was the reason? \_\_\_\_\_

What are your most important health problems? List as many as you can in order of importance.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_

Do you have any known contagious diseases at this time? Y N

If yes, what? \_\_\_\_\_

**FAMILY HISTORY**

	<u>FATHER</u>	<u>MOTHER</u>	<u>BROTHERS</u>	<u>SISTERS</u>	<u>G'PARENTS</u>
Age (if living)	_____	_____	_____	_____	_____
Health ( G=good P=poor )	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____
<b><u>Mark (x) those applicable</u></b>					
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Asthma/Hayfever/Hives	_____	_____	_____	_____	_____

Anemia	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____

**For all the following sections**

Y = a condition you have now P = a condition you have had in the past N = never had the condition

**Childhood Illnesses**

Scarlet fever	Y N	Diphtheria	Y N	Rheumatic fever	Y N
Mumps	Y N	Measles	Y N	German measles	Y N

**Hospitalization and Surgery**

What hospitalizations or surgeries have you had?

\_\_\_\_\_ year: \_\_\_\_\_      \_\_\_\_\_ year: \_\_\_\_\_  
 \_\_\_\_\_ year: \_\_\_\_\_      \_\_\_\_\_ year: \_\_\_\_\_

**X-Rays and Special Studies**

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

\_\_\_\_\_

Electrocardiogram	Y N	Electroencephalogram	Y N
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**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 environmental? \_\_\_\_\_

**Current Medications**

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1) \_\_\_\_\_ 4) \_\_\_\_\_  
 2) \_\_\_\_\_ 5) \_\_\_\_\_  
 3) \_\_\_\_\_ 6) \_\_\_\_\_

**HABITS (Y = now, P = past, N = never)**

Main interests and hobbies? \_\_\_\_\_

Do you exercise? Y N

If yes, what kind? \_\_\_\_\_ How often? \_\_\_\_\_

Average 6-8 hrs. sleep? Y N Enjoy your work? Y N

Sleep well? Y N Take vacations? Y N

Awaken rested? Y N Spend time outside? Y N

Have a supportive relationship? Y N Watch television? Y N

Have a history of abuse? Y N how many hours? \_\_\_\_\_

Any major traumas? Y P N Read? Y N

Use recreational drugs? Y P N how many hours? \_\_\_\_\_

Been treated for drug dependence? Y P N

Do you eat three meals a day? Y N Use alcoholic beverages? Y P N

Do you eat out often? Y N Treated for alcoholism? Y P N

Do you go on diets often? Y N Do you use tobacco? Y P N

Do you drink coffee? Y P N Smoked previously? Y P N

Do you drink black or green tea? Y P N how many years? \_\_\_\_\_

Do you drink cola or other sodas? Y P N how many packs per day? \_\_\_\_\_

Do you eat refined sugar? Y P N

Do you add salt? Y P N

Do you have a religious or spiritual practice? Y N If yes, what? \_\_\_\_\_

Is there any information about your health you would like to add? \_\_\_\_\_

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**GENERAL**

Weight \_\_\_\_\_ lbs. Weight 1 year ago \_\_\_\_\_ lbs.

Maximum Weight \_\_\_\_\_ When \_\_\_\_\_

Height \_\_\_\_\_

When during the day is your energy the best? \_\_\_\_\_ worst? \_\_\_\_\_

**REVIEW OF SYSTEMS**

**FOR THE FOLLOWING, PLEASE CIRCLE**

Y = a condition you have now P = a condition you have in the past N = never had the condition

**MENTAL/ EMOTIONAL**

Treated for emotional problems?	Y P N	Depression?	Y P N
Mood Swings?	Y P N	Anxiety or nervousness?	Y P N
Considered/ Attempted suicide?	Y P N	Tension?	Y P N
Poor concentration?	Y P N	Memory problems?	Y P N

**ENDOCRINE**

Hypothyroid?	Y P N	Heat or cold intolerance?	Y P N
Hypoglycemia?	Y P N	Diabetes?	Y P N
Excessive thirst?	Y P N	Excessive hunger?	Y P N
Fatigue?	Y P N	Seasonal depression?	Y P N

### IMMUNE

Vaccinations?	Y P N	Reactions to vaccinations?	Y P N
Chronic Fatigue Syndrome?	Y P N	Chronic infections?	Y P N
Chronically swollen glands?	Y P N	Slow wound healing?	Y P N

### NEUROLOGIC

Seizures?	Y P N	Paralysis?	Y P N
Muscle weakness?	Y P N	Numbness or tingling?	Y P N
Loss of memory?	Y P N	Easily stressed?	Y P N
Vertigo or dizziness?	Y P N	Loss of balance?	Y P N

### SKIN

Rashes?	Y P N	Eczema, Hives?	Y P N
Acne, Boils?	Y P N	Itching?	Y P N
Color Change?	Y P N	Perpetual Hair Loss?	Y P N
Lumps?	Y P N	Night Sweats?	Y P N

### HEAD

Headaches?	Y P N	Head Injury?	Y P N
Migraines?	Y P N	Jaw/TMJ problems	Y P N

### EYES

Spots in Eyes?	Y P N	Cataracts?	Y P N
Impaired vision?	Y P N	Glasses or contacts?	Y P N
Blurriness?	Y P N	Eye pain/strain?	Y P N
Color blindness?	Y P N	Tearing or dryness?	Y P N
Double Vision?	Y P N	Glaucoma?	Y P N

### EARS

Impaired hearing?	Y P N	Ringing?	Y P N
Earaches?	Y P N	Dizziness?	Y P N

### NOSE AND SINUSES

Frequent colds?	Y P N	Nose Bleeds?	Y P N
Stuffiness?	Y P N	Hayfever?	Y P N
Sinus problems?	Y P N	Loss of smell?	Y P N

### MOUTH AND THROAT

Frequent sore throat?	Y P N	Copious saliva?	Y P N
Teeth grinding?	Y P N	Sore tongue/lips?	Y P N
Gum problems?	Y P N	Hoarseness?	Y P N
Dental cavities?	Y P N	Jaw clicks?	Y P N

### NECK

Lumps?	Y P N	Swollen glands?	Y P N
Goiter?	Y P N	Pain or stiffness?	Y P N

### RESPIRATORY

Cough?	Y P N	Sputum?	Y P N
Spitting up blood?	Y P N	Wheezing	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Pleurisy?	Y P N
Emphysema?	Y P N	Difficulty breathing?	Y P N
Pain on breathing?	Y P N	Shortness of breath?	Y P N
Shortness of breath at night?	Y P N	" " " lying down?	Y P N
Tuberculosis?	Y P N		

### CARDIOVASCULAR

Heart disease?	Y P N	Angina?	Y P N
High/Low Blood Pressure?	Y P N	Murmurs?	Y P N
Blood clots?	Y P N	Fainting?	Y P N
Phlebitis?	Y P N	Palpitations/Fluttering?	Y P N
Rheumatic Fever?	Y P N	Chest pain?	Y P N
Swelling in ankles?	Y P N		

### GASTROINTESTINAL

Trouble swallowing?	Y P N	Heartburn?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea?	Y P N	Vomiting? (Illness or Induced)	Y P N
Vomiting blood?	Y P N	Bowel Movements: How often? _____	
Blood in stool?	Y P N	Is this a change? _____	
Pain or cramps?	Y P N	Constipation?	Y P N
Belching or passing gas?	Y P N	Diarrhea?	Y P N
Black stools?	Y P N	Gall Bladder disease?	Y P N
Jaundice (yellow skin)?	Y P N	Ulcer?	Y P N
Liver Disease?	Y P N	Hemorrhoids?	Y P N

### URINARY

Pain on urination?	Y P N	Increased frequency?	Y P N
Frequency at night?	Y P N	Inability to hold urine?	Y P N
Frequent infections?	Y P N	Kidney stones?	Y P N

### MALE REPRODUCTION

Hernias?	Y P N	Testicular masses?	Y P N
Testicular pain?	Y P N	Prostate disease?	Y P N
Venereal disease?	Y P N	Discharge or sores?	Y P N
Are you sexually active?	Y N	Chlamydia?	Y P N
Sexual orientation: _____		Gonorrhea?	Y P N
Impotence?	Y P N	Condyloma?	Y P N
Premature ejaculation?	Y P N	Herpes?	Y P N
Birth control? Type? _____		Syphilis?	Y P N

### FEMALE REPRODUCTION/BREASTS

Age of first menses? _____			
Age of last mense? _____		Are cycles regular?	Y N

Length of cycle? _____ days	Bleeding between cycles?	Y P N
Duration of menses? _____ days	Pain during intercourse?	Y P N
Painful menses? Y P N	Clotting?	Y P N
Heavy or excessive flow? Y P N	Discharge?	Y P N
PMS? Y P N	Birth control?	Y P N
If yes, what are your symptoms? _____	What type? _____	
_____	Number of pregnancies _____	
_____	Number of live births _____	
Endometriosis? Y P N	Number of miscarriages _____	
Ovarian cysts? Y P N	Number of abortions _____	
Difficulty conceiving? Y P N	Menopausal symptoms? Y P N	
Cervical Dysplasia? Y P N	Abnormal PAP? Y P N	
Sexual difficulties? Y P N	Chlamydia? Y P N	
Gonorrhea? Y P N	Condyloma? Y P N	
Herpes? Y P N	Syphilis? Y P N	
Are you sexually active? Y N	Sexual orientation: _____	
Do you do breast self exams? Y P N	Breast lumps? Y P N	
Breast pain/tenderness? Y P N	Nipple discharge? Y P N	

#### MUSCULOSKELETAL

Joint pain or stiffness? Y P N	Arthritis? Y P N
Broken bones? Y P N	Weakness? Y P N
Muscle spasms or cramps? Y P N	Sciatica? Y P N

#### BLOOD/PERIPHERAL VASCULAR

Easy bleeding or bruising? Y P N	Anemia? Y P N
Deep leg pain? Y P N	Cold hands/feet? Y P N
Varicose veins? Y P N	Thrombophlebitis? Y P N

#### *Consent of Financial Responsibility:*

The ultimate responsibility of the fees is that of the undersigned/patient. **Patients are requested to provide 24-hour notice of cancellation. Without such notice, clients will be charged for the professional time at the regular hourly rate.** Your signature indicates your understanding and acknowledgement of the foregoing information.

Please sign your name: \_\_\_\_\_ Date: \_\_\_\_\_

*Please return this intake form to:*

Jessica Shoemaker, BS, ND  
 The Family Wellness Center at Briarsdale  
 1000 Briarsdale Road, Suite A  
 Harrisburg, PA 17109  
 (717) 558-8500 Ext. 2  
 (717) 558-8567 Fax

*Welcome and Congratulations on your decision  
 to seek Optimal Health!*

*We're glad to serve you! If you have any questions, please ask!*