

Intake form

1. Patient:

Name _____

Date of Birth _____

SSN _____

Address _____

Telephone: Home _____

Mobile _____

Work _____

Do you allow us to leave a message regarding your health care? Yes No

If Yes, Please indicate the most convenient route

How did you learn about us?

2. Emergency contact:

Name _____

Relationship to the patient _____

Telephone _____

3. Employment/ School:

Employer

Address

Telephone

4. Primary care physician (Please indicate name and phone number):

5. Specialist (Please indicate name and phone number):

6. Date of your last comprehensive physical examination:

7. Date of your last dental examination:

8. Please indicate the dates of you last laboratory and diagnostic imaging tests. Please indicate any abnormal findings:

CBC:

Cholesterol:

Glucose:

PSA:

Mammogram:

PAP (for women only):

Colonoscopy:

Chest X-ray:

Tuberculosis screening:

9. Please indicate the dates for the following vaccinations:

Tetanus:

Diphtheria:

Pertussis:

Influenza:

MMR:

Varicella:

Polio:

Hepatitis A

Hepatitis B:

10. Please indicate whether you were in the past or are currently exposed to:

Heavy metals (lead, mercury, arsenic):	Currently	Past	Not
known			

Ionizing radiation:	Currently	Past	Not
known			

11. Please indicate whether you currently have or have had in the past any of the following conditions:

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Hypertension	Current	Past
Thrombophlebitis	Current	Past
Stroke	Current	Past
MI	Current	Past
Congestive heart failure	Current	Past
Asthma	Current	Past
COPD	Current	Past
Cancer (specify the type)	Current	Past
Tuberculosis	Current	Past
Lupus	Current	Past
Rheumatoid arthritis	Current	Past
Hepatitis (specify the type)	Current	Past
Liver cirrhosis	Current	Past
Diabetes	Current	Past
Hyperthyroidism	Current	Past
Hypothyroidism	Current	Past
Stomach ulcer	Current	Past
Ulcerative colitis	Current	Past
Crohn's disease	Current	Past

Any other current or past medical condition not listed here:

12. Major surgery (Indicate for what condition and date):

13. Hospitalization (Indicate for what condition(s) and date(s)):

14. Any known allergies: