

INTAKE FORM

Christina Cooke, ND

Natural medicine healthcare is possible only when the physician completely understands your physical, mental and emotional conditions. The information you provide helps me understand your needs and how to help you reach your health goals. Please write legibly and answer all questions to the best of your ability. Feel free to mark anything you are uncertain about with a question mark.

GENERAL INFORMATION

Patient's Name and Address:

First _____ Middle Initial _____ Last _____

Address _____

City _____ State _____ Zip Code _____

Telephone numbers: Home _____ Work/Cell _____

E-Mail Address (optional) _____

SSN or Driver's License Number _____ Date of Birth _____

Age _____ Gender (check one) M F

Number of children you have _____

Occupation _____ Hours per week _____

Marital Status (put an "X" by the one that applies) Single Separated Partnership
Married Divorced

With whom do you live? (put an "X" by the one that applies) Alone Parents Friends
Spouse Children Partner

Community activities in which you are involved:

Emergency Contact

Name _____

Relationship _____

Telephone Number _____

When did you last visit a doctor's office, medical clinic or hospital? Please explain.

Are you aware of any allergies to food, drugs or other environmental allergies (cats, mold, dust)?
If yes, please list and explain.

What are your main health goals or concerns?

- A. _____
- B. _____
- C. _____
- D. _____

What timeline do you think is reasonable to achieve your goals or address your concerns?

What do you expect from naturopathic care and from me as your doctor?

I like to be in communication with your other health care providers, if possible. Please list any other practitioners on your health care team that I may contact.

- A. Name _____
Address _____
Telephone Number _____
- B. Name _____
Address _____
Telephone Number _____
- C. Name _____
Address _____
Telephone Number _____

Signature _____ Date _____
(Responsible party if patient is a minor)

SELF AND FAMILY HISTORY

What hospitalizations or surgeries have you had?

What diagnostic imaging studies have you had?
(put an "X" by the ones that apply)

Bone density scan
Electrocardiogram
X-rays
Colonoscopy or endoscopy
MRI

Mammogram
Electroencephalogram
CT scan
Nuclear scan
Ultrasound

Medications and/or Supplements

Do you take any of the following?
(put an "X" by the ones that apply)

Pain relievers
Antacids
Diet pills, appetite suppressants
Laxatives
Tranquilizers
Sleeping pills

Antidepressants
Cortisone
Thyroid medication
Antibiotics (cream or pills)
Seizure medication
Hormones e.g. HRT, testosterone, steroids

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

GENERAL

Height _____ Weight _____ lbs. Weight one year ago _____ lbs.

Maximum weight _____ lbs. When? _____

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

Do you feel sleepy after meals? ___ Yes ___ No

Do you have particular lulls in energy during the day and if so, when?

FAMILY HISTORY

Do you have a family history of any of the following?
(put an "X" by the ones that apply)

Anemia
Arthritis
Asthma
Cancer
Cataracts
Epilepsy

Gallbladder disease
Glaucoma
Goiter
Hayfever/Hives
Heart disease
Heart murmur

High blood pressure
Kidney disease
Liver disease
Mental illness
Stroke
Tuberculosis

Is your father still living? Yes, current age _____ No, age at time of death _____

Is your mother still living? Yes, current age _____ No, age at time of death _____

CHILDHOOD ILLNESSES

Please check whether you have had any of the following conditions as a child/adolescent:

Diphtheria	Mumps
German measles	Rheumatic fever
Measles	Scarlet fever

Other (please list)

PAST IMMUNIZATIONS

Please mark an "X" next to any of the following immunizations you have had.
If unsure, please write a question mark beside the immunization.

Diphtheria	Polio
Measles/Mumps/Rubella (MMR)	Tetanus
Pertussis	Pneumonia
Yearly flu shots	

Other (please list)

REVIEW OF SYSTEMS

Please mark an "X" next to any condition that was a past concern or is a current condition.

Skin

Rashes	Color changes	Acne, boils
Eczema	Loss of hair	Skin tags
Lumps	Psoriasis	Itching
Moles	Hives	Night sweats

Musculoskeletal

Joint pain	Muscle spasms	Arthritis
Weakness	Broken bones/fractures	Sciatica

Head

General headaches	Migraine headaches
Head injury	Jaw/TMJ problems

Ears

Ringings in ears	Dizziness or vertigo
Earaches	Impaired hearing

Eyes

Blurred vision	Color blindness	Cataracts
Glasses/contacts	Halos, sparks	Eye pain/strain
Glaucoma	Double vision	Tearing/dryness
Spots in eyes		

Nose/Sinuses

Stiffness	Nose bleeds	Loss of smell
Sinus problems	Frequent colds	Hayfever

Mouth/Throat

Hoarseness	Jaw clicks	Gum problems
Dental cavities	Sore lips/tongue	Frequent sore throat

Neck

Lumps	Swollen glands
Goiter (enlarged thyroid)	Pain or stiffness

Respiratory

Asthma	Wheezing
Spitting up blood	Productive cough with sputum
Cough	Bronchitis
Pneumonia	Difficulty breathing
Pleurisy/pain on breathing	Emphysema
Shortness of breath at night	Shortness of breath lying down
Need to sleep on pillows	Tuberculosis

Cardiovascular

Angina	Fainting	Chest pain
Chest pain with exercise	Low blood pressure	Chest pain at rest
Blood clots	Ankle swelling	Murmur
Heart disease	High blood pressure	Rheumatic fever

Gastrointestinal

Diarrhea	Abdominal pain	Constipation
Thirst changes	Liver disease	Ulcers
Black stool	Heartburn	Bloody stool
Jaundice	Nausea/vomiting	Hemorrhoids
Gall bladder disease		

How many bowel movements per day?

Urinary

Painful urination	Frequent urination
Frequent urination at night	Frequent urinary infections
Trouble with urination	Difficulty holding urine
Kidney stones	

Blood/Peripheral Vascular

Anemia	Easy bruising	Cold hands/feet
Thrombophlebitis	Varicose veins	Leg pain with walking

Neurological

Fainting
Numbness/tingling

Loss of memory
Muscle weakness

Paralysis
Seizures

Emotional

Mood swings
Tension/stress

Depression
Suicidal thoughts or plans

Nervousness
Anxiety

Endocrine

Hypothyroid
Hyperthyroid
Diabetes

Excessive thirst
Excessive hunger

Cold intolerance
Heat intolerance

Male Reproductive

Hernias
Discharge or sores
Sexual difficulty

Impotence
Venereal disease
Testicular pain

Testicular masses
Prostate disease
Premature ejaculation

Female Reproductive

Date of last annual gyn exam _____
Age of first menses _____ Age of last menses (if menopausal) _____
Length of cycle (from first day of period until first day of next period) _____
Duration of menses (number of days of bleeding) _____
Do you do self breast exams? _____ Yes _____ No
Number of pregnancies _____ Number of live births _____
Number of miscarriages _____ Number of abortions _____

Cycles regular
Heavy flow
Bleeding between cycles
Cervical dysplasia
Ovarian cysts
Venereal disease
Menopausal symptoms
Breast lump(s)
Painful menses
PMS
Abnormal pap
Endometriosis
Fertility issues
Sexual difficulty
Breast lumps
Nipple discharge

Birth control _____ Yes _____ No
If so, what type? _____

Sexually active _____ Yes _____ No
With _____ Men _____ Women _____ Both

Is there anything else you would like me to know in order to serve you better?

STATEMENT OF FINANCIAL RESPONSIBILITY

The patient (or undersigned) agrees to pay all fees rendered at the time of service, either via cash, check, debit/credit card, or by special payment plan agreed upon by Dr. Cooke and the undersigned. Since Dr. Cooke does not bill insurance at this time, patients are responsible for billing their insurance companies. If NSF checks are deposited, the undersigned will be charged the overdraft charges incurred by Dr. Cooke. Failure to remit payment for services after 90 days will be cause for termination of service.

I have read, understood, and agree to the terms in the financial agreement above.

Signature of financially responsible party _____ Date _____

Please email to: drclcooke@comcast.net