

**Patient Intake Form**

**Vitalis Naturopathic Centre, INC.**

**Dr. Celeste Saenz, ND**

**Healthcare Team**

Present PCP (Name, Credentials, Phone):

Other healthcare practitioners:

Last physical exam: Date \_\_\_\_\_ Doctor \_\_\_\_\_

Last blood work: Date \_\_\_\_\_ Doctor \_\_\_\_\_

**Present Health Concerns**

What is the main reason for your visit today? Please describe in detail, including date of onset and any factors that may have contributed to its onset or continuation.

Is this concern getting: BETTER WORSE SAME

List types of treatments (including home care) and who treated you for this condition:

List other health concerns and dates of onset in order of importance:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_
- 7. \_\_\_\_\_ 8. \_\_\_\_\_

**Past Medical History**

General childhood health: GOOD FAIR POOR

Childhood Illnesses:

- Scarlet Fever       Rheumatic Fever       German measles       Chicken pox
- Whooping cough       Diphtheria       Asthma       Mumps
- Mono       Other \_\_\_\_\_

Hospitalizations and Surgeries (Type, Year):

Serious Illnesses and Injuries (Type, Cause, Year):

Medications (Prescription, non-prescription and supplements, including dosages):

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_
- 7. \_\_\_\_\_ 8. \_\_\_\_\_

Known Allergies:

Drugs \_\_\_\_\_ Foods \_\_\_\_\_  
Animals \_\_\_\_\_ Other \_\_\_\_\_

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Past Medical History, Cont.

Table with 4 columns: Current, Past, Current, Past. Rows list various medical conditions such as Allergies, Arthritis, Gout, Alcoholism, Bleeding disorder, Cancer, Heart murmur, Asthma, Kidney disease, Liver disease, Diabetes, Anemia, Hepatitis, Eczema, Stroke, Ulcers, Herpes, Candida, Rheumatism, Hypoglycemia, Sinus problems, High blood pressure, Pneumonia, Thyroid problems, Tonsillitis, HIV/AIDS, Tuberculosis, and Venereal disease.

Family Health History

- Heart disease, Bleeding disorder, Asthma, Cancer, Seizures, Osteoporosis, Diabetes, Allergies, High Blood Pressure, Stroke, Sickle Cell Anemia, Congenital Heart Defects

Lifestyle and Habits

Rank each on a scale of 1 to 10 (10 being optimal): Energy, Nutrition, Digestion, Sleep, Exercise, Weight, Work, Family, Well-being. How many hours a day of... Sleep, Relaxation, Work, Exercise. Do you smoke? Have you ever smoked? Do you use recreational or illicit drugs? How much coffee, tea or cola do you drink a day? How much alcohol do you drink a day?

Nutrition

Number of meals per day: Foods restricted from diet, and for how long: Describe any bad reactions you get from food: Do you crave sugar? Starches? Chocolate? Salt? Fat? Other? How much water do you drink per day? Is it filtered?

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**Review of systems**

*Please indicate symptoms that you have experienced in the last six months, or that have recurred throughout your life.*

**General**

- Weight change
- Fever/chills
- Weakness
- Fatigue
- Sweating/night sweats
- Fainting
- Dizziness
- Forgetfulness
- Hair/nail changes

**Skin**

- Itching
- Rashes
- Bruise easily
- Hives
- Athlete's foot
- Eczema/psoriasis
- Change in moles
- Sores that won't heal

**Muscle/Joint/Bone**

- Pain
- Numbness
- Swelling
- Bursitis/tendonitis
- Broken bones
- Sprains/strains
- Spasms/cramps
- Headaches/head injuries
- Low back, hip, leg pain
- Neck, shoulder, arm pain
- Jaw pain/TMJ
- Arthritis

**Eyes**

- Glasses/contacts
- Blurring
- Pain
- Double vision
- Discharge
- Floaters
- Glaucoma
- Cataracts

**Ears**

- Ringing
- Earache/discharge
- Loss of hearing

**Nose**

- Sinusitis
- Bleeding
- Discharge
- Obstruction
- Postnasal drip
- Nasal polyps

**Mouth/Throat**

- Sores
- Bleeding gums
- Teeth
- Hoarseness
- Difficulty swallowing
- Taste

**Pulmonary**

- Shortness of breath
- Wheezing
- Chronic cough
- Coughing blood
- Sputum

**Cardiovascular**

- High blood pressure
- Low blood pressure
- Irregular heartbeat
- Murmurs
- Calf pain with walking
- Edema
- Palpitations
- Chest pain
- Varicose veins

**Gastrointestinal**

- Poor appetite
- Constipation/diarrhea
- Indigestion/heartburn
- Gas/bloating
- Bowel changes
- Excessive hunger
- Excessive thirst
- Nausea/vomiting
- Hemorrhoids
- Blood in stool
- Hernia
- Anal discomfort

**Genitourinary**

- Low back pain
- Painful urination
- Blood in urine
- Frequent/urgent urination
- Loss of bladder control
- Nighttime urination
- Recurrent infections

**Male Only**

- Breast lumps
- Erection difficulties
- Lump/pain in testicles
- Penis discharge
- Sores on penis
- Infertility

**Sexual History**

- Syphilis
- Gonorrhea
- Chlamydia
- Sores/discharge
- Herpes
- Sexual/physical abuse

**Female Only**

- Breast lumps
- Nipple discharge
- Bleeding after menopause
- Hot flashes
- Painful intercourse
- Hysterectomy
- Infertility
- Fibroids
- Vaginal infections
- Abnormal PAP smears
- LMP \_\_\_\_\_

**Endocrine**

- Goiter
- Heat/cold intolerance
- Excessive thirst/hunger
- Hormone therapy

**Allergic**

- Drug/Vaccination allergy

Asthma

- Eczema
- Rhinitis
- Hay fever
- Hives
- Post-nasal drip
- Itchy/watery nose/eyes

**Blood/Lymph**

- Anemia
- Transfusions
- Bleeding tendency
- Lymph node enlargement
- Lymph node pain

**Neurological**

- Fainting
- Convulsions
- Sensations
- Gait/coordination
- Speech
- Numbness/tingling
- Paralysis/weakness

**Psychological**

- Memory loss
- Mood
- Sleep pattern
- Anxiety/depression
- Phobias
- Drug/alcohol abuse

**Other**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_