

MARIO ROXAS, ND  
Naturopathic Physician

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**NEW PATIENT INTAKE FORM**

Please fill this out entirely and bring it with you to your first office visit

Name \_\_\_\_\_ Date \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Hrs per Week \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Dr. Roxas or the clinic office may call patients at times, and we wish to ensure your privacy regarding treatment at our clinic. In the event that we are unable to reach you by phone, **please indicate where it is appropriate to leave messages for you:**

Home voice mail      With family member(s) (indicate below)      At work      Never leave messages

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**What are your primary health concerns? List as many as you can, in the order of their importance to you.**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_
- 8) \_\_\_\_\_

**What are the primary expectations you have for your visit today?**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

**Is this your first visit to a Naturopathic Physician?** \_\_\_\_\_

**General Information:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight 1 yr ago \_\_\_\_\_ Max. weight \_\_\_\_\_ When \_\_\_\_\_

When during the day is your energy and alertness best? \_\_\_\_\_ Worst? \_\_\_\_\_

Blood type, if known \_\_\_\_\_

Primary interests and hobbies \_\_\_\_\_

Primary form of exercise, if any \_\_\_\_\_

How often? \_\_\_\_\_

**Family History: Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply:**

- |                |        |                    |          |                |                     |
|----------------|--------|--------------------|----------|----------------|---------------------|
| Alzheimer's    | Anemia | Arthritis          | Asthma   | Kidney Disease | Multiple Sclerosis  |
| Heart Disease  | Cancer | Diabetes           | Epilepsy | Hypertension   | Parkinson's Disease |
| Mental Illness | Stroke | Other (list below) |          |                |                     |

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

**Are you currently receiving health care? \_\_\_\_\_ If yes, where and from whom? Please provide contact information (phone and address) if available. If not, when was the last time you received medical care and why?**

\_\_\_\_\_  
\_\_\_\_\_

**Which of the following childhood illnesses have you had?**

- |            |         |                |                 |
|------------|---------|----------------|-----------------|
| Diphtheria | Measles | Scarlet Fever  | Rheumatic Fever |
| Chickenpox | Mumps   | German Measles | Other: _____    |

**Which immunizations have you had? If you don't know if you've had one, place a question mark beside it:**

- |            |       |                 |           |                       |
|------------|-------|-----------------|-----------|-----------------------|
| Diphtheria | Polio | Hepatitis A/B/C | Tetanus   | Measles/Mumps/Rubella |
| Chickenpox | Flu   | Meningitis      | Pertussis | Other: _____          |

**Which diagnostic studies have you had?**

- |                            |           |         |                          |
|----------------------------|-----------|---------|--------------------------|
| Electrocardiogram (EKG)    | X-Ray     | CT Scan | Bone Density Scan (DEXA) |
| Electroencephalogram (EEG) | Mammogram | MRI     | Other: _____             |

**Are you aware of having allergies to any of the following? If so, describe your reaction to each one:**

Drugs: \_\_\_\_\_

\_\_\_\_\_

Foods: \_\_\_\_\_

\_\_\_\_\_

Chemicals/Perfumes: \_\_\_\_\_

\_\_\_\_\_

Animals: \_\_\_\_\_

\_\_\_\_\_

**Which medications, either by prescription or over-the-counter, are you taking or have you taken in the past 6 months?**

Antibiotics      Appetite Suppressants      Sleep medication      H2 Blockers/Ulcer medication

Tranquilizers      Cortisone/Prednisone      Thyroid medication      Cholesterol-lowering medication

Antacids      Antidepressants      Laxatives      Pain Relievers

Other(s): \_\_\_\_\_

**Please list, by name, any prescription medications you currently take, over-the-counter medications, and 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) \_\_\_\_\_ 11) \_\_\_\_\_

2) \_\_\_\_\_ 12) \_\_\_\_\_

3) \_\_\_\_\_ 13) \_\_\_\_\_

4) \_\_\_\_\_ 14) \_\_\_\_\_

5) \_\_\_\_\_ 15) \_\_\_\_\_

6) \_\_\_\_\_ 16) \_\_\_\_\_

7) \_\_\_\_\_ 17) \_\_\_\_\_

8) \_\_\_\_\_ 18) \_\_\_\_\_

9) \_\_\_\_\_ 19) \_\_\_\_\_

10) \_\_\_\_\_ 20) \_\_\_\_\_

(continue on back if necessary)

## Life Assessment

In assessing your health, it is helpful to have some sense of the degree of satisfaction you feel in various areas of your life. Using the scales below, please rate yourself in terms of satisfaction and dissatisfaction. Number 1 means you are very dissatisfied or stressed. Number 10 means you are very satisfied or comfortable.

### Friends & Family

0    1    2    3    4    5    6    7    8    9    10

### Physical Health

0    1    2    3    4    5    6    7    8    9    10

### Mental/Emotional Health

0    1    2    3    4    5    6    7    8    9    10

### Career

0    1    2    3    4    5    6    7    8    9    10

### Relationships/Romance

0    1    2    3    4    5    6    7    8    9    10

### Leisure Time

0    1    2    3    4    5    6    7    8    9    10

### Money/Finances

0    1    2    3    4    5    6    7    8    9    10

### Personal Growth/Spirituality

0    1    2    3    4    5    6    7    8    9    10

## Check the appropriate box:

	Yes	No		Yes	No
Get 6-8 hours of sleep nightly?			Wake-up refreshed?		
In a supportive relationship?			Enjoy your work?		
Take vacations?			Spend time outside?		
Eat out more than 3 times/week?			Eat 3 meals daily?		
History of abuse?			Go on a diet more than twice/yr?		
Major life trauma in past 3 years?			Watch TV?    Hours/day? _____		
Drink alcohol?    Drinks/day? _____			Read?            Hours/day? _____		
Use tobacco?    Packs/day? _____			Drink coffee?		
How many years? _____			Drink tea?		
Use recreational drugs?			Drink soda/cola?		
Treated for substance abuse?			Use sugar substitutes?		
			Add sugar/salt to food?		

## Review of Systems

In this section, check the box if you have the symptom currently or if you have experienced it in the past six months. Some questions are yes/no, in which case check the box to indicate “yes.”

### Mental/Emotional

- Anxiety/Nervousness
- Depression
- Mood swings
- Considered/Attempted suicide
- Tension/Irritability
- Poor concentration
- Forgetfulness

### Neurological

- Seizures
- Muscle weakness
- Memory loss
- Vertigo/dizziness
- Paralysis
- Numbness or tingling
- Shakiness in hands

### Immune

- Chronic fatigue
- Swollen glands
- Reaction to vaccines
- Ongoing infections
- Slow wound healing
- Frequent colds/flu

### Endocrine

- Hair loss
- Brittle nails
- Excessive thirst
- Excessive hunger
- Low energy
- Tired after meals
- Heat intolerance
- Cold intolerance
- Seasonal depression

### Head

- Headaches (tension)
- Headaches (migraine)
- Head injury
- Jaw pain/TMD

### Ears

- Impaired hearing
- Earaches/Ear pain
- Ringing in the ears
- Itching inside/outside
- Frequent popping

### Eyes

- Spots in vision
- Blurred vision
- Double vision
- Loss of vision
- Color blindness
- Night blindness
- Eye pain/strain
- Excessive tearing
- Uncomfortable dryness
- Cataracts
- Glaucoma

### Nose & Sinuses

- Frequent head colds
- Stuffiness
- Sinus pain
- Nose bleeds
- Hay fever
- Loss of smell

### Neck

- Lumps/nodules
- Goiter
- Pain/stiffness

### Mouth & Throat

- Frequent sore throat
- Teeth grinding
- Gum problems
- Dental cavities
- Excessive saliva/drooling
- Sore tongue/lips
- Hoarseness
- Jaw clicks

### Skin

- Acne/boils
- Rashes
- Lumps
- Moles
- Color changes
- Scars
- Hives
- Eczema
- Generalized itching
- Night sweats

### Respiratory

- Dry cough
- Productive cough
- Bloody discharge
- Wheezing
- Asthma
- Bronchitis
- Emphysema
- Pleurisy
- Pneumonia
- Lung congestion/sputum
- Shortness of breath (daytime)
- Shortness of breath (nighttime)
- Shortness of breath lying down
- Pain on breathing
- Difficulty breathing
- Difficulty taking a deep breath

### Gastrointestinal

- Difficulty swallowing
- Change in thirst
- Change in appetite
- Nausea/vomiting
- Burning pain in stomach
- Heartburn
- Jaundice
- Liver disease
- Gallbladder disease
- Abdominal pain/cramps
- Excessive belching/gas
- Hemorrhoids
- Constipation
- Diarrhea
- Black/Bloody stools
- Less than one BM daily

### Cardiovascular

- Angina/chest pain
- Heart disease
- High blood pressure
- Low blood pressure
- Blood clots
- Phlebitis
- Rheumatic fever
- Fainting
- Heart palpitations/flutterers
- Heart murmurs

**Musculoskeletal**

Joint pain or stiffness  
 Arthritis  
 Broken bones  
 Muscle spasms or cramps  
 Muscle weakness  
 Sciatica

**Blood/Peripheral Vascular**

Easy bleeding/bruising  
 Deep leg pain  
 Varicose veins  
 Anemia  
 Cold hands/feet  
 Swelling in feet or ankles

**Urinary**

Pain with urination  
 Frequency at night  
 Frequent infections  
 Unable to hold urine  
 Kidney stones  
 Split stream

**Female Reproduction/Breasts** (the following questions apply to lifetime, not just last 6 months)

_____	Age at first menses (first period)	_____	Age of last menses (if menopausal)
_____	Usual length of cycle (number of days between periods)	_____	Duration of menstruation (number of days of bleeding)
_____	Date of last annual exam (Pap)	_____	Number of pregnancies
_____	Number of live births	_____	Number of miscarriages

Do you use birth control? if so, enter type: \_\_\_\_\_

Irregular cycles	Ovarian cysts	Difficulty conceiving
Painful menses	Breast pain/tenderness	Sexual difficulties
Heavy flow	Breast lumps	Cervical dysplasia
Light flow	Dimpling or skin changes	Chlamydia
Bleeding between periods	Nipple discharge	Genital warts
Clotting	Regular self breast exams	Genital herpes
Discharge	Menopausal symptoms	Gonorrhea
PMS	Sexually active	Syphilis
Endometriosis	Pain during intercourse	

**Male Reproduction** (questions apply to lifetime, not just last 6 months)

Hernias	Use condoms	Genital warts
Prostate disease	Sexual difficulties	Genital herpes
Testicular masses or pain	Erectile dysfunction	Chlamydia
Discharge or sores on penis	Premature ejaculation	Gonorrhea
Sexually active	Impotence	Syphilis

**Do you have any other health concerns that have not been covered in this questionnaire?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_