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:_____

Please "star" ** the preferred # above 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❧

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.

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?

GENERAL

Weight: _____ lbs. Maximum Weight _____ lbs.
Weight 1 year ago: _____lbs. When: _____
Height _____
When is your energy the best? _____
When is it the worst? _____

FAMILY HISTORY

	Father	Mother	Brother	Sister	G'Parent	Spouse	Child
Age (if living)							
Health (G=good P=poor)							
Age at death (if deceased)							
Mark BELOW with a ✓							
Cancer							
Diabetes							
Heart Disease							
High Blood Pressure							
Stroke							
Epilepsy							
Mental Illness							
Asthma/Hayfever/Hives							
Anemia							
Kidney Disease							
Tuberculosis							
Alcoholism/Drug Addiction							
Cause of Death (if deceased)							

Any other important family health history? _____
_____

CHILDHOOD ILLNESSES

Scarlet fever	Y N	Diphtheria	Y N	Rheumatic fever	Y N
Mumps	Y N	Measles	Y N	German measles	Y N

Other disease _____

HOSPITIALIZATION AND SURGERIES

What hospitalizations or surgeries have you had? Please include **year**:
_____
_____

XRAYS AND SPECIAL STUDIES

X-rays, CAT scans, MRI, Echocardiogram (heart), EKGs, or ECGs or other studies you have had:
_____Year_____

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

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?

_____

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

_____

_____

*Please fax or mail this intake form **prior to your visit if possible**:*

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