Amy Nelson, ND
955 Carrillo Dr. Suite #105
Los Angeles, CA 90048
Phone: 323.470.0511
www.AmyNelsonND.com

ADULT INTAKE

Name: _____Date: _______________

Address: _____

City: _____State:_____ Zip:_____

Phone # (home): _____**(**cell) _____(work): _____

Email address:_____ Skype name:_____

Age: _____ Date of Birth: _______________ Gender: F M Sexual Preference: _____

Circle One: Married Separated Divorced Widowed Single Partnership

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

Occupation: _____Hours per week:_____

Employer Name and Address:_____

Education level completed: _____

How did you hear about Dr. Nelson? _____

Has any other family member already been a patient with Dr. Nelson? _____

Emergency contact: _____Relationship: _____

Phone: _____Address:_____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come see Dr. Nelson?

What do you know about her approach?

What *three* expectations do you have from *this* visit?

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What *long term* expectations do you have from working with Dr. Nelson?

What expectations do you have of me personally as your health care provider?

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.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

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?

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

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

What do you love to do?

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SCALE OF BALANCE

Wellness is a balance of many factors. Shade in each of the following categories as a level of satisfaction as it relates for you. For example, if you are 60% satisfied with money, shade in 6 blocks.

Career										
Money										
Romance/Relationship										
Fun/Recreation										
Personal Growth										
Physical Environment										
Health										

Are you currently receiving healthcare? Yes / No

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.
7.

Do you have any known contagious diseases at this time? Yes / No
If yes, what? _____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer
Diabetes
Heart Disease
High Blood Pressure
Kidney Disease
Epilepsy
Arthritis
Glaucoma
Tuberculosis
Stroke
Anemia
Mental Illness
Asthma
Hay fever
Hives

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Any other relevant family history?

What is your family heritage?

CHILDHOOD ILLNESSES

Birth weight:
Please circle whether you had any of the following as a child:

Rheumatic fever	Diphtheria	Scarlet fever	Chicken pox
German Measles	Measles	Mumps	

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had? Indicate the year

ALLERGIES

Please list the drugs you are sensitive or allergic to and what reaction you experience:

Please list any foods you are sensitive or allergic to and what reaction you experience:

Please list any environmental or chemicals exposures you are sensitive or allergic to and what reaction you experience?

GENERAL

Height: _____Weight:_____ Weight one year ago: _____

Maximum Weight: _____When: _____
When during the day is your energy the best? _____Worst? _____

Main interests and hobbies: _____

Exercise: Y / N If so, what kind and how often: _____

Watch TV: Y / N If so, how many hours? _____Read: Y / N If so, how many hours? _____

Do you have a religious or spiritual practice? Y / N If so, what kind? _____

CURRENT MEDICATIONS

Do you take or use any of the following (please circle):
Laxatives Pain relievers Antacids Cortisone Antibiotics Tranquilizers
Sleeping Pills Thyroid Medication Birth Control Pills Hormone Replacement

List any prescription medications, over the counter medications, vitamins or other supplements you are taking:

1)	5)
2)	6)
3)	7)
4)	8)

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TYPICAL FOOD INTAKE

Breakfast:

Lunch:

Dinner:

Snacks:

To drink:

FOR THE FOLLOWING, PLEASE CIRCLE:

Y=yes/condition you have now **N**=no/never had P= problem in the past **S**=sometimes a problem now

GENERAL

Do you sleep well? Y N P S
Average 6-8 hours? Y N P S
Awake rested? Y N P S
Have a supportive relationship? Y N P S
Have a history of abuse? Y N P S
Experienced a major trauma? Y N P S
Use recreational drugs? Y N P S
Treated for drug dependence? Y N P S
Use alcoholic beverages? Y N P S
Use tobacco? Y N P S
If in the past, how many years?
How many packs per day?
Do you enjoy your work? Y N P S
Take vacations? Y N P S
Spend time outside? Y N P S
Eat three meals a day? Y N P S
Do you go on diets often? Y N P S
Do you eat out often? Y N P S
Do you drink coffee? Y N P S
Drink black/green tea? Y N P S
Drink soda? Y N P S
Do you eat refined sugar? Y N P S
Do you add salt to your food? Y N P S

NEUROLOGIC

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

ENDOCRINE

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

IMMUNE

Reactions to immunizations? Y N P S
Chronically swollen glands? Y N P S
Slow wound healing? Y N P S
Chronic fatigue syndrome? Y N P S
Chronic infections? Y N P S
Night sweats? Y N P S

EARS

Impaired hearing? Y N P S
Ringing in ears? Y N P S
Dizziness? Y N P S
Ear aches? Y N P S

EYES

Impaired vision? Y N P S
Cataracts? Y N P S
Glaucoma? Y N P S
Spots in vision? Y N P S
Color blindness? Y N P S
Tearing or dryness? Y N P S
Eye pain or strain? Y N P S

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HEAD
Headaches? Y N P S
Migraines? Y N P S
Head injury? Y N P S
Jaw or TMJ problems? Y N P S

NOSE AND SINUS
Frequent colds? Y N P S
Stuffiness? Y N P S
Sinus problems? Y N P S
Nose bleeds? Y N P S
Hayfever? Y N P S
Loss of smell? Y N P S

NECK
Lumps in neck? Y N P S
Goiter? Y N P S
Difficulty swallowing? Y N P S
Pain or stiffness in neck? Y N P S

MOUTH AND THROAT
Frequent sore throat? Y N P S
Copious saliva? Y N P S
Sore tongue or lips? Y N P S
Hoarseness? Y N P S
Jaw clicks? Y N P S
Teeth grinding? Y N P S
Gum problems? Y N P S
Dental cavities? Y N P S

SKIN
Rashes? Y N P S
Acne/boils? Y N P S
Change in skin color? Y N P S
Lumps or bumps on skin? Y N P S
Eczema or hives? Y N P S
Itching? Y N P S
Perpetual hair loss? Y N P S

RESPIRATORY
Cough? Y N P S
Sputum? Y N P S
Asthma? Y N P S
Wheezing? Y N P S
Bronchitis? Y N P S
Coughing up blood? Y N P S
Shortness of breath? Y N P S
Shortness of breath when lying down? Y N P S
Pain in breathing? Y N P S
Emphysema? Y N P S

GASTROINTESTINAL
Trouble swallowing? Y N P S
Change in thirst? Y N P S
Change in appetite? Y N P S
Nausea/vomiting? Y N P S
Ulcer? Y N P S
Jaundice? Y N P S
Gall bladder disease? Y N P S
Liver disease? Y N P S
Hemorrhoids? Y N P S
Pancreatitis? Y N P S
Heartburn? Y N P S
Abdominal pain or cramps? Y N P S
Belching or passing gas? Y N P S
Constipation? Y N P S
Bowel movements: how often?
Is this a change?
Black stools? Y N P S
Blood in stools? Y N P S

MENTAL/EMOTIONAL
Treated for emotional problem? Y N P S
Depression? Y N P S
Anxiety or nervousness? Y N P S
Poor concentration? Y N P S
Do you have mood swings? Y N P S
Considered suicide? Y N P S
Attempted suicide? Y N P S
Tension? Y N P S
Memory problems? Y N P S

URINARY
Increased frequency of urination? Y N P S
Inability to hold urine? Y N P S
Pain in urination? Y N P S
Frequency at night? Y N P S
Frequent UTI's? Y N P S
Kidney stones? Y N P S

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

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

FEMALE REPRODUCTIVE
Age of first menses:
Age of last menses (if menopausal):_
Length of cycle: days
Duration of menses: days
Are your cycles regular? Y N P S
Painful menses? Y N P S
Heavy or excessive flow? Y N P S
PMS? Y N P S
Symptoms:
_____
Bleeding between cycles? Y N P S
Clotting? Y N P S
Endometriosis? Y N P S
Ovarian cysts? Y N P S
Vaginal odor? Y N P S
Vaginal discharge? Y N P S
Date of last pap smear:
Abnormal PAP? Y N P S
Cervical dysplasia? Y N P S
Are you sexually active? Y N P S
Sexual orientation:
Birth control? Type:
Pain during intercourse? Y N P S

FEMALE REPRODUCTIVE CONT.
Gonorrhea? Y N P S
Herpes? Y N P S
Chlamydia? Y N P S
Genital warts? Y N P S
Syphilis? Y N P S
Difficulty conceiving? Y N P S
Number of pregnancies:
Number of live births:
Number of miscarriages:
Number of abortions:
Do you do self breast exams? Y N P S
Breast pain/tenderness? Y N P S
Breast lumps? Y N P S
Nipple discharge? Y N P S
Menopausal symptoms? Y N P S

MALE REPRODUCTIVE
Are you sexually active? Y N P S
Sexual orientation:
Birth control? Type:
Discharge or sores? Y N P S
Chlamydia? Y N P S
Gonorrhea? Y N P S
Genital warts? Y N P S
Herpes? Y N P S
Syphilis? Y N P S
Hernias? Y N P S
Testicular masses? Y N P S
Testicular pain? Y N P S
Prostate disease? Y N P S
Impotence? Y N P S
Premature ejaculation? Y N P