VITALITY NW
NATURAL MEDICINE CLINIC

Ages 18 and Up Intake

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ AGE: _____

GENDER: _____ SEX ASSIGNED AT BIRTH: _____

PREFERRED PRONOUNS: _____

LAST PHYSICIAN SEEN: _____ FOR WHAT?: _____

WHY ARE YOU MAKING THIS APPOINTMENT? _____

□ PRIMARY CARE (We will keep track of preventative health screening like vaccines and paps.

□ ADJUNCTIVE CARE (specialist care because you have a different PCP)

□ ONE TIME ADVICE □UNSURE AT THIS TIME.

HAVE YOU EVER SEEN A NATUROPATH BEFORE? _____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS, FOODS, OR ENVIRONMENTAL EXPOSURES? PLEASE LIST AND EXPLAIN ALLERGIC REACTION.

ALLERGY	REACTION

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PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE TAKING. INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDICATIONS, VITAMINS, MINERALS, HERBS, HOMEOPATHICS, AND PROBIOTICS.

MEDICATION	DOSE	DIRECTIONS

SOCIAL HISTORY

DO YOU FEEL SAFE IN YOUR HOME? _____

DO YOU HAVE ENOUGH FOOD? _____

DO YOU HAVE STABLE HOUSING? _____

RELATIONSHIP STATUS:_____

CHILDREN, AGES: _____

TYPE OF EXERCISE, FREQUENCY: _____

OCCUPATION: _____

_____

CAFFEINE INTAKE: _____

ALCOHOL INTAKE WEEKLY: _____

TOBACCO USE, TYPE: _____

RECREATIONAL DRUGS: _____

PLEASE LIST DATES AND RESULTS FOR YOUR LAST:

BONE DENSITY SCAN: _____

COLONSCOPY: _____

MAMMOGRAM: _____

PAP SMEAR: _____

PROSTATE EXAM: _____

TDaP VACCINE: _____

FLU VACCINE: _____

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MEDICAL HISTORY: PLEASE INDICATE IF YOU HAVE NOW OR HAVE EXPERIENCED IN THE LAST WEEK:

□ NO KNOWN MEDICAL ISSUES	□ SHORTNESS OF BREATH	□MUSCLE PAIN
□ HEADACHE	□ HEART RACING	□ NUMBNESS
□ VISION CHANGE	□ HEART SKIPPING A BEAT	□ TINGLING
□ HEARING CHANGE	□ HEARTBURN/REFLUX	□ FEVER/CHILLS
□ DIZZINESS	□ CHANGE IN APPETITE	□ INSOMNIA
□ TROUBLE SWALLOWING	□ ABDOMINAL PAIN	□ ANXIETY
□ SORE THROAT	□ BLOATING	□ RASH
□ RUNNY NOSE/CONGESTION	□ CONSTIPATION	□ DEPRESSION
□ EAR PAIN	□ DIARRHEA	□ OTHER SYMPTOMS
□ COUGH	□ NAUSEA	
□ CHEST PAIN	□ VOMITING	

MEDICAL HISTORY: PLEASE CHECK OFF PAST OR CURRENT DIAGNOSES

□ NO KNOWN MEDICAL ISSUES	□ FIBROMYALGIA	□ STI/STD
□ ADDICTION	□ GASTRIC REFLUX/HEARTBURN	□ STROKE
□ ANXIETY	□ GENETIC DISORDER	□ TINNITIS
□ AUTOIMMUNE DISEASE	□ HAY FEVER	□ TRAUMA
□ ANEMIA	□ HERPES	□ ULCERS
□ ARTHRITIS	□ HIGH CHOLESTEROL	□ VARICOSE VEINS
□ ASTHMA	□ HIGH BLOOD PRESSURE	□ WEIGHT ISSUES
□BLOOD CLOT	□ INFERTILITY	□ OTHER ISSUES
□ BRAIN INJURY	□ MENSTRUAL ISSUES	
□ CANCER	□ MEMORY PROBLEMS	
□ CHRONIC FATIGUE SYNDROME	□ NARCOLEPSY	
□ DEPRESSION	□ PALPITATIONS	
□ ECZEMA	□ PTSD	
□ FAINTING	□ SLEEP APNEA	

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SURGICAL HISTORY: PLEASE INDICATE YEAR WHEN APPLICABLE

□ NO PRIOR SURGERY
□ APPENDECTOMY
□ BLADDER SURGERY
□ BREAST SURGERY
□ CESAREAN SECTION
□ COLON RESECTION
□ GALLBLADDER REMOVAL
□ HEMORRHOID SURGERY
□ HERNIA REDUCTION
□ HYSTERECTOMY
□ TONSILLECTOMY
□ TUBAL LIGATION
□ VASECTOMY
□ _____
□ _____
□ _____
□ _____
□ _____
□ _____
□ _____

SEXUAL/REPRODUCTIVE HISTORY: PLEASE ANSWER QUESTIONS APPROPRIATE TO YOUR BODY AND HISTORY.

WHAT IS YOUR SEXUAL ORIENTATION?_____

ARE YOU CURRENTLY SEXUALLY ACTIVE? _____

ARE YOU MONOGAMOUS?_____ ARE YOUR PARTNERS? _____

HAVE YOU EXPERIENCED PHYSICAL EMOTIONAL OR SEXUAL VIOLENCE IN THE PAST OR CURRENTLY?

_____

WHAT ARE YOU USING FOR STI PROTECTION AND/OR CONTRACEPTION?_____

FOR FOLKS WITH UTERUSES:

WHEN WAS THE FIRST DAY OF YOUR LAST MENSTRUAL PERIOD? _____

HOW MANY PREGNANCIES HAVE YOU HAD? _____

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FAMILY MEDICAL HISTORY: WHAT HEALTH CONDITIONS HAVE BEEN DIAGNOSED IN PARENTS, GRANDPARENTS AND SIBLINGS?

Family Member	Current Age/Age on Passing	Heart Disease	Diabetes	Cancer	Mental Health Disorders	Genetic Diseases	Thyroid Issues	Auto-immune Disease	Other Conditions
Mother									
Father									
M. Grandmother									
M. Grandfather									
P. Grandmother									
P. Grandfather									
Sibling									
Sibling									
Other:									

CARE TEAM: PLEASE LIST OTHER HEALTH CARE PROVIDERS YOU SEEK CARE FROM. INCLUDE MEDICAL DOCTORS, ACUPUNCTURISTS, CHIROPRACTORS, MASSAGE THERAPISTS, AND ANY OTHER HOLISTIC PROVIDERS.

_____

_____

_____

HOW MUCH SLEEP DO YOU GET?

□ 0-4 HOURS

□ 4-6 HOURS

□ 7-9 HOURS

□ 10+ HOURS

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AVERAGE/TYPICAL DAILY DIET: PLEASE FILL THIS OUT AS BEST YOU CAN.

BREAKFAST	
LUNCH	
DINNER	
SNACKS	
DESSERT	
BEVERAGES	
WATER	