

Patient Intake Form

Please fill out this confidential intake questionnaire as completely as possible. Print legibly, and place a question mark next to any item you are unsure of. It is very important that you bring this completed form with you to your first visit.

Personal Information

Today's Date _____
Name _____ Age _____ Date of Birth ____/____/____
Phone - Day (____) _____ Evening (____) _____ Mobile (____) _____
Preferred ____ Day ____ Evening ____ Mobile Is it OK to leave messages? ____ Yes ____ No
Address _____ Apt. # _____
City _____ State _____ Zip Code _____
Email address _____

Are you interested in receiving an email newsletter or notifications of lectures? ____ Yes ____ No

If the patient is under the age of 18:

Name(s) of legal guardians _____
Contact numbers if different from above _____

Who may I thank for your referral? _____

Current Health Care Provider(s)

Current Health Concerns,
in order of importance

Emergency Contact Name _____ Relationship _____

Daytime contact number (____) _____

Have you received all the standard childhood vaccines? Yes No

Which ones haven't you received? _____

Please indicate any major health issues suffered by parents, grandparents, spouse, children or grandchildren
(Indicate which relative):

For Men Only

Please check all that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Prostate exam <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> | <input type="checkbox"/> Abnormal discharge from penis |
| <input type="checkbox"/> Regular self testicular exam | <input type="checkbox"/> Pain or lump in scrotum |
| <input type="checkbox"/> Impaired fertility | <input type="checkbox"/> Prostate problem |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Sexually transmitted disease |

For Women Only

Please check all that apply to you:

- | | |
|---|--|
| Last Menses <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> | <input type="checkbox"/> Hysterectomy <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> |
| Last pap smear <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> | <input type="checkbox"/> Abnormal pap smear |
| Age menses began _____ | <input type="checkbox"/> Breast pain / lump / discharge |
| Number of pregnancies _____ | <input type="checkbox"/> Sexual difficulties |
| Number of live births _____ | <input type="checkbox"/> Frequent vaginitis |

If you are still having periods:

- | | |
|---|---|
| Average number of days of bleeding _____ | <input type="checkbox"/> Abnormal vaginal discharge |
| Average number of days in cycle _____ | <input type="checkbox"/> Endometriosis |
| Bleeding is <input type="checkbox"/> regular <input type="checkbox"/> irregular | <input type="checkbox"/> Polycystic ovary syndrome |
| <input type="checkbox"/> light <input type="checkbox"/> medium <input type="checkbox"/> heavy | <input type="checkbox"/> Sexually transmitted infection |
| Symptoms <input type="checkbox"/> bleeding b/n periods <input type="checkbox"/> Mood swings | <input type="checkbox"/> Pelvic Inflammatory disease |
| <input type="checkbox"/> PMS <input type="checkbox"/> Painful menses <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Uterine fibroids |

If you are no longer having periods:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Impaired fertility |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Changes in memory | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Spotting | <input type="checkbox"/> Changes in libido | <input type="checkbox"/> Regular self-breast exam |
| <input type="checkbox"/> Facial hair | <input type="checkbox"/> Changes in mood | <input type="checkbox"/> Sexually active |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Hormone replacement therapy | <input type="checkbox"/> Oral contraception |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Urinary tract infections | |

Lifestyle History

Please check any that apply to you and fill in corresponding details:

- | | |
|--|-----------------------------|
| <input type="checkbox"/> Exercise _____ hours per week | Height _____ |
| Type _____ | Weight _____ |
| <input type="checkbox"/> Watch TV _____ hours per week | Weight one year ago _____ |
| <input type="checkbox"/> Tobacco Use _____ packs daily | Maximum weight _____ |
| <input type="checkbox"/> Alcohol Use _____ drinks weekly | when? _____ |
| <input type="checkbox"/> Recreational drug use | Sleep _____ hours per night |
| <input type="checkbox"/> Toxic exposure | Meals per day _____ |
| <input type="checkbox"/> Drink 8 glasses water daily ___ less ___ more | ___ Eat meat |
| <input type="checkbox"/> Drink soda | ___ Eat fast food regularly |
| <input type="checkbox"/> Eat margarine | ___ Cook meals |

Rate your average level of stress on the scale below with an "X"

1 -----2-----3-----4-----5-----6-----7-----8-----9----- 10

What affects your stress level the most? _____

What do you think is happening with your health?

What do you feel you need to do to recover?

Consent for Naturopathic Medical Treatment

I, (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic. I understand that the methods of treatment that are permitted under the California Naturopathic Doctors Act include but are not limited to nutrition and lifestyle counseling, herbal medicine, homeopathy, nutritional supplements, physical treatments, hydrotherapy, and hormone replacement therapy.

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that the modalities outlined above may pose a small level of risk, as do all forms of treatment. I am aware that I have the right to refuse any treatment, and to inquire about the risks associated with any treatment recommendation.

The herbs, homeopathic medicines and nutritional that have been recommended are considered safe when taken as instructed in the practice of naturopathic medicine. It is important that you follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements. Some of these can be toxic when taken in excessively large doses. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify Dr. Slezak if I become aware that I am pregnant.

I will immediately inform Dr. Slezak if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by him. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. If an emergency medical condition arises, I will seek treatment immediately by calling 9-1-1, or going to my local hospital.

I have read, or have had read to me this consent form. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures provided by Dr. Slezak. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME, (printed) _____

PATIENT / GUARDIAN SIGNATURE _____ **Date:** _____

Indicate relationship if signing on behalf of patient _____