Portland Dental and Naturopathic Clinic

Adult Intake Form

Name _____ Date of First Visit _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home)_____ (work) _____

Cell _____Email address_____

Age _____ Date of Birth _____ Gender: female ____ male ____

Education _____

Married _____ Separated _____ Divorced Widowed _____ Single _____ Partnership _____

Live with: Spouse _____ Partner Parents _____ Children _____ Friends _____ Alone _____

Occupation _____ Hours per week _____ Retired _____

Employer _____ S.S.# _____

(Work address) _____

Health insurance co. name and address _____

Telephone number (____)_____ ID # _____ Group # _____

Deductable _____ Copay _____

Policy holder's name _____Employer _____DOB_____

Identification/Social Security # _____

Relationship to the policy holder _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

Emergency contact _____

Relationship _____ Phone _____

Address _____

HEALTH HISTORY QUESTIONNAIRE

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

1. Why did you choose to come to this clinic?

What do you know about our approach?

2. What three expectations do you have from this visit to our clinic?

What long-term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)
1 2 3 4 5 6 7 8 9 10

4. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

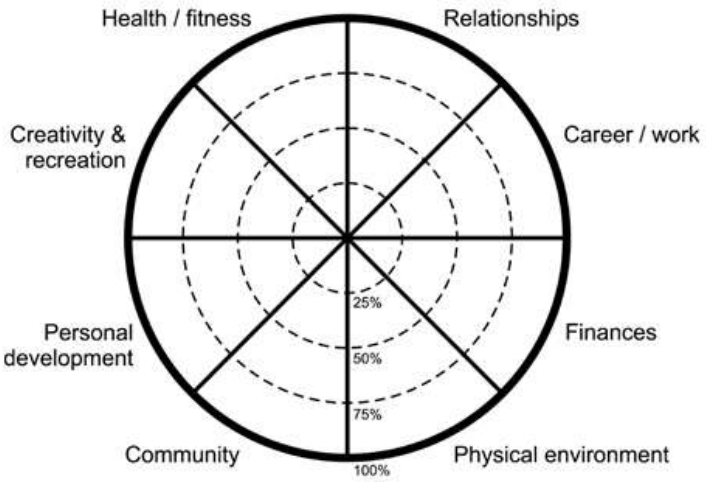
b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

7. What do you LOVE to do?

Life Balance Wheel



Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

Are you currently receiving healthcare? Y N

If yes, where and from whom?_____

_____

If no, when and where did you last receive medical or health care?

_____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Do you have any known contagious diseases at this time? Y N

If yes, what?_____

FAMILY HISTORY

	FATHER	MOTHER	BROTHERS	SISTERS	SPOUSE	CHILD
Age (if living)						
Health (G=good P=poor)						
Age at death (if deceased)						
Check (√) those applicable						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hayfever/Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Cause of Death						
Other						

Childhood Illnesses

Weight at birth:
Please circle if you had any of the following as a child

Scarlet fever Diphtheria Rheumatic fever Mumps Measles
German measles Chicken pox

Hospitalizations and surgeries

_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

X-Ray and special studies

X-rays, CAT scans, electrocardiogram, electroencephalogram or other studies you have had:
_____
_____

Immunizations: Please circle if you had any of the following vaccinations

Polio Pertussis Tetanus shot Diphtheria Measles/Mumps/Rubella Other

Allergies

Are you hypersensitive or allergic to:
Any drugs? _____
Any foods? _____
Any environmentals? _____

Current Medications:

Please circle if you take or use any of the following
Laxatives Pain relievers Antacids Cortisone Appetite suppressants
Antibiotics Tranquilizers Thyroid medication Sleeping pills

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

Medications:	Reason:	Date began:	Dose and Frequency:

Supplements:	Reason:	Date began:	Dose and Frequency:

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

For all the following sections,

Y = a condition you have now **N** = never had **P** = a condition you had in the past

Habits

Main interests and hobbies?_____
Do you exercise? Y N
If yes, what kind?_____ How often? _____

Average 6-8 hrs. sleep?	Y	N	Enjoy your work?	Y	N
Sleep well?	Y	N	Take vacations?	Y	N
Awaken rested?	Y	N	Spend time outside?	Y	N
Have a supportive relationship?	Y	N	Watch television?	Y	N

Have a history of abuse?	Y	N	how many hours? _____		
Any major traumas?	Y P	N	Read?	Y	N
Use recreational drugs?	Y P	N	how many hours? _____		
Been treated for drug dependence?	Y P	N			
Do you eat three meals a day?	Y	N	Use alcoholic beverages?	Y P	N
Do you eat out often?	Y	N	Treated for alcoholism?	Y P	N
Do you go on diets often?	Y	N	Do you use tobacco?	Y P	N
Do you drink coffee?	Y P	N	Smoked previously?	Y P	N
Do you drink black or green tea?	Y P	N	how many years? _____		
Do you drink cola or other sodas?	Y P	N	how many packs per day? _____		
Do you eat refined sugar?	Y P	N			
Do you add salt?	Y P	N			

Do you have a religious or spiritual practice? Y N If yes, what?_____

General

Weight ____ lbs. Weight 1 year ago ____ lbs. Maximum Weight _____ When _Height _____

When during the day is your energy the best? _____ Worst?

Review of System

MENTAL/ EMOTIONAL

Treated for emotional problems?	Y P N	Depression?	Y P N
Mood Swings?	Y P N	Anxiety or nervousness?	Y P N
Considered/Attempted suicide?	Y P N	Tension?	Y P N
Poor concentration?	Y P N	Memory problems?	Y P N

ENDOCRINE

Hypothyroid?	Y P N	Heat or cold intolerance?	Y P N
Hypoglycemia?	Y P N	Diabetes?	Y P N
Excessive thirst?	Y P N	Excessive hunger?	Y P N
Fatigue?	Y P N	Seasonal depression?	Y P N

IMMUNE

Vaccinations?	Y P N	Reactions to vaccinations?	Y P N
Chronic Fatigue Syndrome?	Y P N	Chronic infections?	Y P N
Chronically swollen glands?	Y P N	Slow wound healing?	Y P N

NEUROLOGIC

Seizures?	Y P N	Paralysis?	Y P N
Muscle weakness?	Y P N	Numbness or tingling?	Y P N
Loss of memory?	Y P N	Easily stressed?	Y P N
Vertigo or dizziness?	Y P N	Loss of balance?	Y P N

SKIN

Rashes?	Y P N	Eczema, Hives?	Y P N

Acne, Boils?	Y P N	Itching?	Y P N
Color Change?	Y P N	Perpetual Hair Loss?	Y P N
Lumps?	Y P N	Night Sweats?	Y P N

HEAD

Headaches?	Y P N	Head Injury?	Y P N
Migraines?	Y P N	Jaw/TMJ problems	Y P N

EYES

Spots in Eyes?	Y P N	Cataracts?	Y P N
Impaired vision?	Y P N	Glasses or contacts?	Y P N
Blurriness?	Y P N	Eye pain/strain?	Y P N
Color blindness?	Y P N	Tearing or dryness?	Y P N
Double Vision?	Y P N	Glaucoma?	Y P N

EARS

Impaired hearing?	Y P N	Ringing?	Y P N
Earaches?	Y P N	Dizziness?	Y P N

NOSE AND SINUSES

Frequent colds?	Y P N	Nose Bleeds?	Y P N
Stuffiness?	Y P N	Hayfever?	Y P N
Sinus problems?	Y P N	Loss of smell?	Y P N

MOUTH AND THROAT

Frequent sore throat?	Y P N	Copious saliva?	Y P N
Teeth grinding?	Y P N	Sore tongue/lips?	Y P N
Gum problems?	Y P N	Hoarseness?	Y P N
Dental cavities?	Y P N	Jaw clicks?	Y P N

NECK

Lumps?	Y P N	Swollen glands?	Y P N
Goiter?	Y P N	Pain or stiffness?	Y P N

RESPIRATORY

Cough?	Y P N	Sputum?	Y P N
Spitting up blood?	Y P N	Wheezing	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Pleurisy?	Y P N
Emphysema?	Y P N	Difficulty breathing?	Y P N
Pain on breathing?	Y P N	Shortness of breath?	Y P N
Shortness of breath at night?	Y P N	" " " " " "lying down?	Y P N
Tuberculosis?	Y P N		

CARDIOVASCULAR

Heart disease?	Y P N	Angina?	Y P N
High/Low Blood Pressure?	Y P N	Murmurs?	Y P N
Blood clots?	Y P N	Fainting?	Y P N
Phlebitis?	Y P N	Palpitations/Fluttering?	Y P N

Rheumatic Fever?	Y P N	Chest pain?	Y P N
Swelling in ankles?	Y P N		

GASTROINTESTINAL

Trouble swallowing?	Y P N	Heartburn?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea?	Y P N	Vomiting?	Y P N
Vomiting blood?	Y P N	Bowel Movements: How often? _____	
Blood in stool?	Y P N	Is this a change?_____	
Pain or cramps?	Y P N	Constipation?	Y P N
Belching or passing gas?	Y P N	Diarrhea?	Y P N
Black stools?	Y P N	Gall Bladder disease?	Y P N
Jaundice (yellow skin)?	Y P N	Ulcer?	Y P N
Liver Disease?	Y P N	Hemorrhoids?	Y P N

URINARY

Pain on urination?	Y P N	Increased frequency?	Y P N
Frequency at night?	Y P N	Inability to hold urine?	Y P N
Frequent infections?	Y P N	Kidney stones?	Y P N

MALE REPRODUCTION

Hernias?	Y P N	Testicular masses?	Y P N
Testicular pain?	Y P N	Prostate disease?	Y P N
Venereal disease?	Y P N	Discharge or sores?	Y P N
Are you sexually active?	Y N	Chlamydia?	Y P N
Sexual orientation: _____		Gonorrhea?	Y P N
Impotence?	Y P N	Condyloma?	Y P N
Premature ejaculation?	Y P N	Herpes?	Y P N
Birth control? Type? _____		Syphilis?	Y P N

FEMALE REPRODUCTION/BREASTS

Age of first menses? _____			
Age of last mense? _____		Are cycles regular?	Y N
Length of cycle? _____ days		Bleeding between cycles?	Y P N
Duration of menses? _____ days		Pain during intercourse?	Y P N
Painful menses?	Y P N	Clotting?	Y P N
Heavy or excessive flow?	Y P N	Discharge?	Y P N
PMS?	Y P N	Birth control?	Y P N
If yes, what are your symptoms?		What type? _____	
_____		Number of pregnancies _____	
_____		Number of live births _____	
Endometriosis?	Y P N	Number of miscarriages _____	
Ovarian cysts?	Y P N	Number of abortions _____	
Difficulty conceiving?	Y P N	Menopausal symptoms?	Y P N
Cervical Dysplasia?	Y P N	Abnormal PAP?	Y P N
Sexual difficulties?	Y P N	Chlamydia?	Y P N
Gonorrhea?	Y P N	Condyloma?	Y P N
Herpes?	Y P N	Syphilis?	Y P N

Are you sexually active?	Y N	Sexual orientation: _____	
Do you do breast self exams?	Y P N	Breast lumps?	Y P N
Breast pain/tenderness?	Y P N	Nipple discharge?	Y P N

MUSCULOSKELETAL

Joint pain or stiffness?	Y P N	Arthritis?	Y P N
Broken bones?	Y P N	Weakness?	Y P N
Muscle spasms or cramps?	Y P N	Sciatica?	Y P N

BLOOD/PERIPHERAL VASCULAR

Easy bleeding or bruising?	Y P N	Anemia?	Y P N
Deep leg pain?	Y P N	Cold hands/feet?	Y P N
Varicose veins?	Y P N	Thrombophlebitis?	Y P N

How much change are you willing to make at this time for improving your health?

MINIMAL SOME COMPLETE

Is there any information about your health you would like to add? _____

_____

_____

The above information is true to the best of my knowledge. I understand that, regardless of insurance coverage, I am responsible for payment of services rendered and that a finance charge of 1.5% will be applied, per month, to accounts over 60 days or more. I authorize Portland dental and Naturopathic Clinic to submit charges to my insurance

Please Sign and date below

_____ _____

Signature Date

Welcome! We're glad to serve you! If you have any questions, please ask!