



Patient Intake and Health History Questionnaire

Personal Profile

Date _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone: Home _____ Work _____

Cell _____

Which numbers may we use to leave messages? Home Work Cell

Email _____

Would you like to be emailed monthly newsletters? Yes No

Marital Status: Single Married Separated Divorced Widowed Partnership

Live with: Spouse Partner Parents Children Friends Pets Alone

Occupation _____ Hours per week _____

Employer _____

Emergency Contact _____ Relationship to you _____

Emergency Contact Phone # _____

How did you hear about Olive Branch Wellness Center? _____

I certify that all information provided is correct. I also understand that all information provided on this intake form or during office visits is confidential. Information will only be released with my written and signed request.

Name _____ Date _____



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Your Ethnicity _____

Your Gender Male Female

Date of Birth _____ Age _____
mm / dd /yyyy

Height _____' _____" Current Weight _____ Goal Weight _____

If current weight is different than goal weight, how long has it been since
you were at your goal weight? _____

Medical Information

****Please bring copies of Current (within the past 2 years) medical reports
and laboratory tests to your appointment****

Primary Care Provider _____

Date of last medical or health care visit with primary _____

Reason for last visit _____

Date of last physical exam _____ Blood Type _____

Have you ever contracted an illness while traveling outside the country or shortly upon
your return? Yes No

If yes, please describe _____

What is your major complaint?

When did it start? _____

What makes it better? _____

What makes it worse? _____

Does anything else happen at the same time?



Other Complaints

How long have you had this condition? _____

Have you ever had this or a similar condition in the past? _____

How long has it been since you have REALLY felt good? _____

List all previous diagnosis and treatments you have received prior to your present complaint:

Hospitalizations, Surgeries & Outpatient Procedures

Type	Date	Reason for Procedure	Outcome/Results



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Major Accidents & Traumatic Events

e.g.: car accident, serious shock, nervous breakdown, divorce or death of loved one

Type	Age	Duration	Complete Recovery	Treatment
			Y N	
			Y N	
			Y N	
			Y N	
			Y N	

Family History

Use the key below to identify family members and their associated health conditions

Please list type where parentheses are present.

M: Mother F: Father S: Sister B: Brother G: Grandparent A: Aunt U: Uncle C: Child

ALLERGIES _____

ALCOHOLISM _____

ANEMIA _____

ALZHEIMER'S _____

ARTHRITIS (RHEUMATOID) _____

ARTHRITIS (OSTEO) _____

ASTHMA _____

BLEEDING DISORDER _____

CANCER () _____

CANCER () _____

CELIAC DISEASE _____

CROHNS DISEASE _____

COLITIS _____

DEPRESSION _____

DIABETES TYPE 1 _____

DIABETES TYPE 2 _____

ECZEMA _____

EPILEPSY _____

GOUT _____

HEART DISEASE _____

HIGH BLOOD PRESSURE _____

HIGH CHOLESTEROL _____

KIDNEY DISEASE _____

LUPUS _____

MENTAL DISORDER _____

NERVOUS SYSTEM DISEASE _____

OBESITY _____

STROKE _____

THYROID (HYPO/HYPER) _____

OTHER () _____

OTHER () _____



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Childhood/Adolescence History

How was your health as a child? Excellent Good(typical illnesses) Chronically Ill

Were you troubled by: (Check all that apply)

ACNE ALLERGIES ASTHMA CHRONIC BRONCHITIS CHRONIC SORE THROATS CONSTIPATION
CHRONIC EAR INFECTIONS DEPRESSION FATIGUE SEIZURES ECZEMA CANCER DIARRHEA HEADACHES
SKIN PROBLEMS LEARNING/BEHAVIOR PROBLEMS

Other _____

List medication(s) used for an extended period of time as a child:

Were you overweight as a child / adolescent? Yes No

What age range _____

How would you describe your experience of childhood / adolescence:

Happy / Secure Lonely Stress / Pressured Deprived of Love / Affection

Abused: Verbally Physically Sexually

Any significant childhood / adolescent injuries / illnesses / traumatic events?

For Males Only

Date of last testicular exam _____ Results _____

Date of last digital rectal exam (prostate exam) _____ Results _____

Date of last PSA blood test _____ Results _____

Do you experience any of the following? (check all that apply)

Low Libido Dribbling Decreased Stream Hesitancy Discharge

Erectile Dysfunction Need to Urinate Multiple Times During the Night Pain

Are you sexually active? Y N

If yes, current form of contraception _____

Are there any questions / concerns regarding your sex life or intimacy you wish to discuss?



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For Females Only

Date of last OB/GYN exam _____ Results _____

Date of last PAP smear _____ Results _____

Have you ever had an abnormal PAP? Y N

If yes, describe _____

Date of abnormal PAP _____

Date of last mammogram _____ Results _____

Date of last breast exam performed by physician _____

Are you sexually active? Y N Current form of contraception _____

Have you ever used birth control pills? Y N

If yes, have you ever experienced any side effects from the pill? Explain

Have you ever used an IUD? Y N If yes, for how long? _____

What type of IUD? _____

If yes, have you ever experienced any side effects from the IUD?

Age of first menstruation _____

Did you have a difficult time during puberty (i.e. physically, emotionally)? Yes No

If yes, explain



For Females Only *Continued*

If you experience PMS, please check all symptoms that apply:

NERVOUS TENSION DEPRESSION HEADACHE WEIGHT GAIN

IRRITABILITY FORGETFULNESS CRAVING SWEETS BLOATING

MOOD CHANGES CRYING INCREASED APPETITE SWELLING OF HANDS/FEET

ANXIETY CONFUSION HEART POUNDING BREAST TENDERNESS

INSOMNIA DIZZINESS OR FAINTING CRAMPING FATIGUE

Periods occur every _____ days. Do you ever skip periods? Y N

Date of last period _____ Periods usually last _____ days

Quantity of flow: Light Moderate Heavy

Number of tampons and/or pads used per day: Tampons _____ Pads _____

Quality of menstrual blood: Dark Red Bright Red Large Clots Brown

Describe if necessary: _____

Are you Currently pregnant? Yes No Maybe

of pregnancies (include current): # Births _____ # Miscarriages _____

Abortions _____

Any complications during pregnancy? Yes No If yes, please explain

Did you breastfeed any of your children? Yes No

If Yes, how many did you breastfeed? All Some

Any problems with breastfeeding? Yes No

If yes, please explain



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Are there any questions/concerns regarding your sex life or intimacy you wish to discuss?

Have you reached any of the following?:

Peri-menopause Menopause Post-menopause None

Date of last menstrual cycle _____

Are you taking any kind of hormone replacement therapy? Yes No

When did you start taking HRT? _____

Type of HRT? _____ Dose _____

Have you had a hysterectomy? Yes No

If yes: Partial Complete Date _____

Any complications from the hysterectomy? Yes No

If yes please explain _____

Allergies

Do you suffer from allergies ? Yes No

If yes, to what (ex grass, pollen, dust, animals, food)

Have you ever experienced an anaphylaxis reaction? Yes No

If yes, to what? _____

Have you had allergy testing? Yes No

If yes what type _____

Results



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Diet

List any specific foods or beverages you exclude from your diet, when and why?

How many meals do you generally eat each day?

Have you “yo-yo” dieted in the past? Yes No Explain;

How often do you eat out or eat take-out foods?

Are there specific foods that you feel you can't live without? Yes No
If yes which ones?

List any food or beverages that do not agree with you;

Explain what happens when they don't agree with you;

What foods do you crave?



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Do you consume Candy? Yes No

How often? _____

Do you eat after dinner? _____

Do you feel you need something sweet after a meal? _____

Do you feel sleepy after meals? Yes No

Have you ever felt you have an eating disorder? Yes No

If yes, please explain _____

Typical daily water intake is _____ oz OR _____ glasses

of cups or glasses of the following per day

_____ *COFFEE* _____ *TEA* _____ *POP* _____ *JUICE* _____ *WINE*

_____ *BEER* _____ *LIQUOR/MIXED DRINKS*

Sleep

Average Hours per night _____

Do you have trouble falling asleep? Yes No

If yes, what keeps you awake?

How long does it take you to fall asleep? _____

Do you have trouble staying asleep? Yes No

If yes, how many times do you wake per night and is there a consistent time that you wake through-out the night? _____

Do you snore? Yes No

If yes, please describe:

Do you have recurring dreams? Yes No



If yes, please describe:

Do you wake refreshed? Yes No

What time do you go to bed? _____ What time do you get up? _____

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The Strength For Life Good Health Brings

Today's Date _____

Please initial and date the following statements:

I understand payment is due at the time of service _____

I understand that my insurance will not be billed _____

Recommendations made do not supersede or are not in lieu of any medical advice by your physician. _____

When need be I will be referred out for further care. _____

I have supplied a current list of all medications and supplements that I utilize and will be asked to update this list at each visit. _____

I will provide copies of current medical information if necessary for review. _____

I will provide information regarding other health care professionals that I am seeing on each time I am asked to do so. _____

I ALSO UNDERSTAND THAT IF I DO NOT CANCEL AN APPOINTMENT 24HRS PRIOR I WILL BE CHARGED \$75.00. _____

Supplements I am currently taking: Medications and over the counter items I am taking:

Signature

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The Strength For Life Good Health Brings

Patient Information Please Print

Date _____
Name _____
Address _____

Phone _____
Home _____
Work _____
Cell _____
Date of Birth _____
E-Mail address _____
Emergency Contact Information:
Name _____
Phone # _____
Relation to you _____

How did you hear of us?

Today's Date _____

I understand that Naturopathic Medicine is not currently licensed in the state of Illinois, and that by obtaining information from the Unlicensed physician I am not able to bill my insurance company.

Name _____