Lilac Natural Medicine

Patient Intake Form

Name: _____ Preferred Name: _____ Date: _____

Date of Birth: _____ Email: _____

Street Address: _____

City: _____ State:_____ Zip:_____

Home phone: _____Work Phone:_____Cell Phone:_____

Gender: Male Female Transgender Other _____

Occupation:_____ Hours worked per week: _____

Social Security Number: _____

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

Insurance Company:_____Policy #:_____Group #:_____

Name of Insured: _____ Relation to Insured: _____

Person to call in case of Emergency: _____

Relationship to you: _____ Phone number: _____

Do you have any children? Y / N If yes, please list their ages: _____
Have you ever had a visit with a Naturopathic Physician Y / N
Are you currently receiving healthcare elsewhere? Y / N
If yes, where and from whom?: _____
How did you hear about us?: _____
Primary Care Physician (if applicable): _____

List your health complaints in order of importance:

1.

2.

3.

Last time you had blood work done: _____

(For Office Use) ID Verified by: _____ Date: _____

Family History

Check the corresponding box for any medical conditions experienced by family members

	Mother	Father	Sister(s)	Brother(s)	Child(ren)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Spouse
Age if Living										
Age when Died										
Alcoholism / Addiction										
Allergies										
Asthma										
Auto Immune Disease										
Cancer										
Diabetes										
Genetic										
Heart Disease										
Hypertension										
Psychological										
Stroke / TIA										
Thyroid Condition										
Other										
Other										

Past Medical History

List All Surgeries and Hospitalizations—including date occurred:

1. _____ 3. _____
2. _____ 4. _____

Please Note When and Why You Had Each of the Following:

X-rays: _____

MRI/CT Scans:_____

Ultrasounds:_____

Accidents:_____

Please List All Sensitivities/Allergies/Reactions:

Medications: _____ Foods: _____

Environmental: _____

Did you have the following Disease (D), were Immunized for it (I), or Neither (N):

Measles:	D I N	Diptheria:	D I N
Mumps:	D I N	Tetanus:	D I N
Rubella:	D I N	Pertussis:	D I N
Chicken Pox:	D I N	Hepatitis B:	D I N
Gardasil (HPV):	D I N	Other: _____	

Any vaccination reactions:_____

List **Y**es, **N**o, or **P**ast regarding use of the following:

Antacids:	Y N P	Steroids:	Y N P
Analgesics:	Y N P	Laxatives:	Y N P
Coffee:	Y N P	Cups per day if Yes/Past:_____	
Soda:	Y N P	Ounces per day if Yes/Past:_____	
Alcohol:	Y N P	How often and how much if Yes/Past:_____	
Recreational drugs:	Y N P	What type and how often if Yes/Past:_____	
Any substance addiction:	Y N P	What type and when if Yes/Past:_____	
Any substance treatment:	Y N P	What type and when if Yes/Past:_____	

Tobacco:

Secondhand smoke exposure: Y N P What type and when if Yes/Past:_____

___ Never a smoker
___ Former smoker, cigarettes/day: _____
___ Current smoker, cigarettes/day: _____
___ Social smoker, cigarettes/day: _____

List all Prescription Medicine, Supplements, Herbs, Homeopathy, Vitamins you are taking, including dose.

Please bring the bottles of anything you're taking to your first appointment:

Review Of Systems:

Present Weight:_____ Weight one year ago: _____
Height: _____ Maximum weight and when:_____
Minimum Weight as adult and when: _____
Ideal Weight:_____

REGARDING THE NEXT SECTION:

Please Circle

- **Y** if you have the problem **NOW**
- **N** if you've **NEVER** had the problem
- **P** if you had the problem in the **PAST**

Good Energy: Y N P Fatigue: Y N P
If you have fatigue, what time of day is it worst (morning, afternoon, evening, all day)?
If you have fatigue, can you do what you need to during the day?: Y N

Skin:

Rash:	Y N P	Color Change:	Y N P
Hives:	Y N P	Lump:	Y N P
Psoriasis/eczema:	Y N P	Itchy:	Y N P
Dry:	Y N P	Warts/moles:	Y N P
Cancer:	Y N P	Perspiration:	Y N P

Head:

Headache:	Y N P	Migraine:	Y N P
Dandruff:	Y N P	Head Injury:	Y N P
Oil/dry hair:	Y N P	Hair loss:	Y N P

Eyes:

Dry/Watery:	Y N P	Blurry vision:	Y N P
Double vision:	Y N P	Cataracts:	Y N P
Glaucoma:	Y N P	Styes:	Y N P
Strain:	Y N P	Discharge:	Y N P
Itchy:	Y N P	Dark under eyelid:	Y N P
Date of last Eye Exam: _____		Glasses/Contacts:	Y N P

Ears:

Earache:	Y N P	Discharge:	Y N P
Tinnitus:	Y N P	Hearing Changes:	Y N P
Infections:	Y N P	Dizziness:	Y N P

Nose:

Frequent colds:	Y N P	Nosebleeds:	Y N P
Congestion:	Y N P	Post nasal drip:	Y N P
Polyps:	Y N P	Seasonal allergies:	Y N P

Mouth/Throat:

Canker sores: Y N P
Cold sores: Y N P
Sore throat: Y N P
Gum disease: Y N P
Dentures: Y N P
Cavities: Y N P
Loss of taste: Y N P
Hoarseness: Y N P
Date of last Dental Exam: _____

Neck:

Stiffness: Y N P
Swollen glands: Y N P
Lack of full movement: Y N P
Tension: Y N P

Respiratory:

Cough: Y N P
TB: Y N P
Shortness of breath with exertion: Y N P
Bronchitis: Y N P
Shortness of breath sitting: Y N P
Pneumonia: Y N P
Shortness of breath lying down: Y N P
Asthma: Y N P
Wheezing: Y N P
Painful breathing: Y N P

Cardiovascular:

High blood pressure: Y N P
Rheumatic Fever: Y N P
Low blood pressure: Y N P
Murmurs: Y N P
Arrhythmias: Y N P
Palpitations: Y N P
Edema: Y N P
Chest pain: Y N P

Gastrointestinal:

Heartburn: Y N P
Bowel movement frequency:_____
Indigestion: Y N P
Recent change in BM: Y N P
Bloating: Y N P
Diarrhea or constipation: Y N P
Nausea: Y N P
Hemorrhoids: Y N P
Vomiting: Y N P
Gall bladder disease: Y N P
Change in Appetite: Y N P
Liver disease: Y N P
Pancreatitis: Y N P
Ulcer: Y N P

Urinary Tract:

Incontinence: Y N P
Pain with urination: Y N P
Frequent infections: Y N P
Kidney stones: Y N P
Urgency: Y N P
Discharge/blood: Y N P

Males:

Testicular pain/swelling/lumps: Y N P
Sexually active: Y N P
Hernia: Y N P
Sexually Transmitted Disease:Y N P
Discharge: Y N P
Prostate Disease/Symptoms: Y N P
Impotence: Y N P
Healthy Libido: Y N P
Do you perform self-testicular exams?: Y N P
Sexual orientation: Heterosexual Homosexual Bisexual Queer MSM Other _____
Current form of Birth Control (if applicable): _____

Female:

Age periods began:_____
How long periods last: _____
How often periods occur:_____
Heavy Bleeding: Y N P
Cramping: Y N P
Moodiness: Y N P
Food Cravings: Y N P
Date of last Pap Smear:_____
Any Abnormal Paps: Y N P
Sexually Transmitted Disease: Y N P
Do you perform self-breast exams?: Y N P
Sexually Active: Y N P
Healthy Libido: Y N P
Times Pregnant:_____
Number of Births:_____
Miscarriages:_____
Abortions:_____
Menopausal Symptoms: Y N P
Vaginal Dryness: Y N P
Vaginitis: Y N P
Painful Intercourse: Y N P
Use of Hormones: Y N P
Date of last Mammogram (if applicable): _____ Results:_____
Date of last Bone Scan (if applicable): _____ Results:_____
Sexual orientation: Heterosexual Homosexual Bisexual Queer Other _____
Current form of Birth Control (if applicable): _____

Musculoskeletal:

Weakness: Y N P
Stiffness: Y N P
Tremors: Y N P
Arthritis: Y N P
Leg cramps: Y N P
Pain: Y N P

Nervous:

Paralysis: Y N P
Tingling/numbness: Y N P
Seizures: Y N P
Sciatica: Y N P
Carpal tunnel syndrome: Y N P
Fainting: Y N P

Mental/Emotional:

Depression: Y N P
Suicidal: Y N P
Anxiety: Y N P
Anger/irritability: Y N P
High-strung/tense: Y N P
Fear/Panic: Y N P

Exercise:

How often:_____
What type(s):_____
For How long:_____

Hobbies:

_____
_____

Sleep:
How long per night: _____
If you wake up frequently, what is the reason: _____
Nightmares: Y N P
Wake refreshed: Y N P
Must Nap during the day: Y N P
Sleep walk: Y N P
Grind Teeth: Y N P
Snore: Y N P

Food:
Appetite Good?: Y N P
Foods Crave: _____
Foods Dislike: _____
Foods that don't sit well:_____

Typical Day's Diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

Toxin Exposure:
Did you grow up near any refinery, or polluted area, or in home with leaded paint?
If so, what sort of pollution were you exposed to?: _____
Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:_____
Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?:_____
Are you particularly sensitive to perfumes, gasoline, or other vapors?:_____
Do you use pesticides, herbicides, other chemicals around your home?_____

Social Life:
Enjoy job?: Y N P
Active Religious / Spiritual practice: Y N P
Quality of most significant relationship?_____
History of sexual, mental/emotional, physical abuse?: Y N
If so, at what age and by whom?: _____
What is your greatest health concern?_____
How does it limit you the most? _____
How committed are you toward making valuable changes: Little Moderately Very