



**SONOMA  
NATUROPATHIC  
MEDICINE**

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### PATIENT INFORMATION

Patient's Name: \_\_\_\_\_  
First Middle Initial Last Preferred name

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Telephone numbers: home \_\_\_\_\_ work/cell: \_\_\_\_\_

Preferred # for appointment reminders and other messages – no health information will be disclosed: \_\_\_\_\_

SS #: \_\_\_\_\_ Driver's license #: \_\_\_\_\_ Birth date: \_\_\_\_\_

Age: \_\_\_\_\_ Biological Gender (circle one): M F Other Number of children you have: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer address: \_\_\_\_\_

Marital status:  Single  Married  Partnership  Separated  Divorced

With whom do you live  Spouse  Partner  Parents  Friends  Children  Alone

Spouse/parent name: \_\_\_\_\_ Spouse/parent SS#: \_\_\_\_\_

Spouse/parent phone: \_\_\_\_\_ Spouse/parent birth date: \_\_\_\_\_

Spouse/parent address: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone number: \_\_\_\_\_

If someone other than patient is responsible for payment, please complete the following:

Name of responsible party: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

I acknowledge that by completing this patient intake form that I fully authorize and consent to treatment at Sonoma Naturopathic Medicine, office of Dr. Marcus Porrino and Dr. Rebecca H. Porrino.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

How did you hear about our clinic \_\_\_\_\_  
 Yes, please send me the quarterly newsletter: Email : \_\_\_\_\_

# HEALTH HISTORY QUESTIONNAIRE

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Naturopathic healthcare is most effective when the doctor completely understands the patient's physical, mental, and emotional concerns and conditions. The information you provide helps me understand your needs and how to best help you reach your health goals. Your time, honesty, and thoughtfulness is appreciated. Feel free to mark anything you may have a question about.

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Why did you choose to come to this clinic? \_\_\_\_\_

Are you currently receiving healthcare? Y N

If yes, where and from whom? \_\_\_\_\_

\_\_\_\_\_

If no, when and where did you last receive medical or health care?

\_\_\_\_\_

What was the reason? \_\_\_\_\_

What are your most important health problems? List them in order of importance.

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

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

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

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

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

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

What three expectations do you have from this visit to our clinic?

What expectations do you have of me as your doctor?

What is your present level of commitment to addressing the underlying causes of the health problems listed above? (Rate from 0 to 10-- 0 being little commitment, 10 being 100% committed)

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

What behaviors or habits do you engage in regularly that you believe support your health?

What behaviors or habits do you engage in regularly that you believe do not support your health?

What do you love to do?



IMMUNIZATIONS

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Other _____	

ALLERGIES

Are you hypersensitive or allergic to:  
 Any medications: \_\_\_\_\_  
 Any foods: \_\_\_\_\_  
 Other: \_\_\_\_\_

CURRENT MEDICATIONS

Do you take or use:

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Hormones	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list ALL prescription medications, over the counter medications, vitamins or other supplements you are taking:

- |          |          |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

HABITS (Y = now, P = past, N = never)

Do you exercise? Y N      If yes, what kind \_\_\_\_\_  
 How often \_\_\_\_\_

Spend time outside? Y N  
 How many hours of sleep do you get each night? \_\_\_\_\_

Sleep well	Y P N	Do you drink coffee	Y P N
Awaken rested	Y P N	Do you use tobacco	Y P N
Use recreational drugs	Y P N	Smoked previously	Y P N
Do you eat three meals a day	Y P N	Been treated for drug dependence	Y P N
Treated for alcoholism	Y P N	Use alcoholic beverages	Y P N
Do you go on diets often	Y P N	How often? _____	

REVIEW OF SYSTEMS

MENTAL/ EMOTIONAL

Treated for emotional problems	Y P N	Depression	Y P N
Mood Swings	Y P N	Anxiety or nervousness	Y P N
Considered/Attempted suicide	Y P N	Tension	Y P N
Poor concentration	Y P N	Memory problems	Y P N

## ENDOCRINE

Hypothyroid	Y P N	Heat or cold intolerance	Y P N
Low blood sugar	Y P N	Diabetes	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N
Fatigue	Y P N	Seasonal depression	Y P N

## IMMUNE

Vaccinations	Y P N	Reactions to vaccinations	Y P N
Chronic Fatigue Syndrome	Y P N	Chronic infections	Y P N
Chronically swollen glands	Y P N	Slow wound healing	Y P N

## NEUROLOGIC

Seizures	Y P N	Paralysis	Y P N
Muscle weakness	Y P N	Numbness or tingling	Y P N
Loss of memory	Y P N	Easily stressed	Y P N
Dizziness	Y P N	Loss of balance	Y P N

## SKIN

Rashes	Y P N	Eczema, Hives	Y P N
Acne, Boils	Y P N	Itching	Y P N
Color Change	Y P N	Unusual Hair Loss	Y P N
Lumps	Y P N	Night Sweats	Y P N

## HEAD

Headaches	Y P N	Head Injury	Y P N
Migraines	Y P N	Jaw/TMJ problems	Y P N

## EYES

Spots in Eyes	Y P N	Cataracts	Y P N
Impaired vision	Y P N	Glasses or contacts	Y P N
Blurriness	Y P N	Eye pain/strain	Y P N
Color blindness	Y P N	Tearing or dryness	Y P N
Double Vision	Y P N	Glaucoma	Y P N

## EARS

Impaired hearing	Y P N	Ringling	Y P N
Earaches	Y P N	Dizziness	Y P N

## NOSE AND SINUSES

Frequent colds	Y P N	Nose Bleeds	Y P N
Stuffiness	Y P N	Hayfever	Y P N
Sinus problems	Y P N	Loss of smell	Y P N

## MOUTH AND THROAT

Frequent sore throat	Y P N	Copious saliva	Y P N
Teeth grinding	Y P N	Sore tongue/lips	Y P N

Gum problems	Y P N	Hoarseness	Y P N
Dental cavities	Y P N	Jaw clicks	Y P N

NECK

Lumps	Y P N	Swollen glands	Y P N
Goiter	Y P N	Pain or stiffness	Y P N

RESPIRATORY

Cough	Y P N	Phlegm (flem)	Y P N
Spitting up blood	Y P N	Wheezing	Y P N
Asthma	Y P N	Bronchitis	Y P N
Pneumonia	Y P N	Pleurisy	Y P N
Emphysema	Y P N	Difficulty breathing	Y P N
Pain on breathing	Y P N	Shortness of breath	Y P N
Shortness of breath at night	Y P N	" " " lying down	Y P N
Tuberculosis	Y P N		

CARDIOVASCULAR

Heart disease	Y P N	Angina	Y P N
High/Low Blood Pressure	Y P N	Murmurs	Y P N
Blood clots	Y P N	Fainting	Y P N
Phlebitis	Y P N	Palpitations/Fluttering	Y P N
Rheumatic Fever	Y P N	Chest pain	Y P N
Swelling in ankles	Y P N		

GASTROINTESTINAL

Trouble swallowing	Y P N	Heartburn	Y P N
Change in thirst	Y P N	Change in appetite	Y P N
Nausea	Y P N	Vomiting (Illness or Induced)	Y P N
Vomiting blood	Y P N	Bowel Movements: How often _____	
Blood in stool	Y P N	Is this a change _____	
Pain or cramps	Y P N	Constipation	Y P N
Belching or passing gas	Y P N	Diarrhea	Y P N
Black stools	Y P N	Gall Bladder disease	Y P N
Yellowing skin or eyes	Y P N	Ulcer	Y P N
Liver Disease	Y P N	Hemorrhoids	Y P N

URINARY

Pain on urination	Y P N	Increased frequency	Y P N
Frequency at night	Y P N	Inability to hold urine	Y P N
Frequent infections	Y P N	Kidney stones	Y P N

MEN

Hernias	Y P N	Testicular masses	Y P N
Testicular pain	Y P N	Prostate issues	Y P N

Feminization/ hormonal issues	Y N	Discharge or sores	Y P N
Are you sexually active	Y N	Sexually transmitted illness	Y P N
Sexual orientation:	Het. Hom. Bis.	-If yes, which one(s):	_____
Impotence	Y P N	Premature ejaculation	Y P N

**WOMEN**

Age of first menses: _____		Birth control	Y P N
Age of last mense: _____		**What type: _____	
Sexual orientation: _____		Number of pregnancies: _____	
Are you sexually active	Y N	Number of live births: _____	
Length of cycle: _____ days		Number of miscarriages: _____	
Duration of menses: _____ days		Number of abortions: _____	
Painful menses	Y P N	Date of last pap: _____	
Heavy or excessive flow	Y P N	Ever had abnormal pap?	Y P N
PMS	Y P N	Breast lumps	Y P N
Are cycles regular	Y N	Do you do breast self exams	Y P N
Bleeding between cycles	Y P N	Breast pain/tenderness	Y P N
Pain during intercourse	Y P N	Nipple discharge	Y P N
Menopausal symptoms	Y P N	Sexually transmitted disease?	Y P N
Ovarian cysts	Y P N	-If yes, which one(s): _____	
Infertility	Y P N		
Cervical Dysplasia	Y P N		
Fibroids	Y P N		
Endometriosis	Y P N		

**MUSCULOSKELETAL**

Joint pain or stiffness	Y P N	Arthritis	Y P N
Broken bones	Y P N	Weakness	Y P N
Muscle spasms or cramps	Y P N	Sciatica	Y P N

**BLOOD/PERIPHERAL VASCULAR**

Easy bleeding or bruising	Y P N	Anemia	Y P N
Deep leg pain	Y P N	Cold hands/feet	Y P N
Varicose veins	Y P N	Thrombophlebitis	Y P N

Are there any cultural or religious practices we should be aware of when providing healthcare to you?

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

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Please fax or mail this intake form or bring it on your first visit::

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