Adult Health Intake

Preferred method of communication: ☐ Phone ☐ Email

Name: ______________________________ Date of Birth: ___________ Sex: _______ Age: ________

Blood Type: ______ Occupation: _______________________ Last grade school completed: __________

Health Concerns: Please list in order of importance. Rate severity (1 is low, 10 is high) and success (1 is no success, 10 is very successful)

Concern	Severity (1-10)	Past/Present Treatments	Success (1-10)

Are you currently under the care of a physician? Yes / No

If yes, with whom? Specialty? What condition? ____

If no, when did you last receive medical care? ____

Date of last physical exam and any significant findings: ____

Known drug, food, or environmental allergies with reaction: _______________________________________

Medications/Supplements

Current

Name	Strength	Dosage	Reason	Duration

Past (Within the last six months; circle any that apply)

Pain Relievers	Appetite suppressants	Hormones	Sedatives	Thyroid
Antacids	Birth Control	Insulin	Sleeping	Antidepressants
Antibiotics	Blood Pressure	Laxatives	Steroids	Supplements:

Past Medical History

Previous Medical Diagnoses or Conditions with year diagnosed: ______________________________________

____

Childhood Illnesses and Vaccinations

Illness	Yes, had it	No, never had it	Vaccinated	Illness	Yes, had it	No, never had it	Vaccinated
Scarlet Fever				Smallpox			
Mumps				Pertussis			
Measles				Polio			
Rubella				Tetanus			
Rheumatic Fever				Hepatitis B			
Diptheria				Influenza			
Chicken Pox				Meningitis			
Shingles				HPV			

Vaccine reactions: ____

Surgeries with year:____

Hospitalizations with year and reason: ____

Diagnostic Procedures (Colonoscopy, Mammography, DEXA, Ultrasound, X-ray, CT/MRI) with year and reason:

____

Family History

	Age if Living	Age of Death	Health Problems (cancers, diabetes, cardiovascular disease, thyroid disease, autoimmune disease, osteoporosis)
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Spouse			
Children			

Social History

With whom do you live? ____________________ Pets: ________ Indoor/Outdoor

Have you lived or traveled outside the US? If so, where, and when? ____________________

Typical Breakfast: ____________________ Time: ________

Lunch: ____________________ Time: ________

Dinner: ____________________ Time: ________

Snacks: ____________________ Time(s): ________

Dietary restrictions or food aversions: ____________________ Food cravings: ________

Water intake (oz/day): ________ Coffee (cups/day): ________ Tea (type, cups/day): ________

Soda (diet, regular, #/day): ________ Alcohol (type, #/day): ____________________

Have you dieted in the past? Yes / No Highest and lowest weight with years: ____________________

Tobacco: Current / Never / Past Packs per day and years: ________ Recreational drugs: Yes / No

Exercise: Yes / No Type(s): ____________ Frequency: ________ Duration: ________

Interests and Hobbies: ____________ Do you take vacations? Yes / No Week off per year: ____

Do you have supportive relationships? ____________ Relationship status: ________

How important is spirituality or religion in your life? ____________

Sleep

Time to bed: ______ Hours/night: ____ Wake refreshed? Yes / No Fall asleep easily (within 10 min)? Yes / No

Wake at night? Yes / No Time/Reason: ________ Do you snore or stop breathing during sleep? Yes / No

Concerns about sleep: ____________________ Energy (1-10, 10 is best): ______

Stress (1-10, 10 is most severe): ____ Sources of stress: ____________________

Do you have tools to manage stress? Yes / No

Environmental History

Please indicate if you have any current or past exposure to the following:

Exposure	Current	Past	Reaction	Exposure	Current	Past	Reaction
Leaded paint				Industrial fumes/ chemicals			
Near refinery or industry				Perfume sensitivity			
New carpet/paint/etc				Detergent sensitivity			
Pesticide/Insecticide use				Radiation			
Dry cleaning				Infectious			
Smoking in household or work environment				Mercury fillings? Number? How many removed?			
Solvent exposure				Root canals? Number removed?			
Heavy metals				Other			

Review of Systems

(Y)=currently have or had *within the last 6 months*, (N)=never had, (P)=had *more than 6 months ago*

Fatigue	Y	N	P	Lightheadedness	Y	N	P	Nosebleeds	Y	N	P	Urinary urgency	Y	N	P
Daytime sleepiness	Y	N	P	Fainting	Y	N	P	Sinus infection	Y	N	P	Incontinence	Y	N	P
Early waking	Y	N	P	Nerve pain	Y	N	P	Bad breath	Y	N	P	Wake to urinate	Y	N	P
Fever	Y	N	P	Tremor	Y	N	P	Cough	Y	N	P	Urinary hesitancy	Y	N	P
Flushing	Y	N	P	Rash	Y	N	P	Phlegm	Y	N	P	Kidney disease/stones	Y	N	P
Night sweats	Y	N	P	Eczema	Y	N	P	Asthma	Y	N	P	Blood in urine	Y	N	P
Sleepwalking	Y	N	P	Psoriasis	Y	N	P	Shortness of breath	Y	N	P	Low libido	Y	N	P
Nightmares	Y	N	P	Hives	Y	N	P	Heart palpitations	Y	N	P	Sexual difficulty	Y	N	P
No dream recall	Y	N	P	Acne	Y	N	P	Chest pain	Y	N	P	Sexual infections	Y	N	P
Unintended weight loss	Y	N	P	Excess hair loss	Y	N	P	Low blood pressure	Y	N	P	MALE			
Chronic infection	Y	N	P	Itching	Y	N	P	Heart murmur	Y	N	P	Testicular pain	Y	N	P
Swollen lymph nodes	Y	N	P	Fungal infections	Y	N	P	Swelling in ankles/feet	Y	N	P	Testicular mass	Y	N	P
Slow wound healing	Y	N	P	Weak or brittle nails	Y	N	P	Easy bruising	Y	N	P	Prostate problems	Y	N	P
Hot / Cold intolerance	Y	N	P	Headache	Y	N	P	Anemia	Y	N	P	FEMALE			
Hyper / Hypo glycemia	Y	N	P	Migraine	Y	N	P	Varicose veins	Y	N	P	Age at menarche:			
Excess thirst	Y	N	P	Head injury	Y	N	P	Hemorrhoids	Y	N	P	Date of last menses:			
Excess hunger	Y	N	P	Jaw/TMJ problems	Y	N	P	Heartburn/Reflux	Y	N	P	Days of bleeding:			
Cold hands and feet	Y	N	P	Teeth grinding	Y	N	P	Nausea/Vomiting	Y	N	P	Cycle length (days):			
Difficulty concentrating	Y	N	P	Dental problems	Y	N	P	Gas or bloating	Y	N	P	Painful menses	Y	N	P
Mood swings	Y	N	P	Gum problems	Y	N	P	Abdominal pain	Y	N	P	Heavy menses	Y	N	P
Memory problems	Y	N	P	Eye infections	Y	N	P	Blood in stool	Y	N	P	Light menses	Y	N	P
Depression	Y	N	P	Vision problems	Y	N	P	Mucus in stool	Y	N	P	Bleeding mid-cycle	Y	N	P
Anxiety/Nervousness	Y	N	P	Eye tearing/dryness	Y	N	P	How often have a bowel movement:				Abnormal vaginal discharge/itching	Y	N	P
Panic attacks	Y	N	P	Eye pain/strain	Y	N	P	Diarrhea	Y	N	P	Abnormal pap	Y	N	P
Suicidal thoughts	Y	N	P	Impaired hearing	Y	N	P	Black or tarry stool	Y	N	P	Pain with penetration	Y	N	P
Seizures	Y	N	P	Ringing in ears	Y	N	P	Gall bladder problems	Y	N	P	Number of pregnancies:			
Paralysis	Y	N	P	Ear pain	Y	N	P	Jaundice	Y	N	P	Number of miscarriages:			
Joint pain/arthritis	Y	N	P	Frequent sore throat	Y	N	P	Ulcer	Y	N	P	Difficulty conceiving	Y	N	P
Muscle pain/spasm	Y	N	P	Dry mouth	Y	N	P	Pain with urination	Y	N	P	Breast lumps or cysts	Y	N	P
Numbness/tingling	Y	N	P	Difficulty swallowing	Y	N	P	Urinary frequency	Y	N	P	Breast pain/tenderness	Y	N	P
Vertigo/Dizziness	Y	N	P	Cold sores	Y	N	P	Bladder pain	Y	N	P	Nipple discharge	Y	N	P

Context of Care Questionnaire

1. Why did you choose to come see me?

   What do you know about my approach?

2. What 3 expectations do you have about this first visit?
   1.
   2.
   3.

   What long-term expectations do you have about working with naturopathic medicine?

   What expectations do you have of me personally as your naturopathic doctor?

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (0-10, 10 being 100% committed)

   1 2 3 4 5 6 7 8 9 10

4. What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

   What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive?

5. What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols which I 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?

In seeking care from Michelle Crowder, Naturopathic Doctor, I understand the following:

1. The State of Michigan does not currently regulate or license Naturopathic Physicians or the practice of Naturopathic Medicine. Therefore, Michelle Crowder, ND cannot diagnose, treat, or cure any condition. Instead, she provides health information and recommendations.

2. Michelle Crowder, ND is licensed in the State of Oregon and regulated by the Oregon Board of Naturopathic Medicine.

3. I should remain under the care of my primary care physician and will discuss any changes to my current medications or treatment with my primary care physician.

4. My consultations with Michelle Crowder, ND are confidential and will not be disclosed except where required by law or with prior authorization.

5. Payment is due at the time of service.

6. Because Naturopathic Physicians are not currently licensed in the state of Michigan, their services may not be covered under a Health Savings Account or Flex Spending Account. If you chose to use these methods as forms of payment, it is at your own risk.

7. If you would like to submit a claim to your insurance company for services provided by Michelle Crowder, ND, you must obtain proper documentation. Please inquire.

8. No Show Policy: Please allow at least 24 hours notice if you need to reschedule or cancel your appointment. Missed appointments are subject to the following fees: $200 for new patient visits; $90 for follow-up visits.

9. Email is not a secure form of communication. If I choose to communicate with Michelle Crowder, ND via this method, she is not responsible for any lost or compromised information.

10. If you would like Michelle Crowder, ND to communicate about your care with other physicians or practitioners, please provide their contact information below:

    Name: ______________________________ Phone: ________________________

    Name: ______________________________ Phone: ________________________

    Name: ______________________________ Phone: ________________________

Signed: ____ Date: ________________

Printed Name: ___________________________________