5675 N Oracle Rd, Suite 3101
Tucson, AZ 85704
Phone: 520.333.3320
www.intuitionwellness.com

INTAKE - ADULT

NATUROPATHIC MEDICINE

Patient's Name: ______________________________ *Date:* ____________

Date of Birth: ________________

Occupation: ______________________________ *Hours per week:* ________

Martial Status: ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed* ☐ *Single* ☐ *Partnership*

Live With: ☐ *Spouse* ☐ *Partner* ☐ *Parents* ☐ *Children* ☐ *Friends* ☐ *Alone*

Current Providers:

Family Physician: ____

Name *Phone*

Counselor/Therapist: ____

Name *Phone*

Psychiatrist: ____

Name *Phone*

Additional Providers (name and phone):

____

____

____

____

What are your main health concerns, in order of importance to you?

1. ____
2. ____
3. ____
4. ____

Medical History:

Date of last physical exam: ________________ *Current Height:* ________________ *Weight:* _____________

Maximum Weight: _______________ *When?* ______________ *Energy Level (1-10; 10 highest):* _________

Are you hypersensitive or allergic to any:

Drugs: ____

Foods: ____

Environment/Chemicals: ____

How would you describe your general health?

☐ *Poor* ☐ *Fair* ☐ *Good* ☐ *Excellent*

Do you smoke or use tobacco products? _______ *times/day* *Other:* _________________________________

How often do you drink alcohol? _______ *times/week* *Other:* ______________________________________

Additional treatments or healthcare (e.g., physiotherapy, massage, chiropractic, etc.): _______________

____

____

Please indicate any serious conditions, illnesses, surgeries, and hospitalizations with approximate dates:

____

____

____

Do you receive regular screening tests preformed by another doctor (e.g., pap, blood tests, etc.)?:

____

____

____

Do you have any dietary restrictions (e.g., religious, vegetarian/vegan, etc.)?: ______________________

____

____

Which medications, either by prescription or over-the-counter, are you currently taking or have taken over the past six months?

_____ *Laxatives*	_____ *Antidepressants*	_____ *Cholesterol-lowering medication*
_____ *Pain Relievers*	_____ *Antibiotics*	_____ *Ulcer medication*
_____ *Sleeping Meds*	_____ *Sedatives*	_____ *Birth Control Pills*
_____ *Antacids*	_____ *Thyroid Medication*	_____ *Hormone Replacement*
_____ *Cortsone/Prednisone*	_____ *Antidepressants*	

Please list, by name, any prescription medications you currently take, and over-the-counter medications, all vitamins/supplements/herbs you take regularly at this time. Include dosage, if known. ***Note: Please bring each of these with you to your first office visit.***

1. ____

2. ____

3. ____

4. ____

5. ____

Family History:

Do you have a family history of any of the following diseases or conditions? If known, please include your parents, siblings, and grandparents.

_____ *Anemia*	_____ *Arthritis*	_____ *Asthma*
_____ *Cancer*	_____ *Diabetes*	_____ *Epilepsy*
_____ *Heart Disease*	_____ *Hypertension*	_____ *Kidney Disease*
_____ *Mental Illness*	_____ *Multiple Sclerosis*	_____ *Parkinson's*
_____ *Alzheimer's*	_____ *Stroke*	

Please list other significant family medical history not listed above:

____

____

____

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

____

____

____

____

Thank you for choosing Intuition Wellness Center to assist you and your family to live in health and joy!