# *San Jose Integrative Medicine*

## MEN'S NATUROPATHIC HEALTH INTAKE FORM

### PATIENT INFORMATION

| Name: | | Date: |
|---|---|---|
| Date of Birth: | Age: | Gender: |
| Address: | | |
| City, State, Zip: | | |

**Phone**:

May we leave detailed messages regarding your appointments at this number? ☐ Yes ☐ No

Would you like to receive a text reminder for appointments? ☐ Yes ☐ No

**Email**:

May we email you information, appointment reminders, and periodic announcements from our office? ☐ Yes ☐ No

If you answered no to any of the above, please specify if we can :

* "information" can mean lab work, billing statements, or anything pertinent to your current medical condition

☐ Leave a name and number only at the phone number provided ☐ Mail information to your home address ☐ Only mail billing statements to my home

Emergency Contact (name and phone):
Relationship to you:

Insurance Company_____ ID #_____

When were you last seen by a medical professional and for what condition?

How did you find our office?
Search words used?

**WHAT ARE YOUR CURRENT HEALTH CONCERNS? PLEASE LIST IN ORDER OF IMPORTANCE.**

1. 4.
2. 5.
3. 6.

**PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE INTERESTED IN:**

| | | |
|---|---|---|
| Food Intolerance Testing | Hormone Testing | Wellness Screening |
| Nutritional Testing | Fertility Testing | Digestive Analysis |
| Adrenal Testing | Complete Cardiovascular Panel | |

## Medical and Family History

Please list your current and past diagnoses (if any):

Please list past hospitalizations and surgical procedures (include date and hospital):

Have you been fully vaccinated? ☐ Yes ☐ No ☐ Unsure

List any known allergies to medications, foods or other substances as well as your reaction:

### Medications and Supplements

List all current medications, vitamins, herbs and other supplements you take, including dosages.

| Medications: | Vitamins, Herbs, Other Supplements: |
|---|---|
| | |

### Family History

List any serious health conditions your family members have experienced. Include diabetes, heart disease, autoimmune disease, cancer, additions, eating disorders, mental disorders, allergies, genetic disorder or any other major concerns.

| Condition: | Family Member: | Age of onset/age of death: |
|---|---|---|
| | | |

## General Health Information

Please check all that apply:

### Gastrointestinal Health

| | Yes | | Yes |
|---|---|---|---|
| Number of bowel movements per day: _____ | | | |
| Any constipation? | ☐ | Any blood or mucous in stool? | ☐ |
| Any diarrhea? | ☐ | Any abdominal pain or upset stomach? | ☐ |
| Recent changes in bowel habits? | ☐ | Any heartburn? Or Reflux? | ☐ |
| Recent changes in appetite? | ☐ | Any nausea or vomiting? | ☐ |
| Any excessive gas or bloating? | ☐ | Have you had a colonoscopy? | ☐ |
| Any loss of bowel control? | ☐ | | |
| Do you have hemorrhoids? | ☐ | | |
| Have you been diagnosed with IBS? | ☐ | | |

### Weight History

| | | |
|---|---|---|
| Are you content with your current weight? | ☐ | Current height? |
| Does your weight fluctuate? | ☐ | Current weight? |
| Any family history of weight problems? | ☐ | Desired weight? |

### Nervous System/Ears, Eyes, Nose and Throat

| | | | |
|---|---|---|---|
| Loss of consciousness | ☐ | Vertigo or dizziness | ☐ |
| Loss of hearing | ☐ | Ringing or buzzing in ears | ☐ |
| Sinus problems | ☐ | Loss of smell | ☐ |
| Chronic congestion or nasal discharge | ☐ | Ear infections | ☐ |
| Frequent sore throats | ☐ | Difficulty swallowing | ☐ |
| Excessive tearing or dry eyes | ☐ | Loss of vision | ☐ |
| Light sensitivity | ☐ | Double or blurred vision | ☐ |
| Tooth pain | ☐ | Sores in mouth, lips or gums | ☐ |

### Respiratory Health

| | | | |
|---|---|---|---|
| Chronic cough | ☐ | Difficulty breathing | ☐ |
| Bronchitis | ☐ | Asthma or Emphysema | ☐ |
| Tuberculosis or pneumonia | ☐ | | |

### Sexual Health

| | |
|---|---|
| Decreased/absence of libido | ☐ |
| Erectile dysfunction | ☐ |

## General Health Information (continued)

Please check all that apply:

### Cardiovascular Health

| | Yes |
|---|---|
| Chest pain | ☐ |
| Heart murmur | ☐ |
| High or low blood pressure | ☐ |
| Heart palpitations | ☐ |
| Cold extremities | ☐ |
| Decreased physical agility | ☐ |

### Mental Emotional Health

| | |
|---|---|
| Tension | ☐ |
| Anxiety | ☐ |
| Depression | ☐ |
| Chronic procrastination | ☐ |
| Nervousness | ☐ |
| Irritability | ☐ |
| Inability to concentrate | ☐ |
| Eating disorder | ☐ |
| Memory changes | ☐ |
| Mood changes | ☐ |

### Habits

| | |
|---|---|
| Current tobacco use | ☐ |
| Past tobacco use | ☐ |
| Alcohol consumption | ☐ |
| Recreational drug use | ☐ |
| Exposure to toxic chemicals or toxins | ☐ |
| Caffeine use | ☐ |
| Regular exercise | ☐ |

### Endocrine Health

| | |
|---|---|
| Fatigue | ☐ |
| Excessive hunger or thirst | ☐ |
| Hypoglycemia | ☐ |
| Hot flashes/Night sweats | ☐ |
| Autoimmune disorder | ☐ |
| Heat or cold intolerance | ☐ |
| Fever or excessive sweating | ☐ |
| Diabetes | ☐ |
| Thyroid conditions | ☐ |
| Hair loss | ☐ |

### Stress

Current stress level: ☐ Low ☐ Medium ☐ High

### Sleep

| | |
|---|---|
| Problems falling asleep | ☐ |
| Problems staying asleep | ☐ |
| Do you wake feeling refreshed? | ☐ |
| Do you snore or have sleep apnea? | ☐ |
| Insomnia? | ☐ |

### Nutrition

| | |
|---|---|
| Do you follow a particular diet? | |
| Are there foods that you avoid eating? | ☐ |
| Are you satisfied with your diet? | ☐ |

### Musculoskeletal/ Bone Health

| | |
|---|---|
| Headaches | ☐ |
| Migraines | ☐ |
| Numbness or tingling | ☐ |
| Metal implants | ☐ |
| Pain/achiness | ☐ |
| Joint pain | ☐ |
| Bone density checked | ☐ |
| Osteopenia | ☐ |
| Osteoporosis | ☐ |
| Muscle weakness | ☐ |