# *San Jose Integrative Medicine*

## WOMEN'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 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.
2.
3.
4.
5.
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 |
|---|---|
| Number of bowel movements per day: | |
| Any constipation? | ☐ |
| Any diarrhea? | ☐ |
| Recent changes in bowel habits? | ☐ |
| Recent changes in appetite? | ☐ |
| Any excessive gas or bloating? | ☐ |
| Any loss of bowel control? | ☐ |
| Do you have hemorrhoids? | ☐ |
| Have you been diagnosed with IBS? | ☐ |
| Any blood or mucous in stool? | ☐ |
| Any abdominal pain or upset stomach? | ☐ |
| Any heartburn? Or Reflux? | ☐ |
| Any nausea or vomiting? | ☐ |
| Have you had a colonoscopy? | ☐ |

### Weight History

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

Current height? _______________

Current weight? _______________

Desired weight? _______________

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

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

### Respiratory Health

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

## 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 | ☐ |

### Mental Emotional Health

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

### 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? | ☐ |

### Habits

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

### Nutrition

| | |
|---|---|
| Do you follow a particular diet? | ☐ |
| Are there foods that you avoid eating? | ☐ |
| Do you cook your own food? | ☐ |
| Do you eat processed foods? | ☐ |
| Are you thirstier than normal? | ☐ |
| Are you satisfied with your diet? | ☐ |

### Endocrine Health

| | |
|---|---|
| Fatigue | ☐ |
| Excessive hunger or thirst | ☐ |
| Hypoglycemia | ☐ |
| Adrenal Fatigue | ☐ |
| Autoimmune disorder | ☐ |
| Heat or cold intolerance/cold extremities | ☐ |
| Fever or excessive sweating | ☐ |
| Diabetes | ☐ |
| Thyroid conditions | ☐ |
| Hair loss | ☐ |

### Musculoskeletal/ Bone Health

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

## FEMALE HEALTH INFORMATION

Please check all that apply:

**DO YOU HAVE OR HAVE YOU HAD OF ANY OF THE FOLLOWING:**

| | Yes | | Yes |
|---|---|---|---|
| Pelvic Inflammatory Disease | ☐ | Fibroids | ☐ |
| Chronic yeast or vaginal discharge | ☐ | Urinary tract infections | ☐ |
| Loss of bladder control | ☐ | Breast cancer or benign tumors | ☐ |
| Blood in urine | ☐ | Painful urination | ☐ |
| Chronic vaginal itching or burning | ☐ | PMS/PMDD | ☐ |

### MENSTRUAL HISTORY

| | Yes | | Yes |
|---|---|---|---|
| Date of last period: ______________ | | Age at first period: ______________ | |
| Did you have a normal puberty? | ☐ | Date of last breast exam: ______________ | |
| Are your periods currently regular? | ☐ | Were the results normal? | ☐ |
| Date of last PAP: ______________ | | Date of last mammogram: ______________ | |
| Were the results normal? | ☐ | Were the results normal? | ☐ |
| History of abnormal PAPs? | ☐ | | |
| Have you had your bone density checked? | ☐ | | |

**SYMPTOMS:** Please check all that apply:

| | | | |
|---|---|---|---|
| ☐ Cramping or pain | ☐ Headache | ☐ Bloating | ☐ Weight gain |
| ☐ Constipation | ☐ Breast tenderness | ☐ Increased appetite | ☐ Sweet cravings |
| ☐ Depression | ☐ Anxiety | ☐ Irritability | ☐ Mood changes |
| ☐ Forgetfulness | ☐ Insomnia | ☐ Confusion | ☐ Crying |
| ☐ Heart pounding | ☐ Abnormal hair growth | ☐ Fatigue | ☐ Acne |
| ☐ Hot flashes | ☐ Vaginal Dryness | ☐ Hair Loss | ☐ Achiness |
| ☐ Decreased libido | ☐ Memory Loss | ☐ Joint Pain | |

### OBSTETRIC HISTORY

| | Yes |
|---|---|
| Are you currently pregnant? | ☐ |
| Are you trying to conceive? | ☐ |
| Have you had problems with infertility? | ☐ |
| Any pregnancy complications? | ☐ |
| Are you currently breast feeding? | ☐ |

### SEXUAL HEALTH

| | Yes |
|---|---|
| Are you currently sexually active? | ☐ |
| Are you content with your libido/sex life? | ☐ |
| Painful intercourse? | ☐ |

### CHILDREN

| | |
|---|---|
| Do you have children? | ☐ |
| Are you trying to conceive? | ☐ |

# of pregnancies: _______ Births: ______ Miscarriages: _______ Abortions: _______