Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ **Date:** _____

Insurance: _____ (dd/mm/yr)

Date of Birth: _____ ☐ male ☐ female

Address: _____

_____ **Marital status**

_____ S | M | W | D | SEP

Phone #: home: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
- ☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____ Length of cycle: ____

Date - 1st day last period: _____

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? ____

How many children do you have? ____

Birth control method: _____

Date of last PAP test: _____

☐ normal, ☐ abnormal

Date of last mammogram: _____

☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

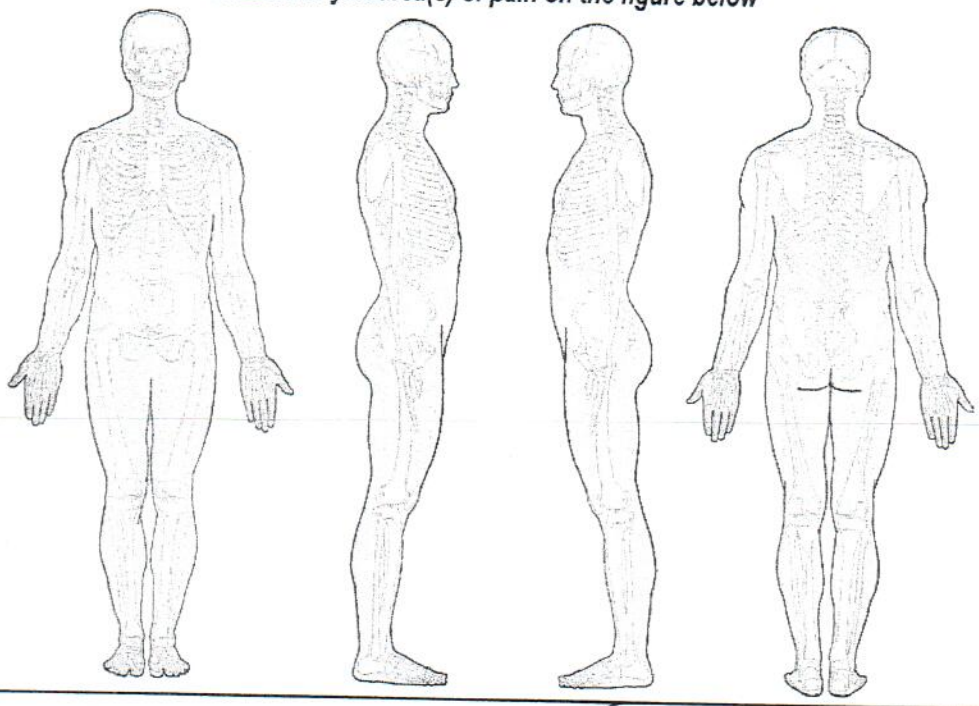
What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:

Worst Possible Pain

No Pain



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

DR. Alan Rosenthal, D.C.

Initial Intake Form

List major childhood illnesses: (ear infections, strep throat, tonsillitis, chicken pox, measles, etc.)

Vaccinations: ☐ I have been fully vaccinated ☐ I get the flu shot regularly ☐ I have had some vaccines
☐ I haven't been vaccinated ☐ I have had travel vaccines (ie. Hepatitis) ☐ I don't know/don't remember

Successful health care and preventive medicine are only possible when I have a complete understanding of you – including your expectations and obstacles to cure. The nature of your responses to the following questions will go a long way in assisting how I can best help you. Your time, thoughtfulness and honesty in completing this overview are appreciated.

1. What do you know about the naturopathic approach?

2. What expectations do you have from **this** visit to our clinic?

3. What **long term** expectations do you have from working with our clinic?

4. What expectations do you have **of me personally** as your health care provider?

5. What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? Circle level of commitment:

   0% 1 2 3 4 5 6 7 8 9 10 (100%)

6. What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

7. What behaviors or lifestyle habits do you currently engage in regularly that you believe are **self-destructive?**

8. What potential **obstacles** do you foresee in adhering to the therapeutic protocols that I will be sharing with you?

9. Do you feel you are fulfilling your purpose in life? If no, what is standing in your way?

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with _____ (health care providers name).

Dated this _____ day of _____ 20___

_____
Patient signature (or Legal Guardian)
Print Name:_____

_____
Signature of Witness
Print Name:_____