www.healyslowerbackpain.com

Initial Intake Form

PATIENT INFORMATION

Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Address: _____

(Street) (City) (Postal Code)

Home Ph. #: _____ Cell: _____ Email: _____

Marital status: _____ # of Children: _____ Occupation: _____

Do you wish to receive Dr. Elliott's health E-Newsletter? Y/ N

Can Dr. Elliott use your email address to contact you concerning your care? Y/N

How did you hear about this clinic: ☐ Walk by ☐ Website ☐ Flyer

☐ Referral: _____ ☐ Newspaper ☐ Other: _____

Name of Medical Doctor: _____ Permission to contact for labs, etc. Y/N

MAIN HEALTH CONCERNS

My usual health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list, in order of importance, your chief concerns:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions:

Cancer:	Autoimmune disease:
Eczema:	Arthritis:
Diabetes:	Allergies:
Heart disease:	Asthma:
High blood pressure:	Addictions:
Stroke:	Liver disease:
Thyroid disease:	Mental illness:

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List major childhood illnesses: (ear infections, strep throat, tonsillitis, chicken pox, measles, etc.)

_____

Vaccinations: ❑ I have been fully vaccinated ❑ I get the flu shot regularly ❑ I have had some vaccines
❑ I haven't been vaccinated ❑ I have had travel vaccines (ie. Hepatitis) ❑ I don't know/don't remember

Successful health care and preventive medicine are only possible when I have a complete understanding of you – including your expectations and obstacles to cure. The nature of your responses to the following questions will go a long way in assisting how I can best help you. Your time, thoughtfulness and honesty in completing this overview are appreciated.

1. What do you know about the naturopathic approach?

2. What expectations do you have from **this** visit to our clinic?

3. What **long term** expectations do you have from working with our clinic?

4. What expectations do you have **of me personally** as your health care provider?

5. What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? Circle level of commitment:

   0% 1 2 3 4 5 6 7 8 9 10 (100%)

6. What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

7. What behaviors or lifestyle habits do you currently engage in regularly that you believe are **self-destructive?**

8. What potential **obstacles** do you foresee in adhering to the therapeutic protocols that I will be sharing with you?

9. Do you feel you are fulfilling your purpose in life? If no, what is standing in your way?

Initial Intake Form

Please list hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc.

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Major mental/emotional traumas: (loss of loved one, divorce, career change, miscarriage, major disease, etc.)

_____

List any real or suspected allergies/sensitivities to drugs, food, alcohol, caffeine, chemicals, perfumes, smoke, environment, or other: _____

_____

Please list supplements you are currently taking:

1. _____ (Brand) (Supplement Name) (Daily Dose)
2. _____ (Brand) (Supplement Name) (Daily Dose)
3. _____ (Brand) (Supplement Name) (Daily Dose)
4. _____ (Brand) (Supplement Name) (Daily Dose)
5. _____ (Brand) (Supplement Name) (Daily Dose)
6. _____ (Brand) (Supplement Name) (Daily Dose)
7. _____ (Brand) (Supplement Name) (Daily Dose)
8. _____ (Brand) (Supplement Name) (Daily Dose)
9. _____ (Brand) (Supplement Name) (Daily Dose)
10. _____ (Brand) (Supplement Name) (Daily Dose)

Read the following questions and fill in the number that applies:

0 (leave blank) = Never consume or use
1 = Consume or use several times per month
2 = Consume or use weekly
3 = Consume or use daily

DIET

____ Alcohol
____ Artificial sweeteners
____ Candy or other sweets
____ Pop/soda
____ Chewing tobacco
____ Cigarettes
____ Cigars/pipes
8. _____ Coffee
9. _____ Fast food
10. _____ Fried foods
11. _____ Luncheon meats/hot dogs
12. _____ Margarine
13. _____ Milk/cheese/yogurt, etc.
14. _____ Non-herbal tea
15. _____ Refined flour/baked goods
16. _____ Refined sugar
17. _____ Vitamins and minerals
18. _____ Water, distilled
19. _____ Water, tap
20. _____ Water, well
21. _____ Diet often (Y or N)

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LIFESTYLE

_____ Exercise (3 = 5+ times per week, 2 = 2-4 times per week, 1 = once per week, 0 = none)
_____ Stress (3 = heavy/chronic, 2 = moderate/often stressed, 1 = light/occasionally stressed, 0 = none)
_____ Changed jobs (3 = within last 2 months, 2 = within last 6 months, 1 = within last 12 months)
_____ Divorced (3 = within last 6 months, 2 = within last year, 1 = within last 2 years, 0 = never)
_____ Work over 40 hours/week (3 = always, 2 = usually, 1 = occasionally, 0 = never)

MEDICATIONS

Indicate with a check mark any medications you're currently taking or have taken in the past month:

_____ Antacids
_____ Antibiotics
_____ Anticonvulsants
_____ Antidepressants
_____ Antifungals
_____ Aspirin/Ibuprofen
_____ Asthma inhalers
_____ Beta blockers
_____ Birth control
_____ Chemotherapy
_____ Cortisone
_____ Diabetic medications
_____ Diuretics
_____ Heart medications
_____ High blood pressure
_____ Hormone Therapy
_____ Laxatives
_____ Insulin
_____ Recreational drugs
_____ Relaxants/Sleeping pills
_____ Thyroid medication
_____ Tylenol/acetaminophen
_____ Ulcer medications
Other: _____

Read the following questions and circle the number that applies:

0 (leave blank) = Do not experience
1 = Minor or mild symptom, or it rarely occurs (once a month or less)
2 = Moderate symptom or it occasionally occurs (weekly)
3 = Severe symptom or it frequently occurs (daily or almost daily)

UPPER GASTROINTESTINAL SYSTEM

Belching or gas within 1 hr. of a meal	0	1	2	3
Heartburn or acid reflux	0	1	2	3
Bloating shortly after eating	0	1	2	3
Are you a vegan	No			Yes
Bad breath	0	1	2	3
Loss of taste for meat	0	1	2	3
Sweat has a strong odor	0	1	2	3
Nausea from taking vitamins	0	1	2	3
Sense of excess fullness after meals	0	1	2	3
Do you feel like skipping breakfast?	0	1	2	3
Do you feel better if you don't eat?	0	1	2	3
Sleepy after meals	0	1	2	3
Fingernails chip, peel or break easily	0	1	2	3
Anemia unresponsive to iron	0	1	2	3
Stomach pains or cramps	0	1	2	3
Diarrhea, chronic	0	1	2	3
Diarrhea shortly after meals	0	1	2	3
Black or tarry stools	0	1	2	3
Undigested food in stool	0	1	2	3

LIVER/GALLBLADDER

Pain between shoulder blades	0	1	2	3
Stomach upset by greasy foods	0	1	2	3
Greasy or shiny stools	0	1	2	3
Nausea	0	1	2	3
Motion sickness (air, car, boat)	0	1	2	3
History of morning sickness (pregnancy)	No			Yes
Light or clay colored stools	0	1	2	3
Dry skin, itchy feet or skin peels on feet	0	1	2	3
Headache over the eye	0	1	2	3
Gallbladder attacks (past or present)	0	1	2	3
Gallbladder removed	No			Yes
Bitter taste in mouth, esp. after meals	0	1	2	3
Become sick if drinking wine	0	1	2	3
If drinking alcohol, easily intoxicated	0	1	2	3
Alcoholic beverages per week	0	1	2	3
Recovering alcoholic	No			Yes
Hangovers after drinking alcohol	0	1	2	3
History of drug or alcohol abuse	No			Yes
History of hepatitis	No			Yes
Long term use of Rx medications	No			Yes
Sensitive to chemicals (perfume, etc.)	0	1	2	3

Sensitive to tobacco smoke	0	1	2	3	Nutrasweet (aspartame) consumption	0	1	2	3
Exposure to diesel fumes	0	1	2	3	Bothered by aspartame	0	1	2	3
Pain under right side of rib cage	0	1	2	3	Chronic fatigue syndrome or fibromyalgia	0	1	2	3
Hemorrhoids or varicose veins	0	1	2	3					

SMALL INTESTINE

Food allergies	0	1	2	3	Crohn's disease	No			Yes
Abdominal bloating 1-2 hrs after eating	0	1	2	3	Wheat or grain sensitivity	0	1	2	3
Specific foods cause fatigue or bloating	0	1	2	3	Dairy sensitivity	0	1	2	3
Pulse speeds after eating	0	1	2	3	Are there foods you could not give up?	No			Yes
Airborne allergies	0	1	2	3	Asthma, sinus infections, stuffy nose	0	1	2	3
Experience hives	0	1	2	3	Bizarre, vivid or nightmarish dreams	0	1	2	3
Sinus congestion, "stuffy head"	0	1	2	3	Use over-the-counter pain medications	0	1	2	3
Crave bread or pasta	0	1	2	3	Feel spacey or unreal	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3					

LARGE INTESTINE

Anus itches	0	1	2	3	Less than one bowel movement				
Coated tongue	0	1	2	3	every day	No			Yes
Feel worse in moldy or musty places	0	1	2	3	Stools have corners, or edges are flat				
Taken an antibiotic for a length of time					and/or ribbon shaped	0	1	2	3
of 1 = < 1 mo, 2 = < 3 mos., 3 = > 3 mos.	0	1	2	3	Stools are not well formed (loose)	0	1	2	3
Fungus or yeast infections	0	1	2	3	Irritable bowel syndrome	0	1	2	3
Ring worm, "jock itch", athlete's foot,					Blood in stool	0	1	2	3
or nail fungus	0	1	2	3	Mucus in stool	0	1	2	3
Eating sugar, starch or drinking alcohol					Excessive foul smelling gas	0	1	2	3
increases yeast symptoms	0	1	2	3	Bad breath or strong body odor	0	1	2	3
Stools hard or difficult to pass	0	1	2	3	Painful to press outer sides of thighs	0	1	2	3
History of parasites	No			Yes	Cramping in lower abdomen	0	1	2	3

MINERAL NEEDS

History of carpal tunnel syndrome	No			Yes	Morning stiffness	0	1	2	3
History of lower right abdominal pain	No			Yes	Vomiting or nausea	0	1	2	3
History of stress fractures	No			Yes	Crave chocolate	0	1	2	3
Bone loss (reduced density on bone scan)	0	1	2	3	Feet have a strong odor	0	1	2	3
Are you shorter than you used to be?	No			Yes	Tendency to anemia (low red blood cells)	0	1	2	3
Calf, foot or toe cramps at rest	0	1	2	3	Whites of eyes (sclera) are tinted blue	0	1	2	3
Cold sores, blisters or herpes lesions	0	1	2	3	Hoarseness of voice	0	1	2	3
Frequent fevers	0	1	2	3	Difficulty swallowing	0	1	2	3
Frequent skin rashes and/or hives	0	1	2	3	Lump in throat	0	1	2	3
Have you ever had a herniated disc?	No			Yes	Dry mouth, eyes and/or nose	0	1	2	3
Excessively flexible joints/double jointed	0	1	2	3	Gag easily	0	1	2	3
Joints pop or click	0	1	2	3	White spots on fingernails	0	1	2	3
Pain or swelling in joints	0	1	2	3	Cuts heal slowly and/or scar easily	0	1	2	3
Bursitis or tendonitis	0	1	2	3	Decreased sense of taste or smell	0	1	2	3
History of bone spurs	No			Yes					

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ESSENTIAL FATTY ACIDS

Aspirin is an effective pain reliever	No			Yes	Headaches when out in the hot sun	0	1	2	3
Crave fatty or greasy foods	0	1	2	3	Sunburn easily or suffer sun stroke	0	1	2	3
Low or reduced-fat diet (past or present)	0	1	2	3	Muscles become easily fatigued	0	1	2	3
Tension headaches at base of skull	0	1	2	3	Dry, flaky skin and/or dandruff	0	1	2	3

SUGAR HANDLING

Awaken a few hours after falling asleep, and difficulty getting back to sleep	0	1	2	3	Fatigue that is relieved by eating	0	1	2	3
					Headache if meals are skipped or delayed	0	1	2	3
Crave sweets	0	1	2	3	Irritable when skipping meals	0	1	2	3
Eat desserts or sugary snacks	0	1	2	3	Shaky if meals are delayed	0	1	2	3
Binge or uncontrolled eating	0	1	2	3	Family members with diabetes 0 = 0				
Excessive appetite	0	1	2	3	1 = 2 or less, 2 = 2 – 4, 3 = More than 4	0	1	2	3
Crave coffee or sugar in the afternoon	0	1	2	3	Frequent thirst	0	1	2	3
Sleepy in afternoon	0	1	2	3	Frequent urination	0	1	2	3

VITAMIN NEEDS

Muscles become easily fatigued	0	1	2	3	Can hear heart beat on pillow at night	0	1	2	3
Feel worse or sore after exercise	0	1	2	3	Body or limb jerks when falling asleep	0	1	2	3
Vulnerable to insect bites	0	1	2	3	Night sweats	0	1	2	3
Heaviness in arms/legs	0	1	2	3	Restless leg syndrome	0	1	2	3
Enlarged heart, or heart failure	0	1	2	3	Cracks or cuts at corner of mouth	0	1	2	3
Pulse slow (< 65 beats per minute)	No			Yes	Fragile skin, easily chaffed (ie. shaving)	0	1	2	3
Ringing in ears	0	1	2	3	Polyps or warts	0	1	2	3
Numbness, tingling or itching					MSG sensitivity	0	1	2	3
in extremities	0	1	2	3	Can't remember dreams on waking	0	1	2	3
Depressed	0	1	2	3	Taking the birth control pill	0	1	2	3
Fear of impending doom	0	1	2	3	Small bumps on back of upper arms	0	1	2	3
Worrier, apprehensive, anxious	0	1	2	3	Strong light at night irritates eyes	0	1	2	3
Nervous or agitated	0	1	2	3	Nose bleeds and/or easy bruising	0	1	2	3
Feelings of insecurity	0	1	2	3	Bleeding gums (ie. when brushing teeth)	0	1	2	3
Heart races	0	1	2	3					

ADRENAL GLAND

Tend to be a "night person"	0	1	2	3	Crave salty foods	0	1	2	3
Difficulty falling asleep	0	1	2	3	Salt foods before tasting	0	1	2	3
Slow starter in the morning	0	1	2	3	Perspire easily	0	1	2	3
Keyed up, trouble calming down	0	1	2	3	Chronic fatigue, or get drowsy often	0	1	2	3
High blood pressure (normal = 110/70)	0	1	2	3	Afternoon yawning	0	1	2	3
Headache after exercising	0	1	2	3	Afternoon headache	0	1	2	3
Feeling wired or jittery with coffee	0	1	2	3	Asthma, wheezing or difficulty				
Clench or grind teeth	0	1	2	3	breathing	0	1	2	3
Calm on the outside, troubled inside	0	1	2	3	Pain on the inner side of the knee	0	1	2	3
Chronic low back pain, worse tired	0	1	2	3	Tendency to sprain ankles or develop				
Become dizzy/faint upon standing	0	1	2	3	"shin splints"	0	1	2	3
Difficult maintaining a chiropractic					Tendency to require sunglasses	0	1	2	3
adjustment	0	1	2	3	Allergies and/or hives	0	1	2	3
Pain after manipulative correction	0	1	2	3	Weakness, dizziness	0	1	2	3
Arthritic tendencies	0	1	2	3	Easily stressed out	0	1	2	3

PITUITARY GLAND

Over 6'6" tall	0	1	2	3	Decreased libido	0	1	2	3
Early sexual development (< age 10)	No			Yes	Abnormal thirst	0	1	2	3
Increased libido	0	1	2	3	Weight gain around hips or waist	0	1	2	3
Splitting type headache	0	1	2	3	Menstrual disorders	0	1	2	3
Memory failing	0	1	2	3	Delayed sexual development (> age 13)	No			Yes
Ability to tolerate sugar; fine with eating	0	1	2	3	Tendency to have ulcers or colitis	0	1	2	3
Under 4'10" (mature height)	0	1	2	3					

THYROID

Allergic to iodine	0	1	2	3	Mentally sluggish, lacking motivation	0	1	2	3
Difficulty gaining weight	0	1	2	3	Easily fatigued, sleepy during the day	0	1	2	3
Nervous, emotional, or can't work					Cold hands and feet, poor circulation	0	1	2	3
under pressure	0	1	2	3	Chronic constipation or sluggish digestion	0	1	2	3
Inward trembling	0	1	2	3	Excessive hair loss and/or coarse hair	0	1	2	3
Flush easily	0	1	2	3	Morning headaches, fade with time	0	1	2	3
Fast pulse at rest	0	1	2	3	Loss of outside 1/3 of eyebrow	0	1	2	3
Intolerance to high temperatures	0	1	2	3	Seasonal sadness	0	1	2	3
Difficulty losing weight	0	1	2	3					

MEN ONLY

Prostate problems	0	1	2	3	Interruption of stream during urination	0	1	2	3
Urination difficult or dribbling	0	1	2	3	Pain on inside of legs or heels	0	1	2	3
Difficult to start and stop urine stream	0	1	2	3	Feeling of incomplete bowel evacuation	0	1	2	3
Pain or burning with urination	0	1	2	3	Decreased sexual function	0	1	2	3
Waking to urinate at night	0	1	2	3	History of sexually transmitted infections	No			Yes

WOMEN ONLY

Depression during periods	0	1	2	3	Vaginal discharge	0	1	2	3
Premenstrual syndrome (PMS)	0	1	2	3	Vaginal dryness	0	1	2	3
Crave chocolate around periods	0	1	2	3	Vaginal itchiness	0	1	2	3
Breast tenderness associated with cycle	0	1	2	3	Weight gain around hips, thighs				
Excessive menstrual flow	0	1	2	3	and buttocks	0	1	2	3
Scanty blood flow during periods	0	1	2	3	Excess facial or body hair	0	1	2	3
Occasional skipped periods	0	1	2	3	Thinning skin	0	1	2	3
Variations in menstrual cycles	0	1	2	3	Hot flashes	0	1	2	3
Endometriosis	0	1	2	3	Night sweats (in menopausal females)	0	1	2	3
Uterine fibroids	0	1	2	3	Pregnant	No			Yes
Breast fibroids, benign masses	0	1	2	3	History of sexually transmitted infections	No			Yes
Painful intercourse (dyspareunia)	0	1	2	3	Difficulty conceiving/infertility	No			Yes

CARDIOVASCULAR

Aware of heavy and/or irregular					Ankles swell, especially at end of day	0	1	2	3
breathing	0	1	2	3	Cough at night	0	1	2	3
Discomfort at high altitudes	0	1	2	3	Blush or face turns red for no reason	0	1	2	3
"Air hunger" and/or yawn frequently	0	1	2	3	Dull pain or tightness in chest, possibly				
Compelled to open windows in a					radiates into arm, worse w/exertion	0	1	2	3
closed room	0	1	2	3	Muscle cramps with exertion	0	1	2	3
Shortness of breath with exertion	0	1	2	3					

KIDNEY & BLADDER

Pain in mid back region	0	1	2	3	Cloudy, bloody or darkened urine	0	1	2	3
Dark circles under eyes and/or puffy eyes	0	1	2	3	Urine has a strong odor	0	1	2	3
History of kidney stones	No		Yes						

IMMUNE SYSTEM

Runny or drippy nose	0	1	2	3	Never get sick (3 = not in last 7 yrs,				
Catch colds at the beginning of winter	0	1	2	3	2 = not in last 4 yrs, 1 = not in last 2 yrs)	0	1	2	3
Mucus-producing cough	0	1	2	3	Acne (adult)	0	1	2	3
Frequent infections (ear, sinus, lung,					Itchy skin/dermatitis	0	1	2	3
skin, bladder, kidney, etc.)	0	1	2	3	Cysts, boils, rashes	0	1	2	3
Frequent colds or flu	0	1	2	3	History of viruses: Epstein Bar, mono, herpes,				
					shingles, chronic fatigue, hepatitis	0	1	2	3

PSYCHOLOGICAL

Treated for emotional issues	0	1	2	3	Mood swings	0	1	2	3
Depression	0	1	2	3	Ever considered suicide	0	1	2	3
Anxiety/nervousness	0	1	2	3	Ever attempted suicide	0	1	2	3
Poor concentration	0	1	2	3					

Height: _____ Weight: _____ Do you have a religious/spiritual practice? Y/N _____

Blood Type (if known): _____ Do you crave certain foods? Y/N _____

Do you have energy crashes? Y/N Time/s: _____

Informed Consent and Request for Naturopathic Medical Care and Acupuncture

As a patient, I have the right to be informed about my health condition(s) and recommended treatments. Dr. _____ will discuss the potential benefits, risks and hazards involved. After signing this consent form, I understand I can withdraw consent at any time.

I recognize that even the gentlest therapies may potentially have complications in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs.

I give my written consent for evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

_____ _____ _____

Printed Name Signature Date