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: cell: _____ work/home:_____

Please "star" ** the preferred # above for appointment reminders and other messages – no health information will be disclosed.

SS #: _____ Driver's license #: _____ Birth date: _____

Age: _____ Gender: (circle one): M F Non-Binary # of children you have: _____

Occupation: _____ Hours per week: _____

Employer: _____ Employer address: _____

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Marital status: ____ Single ____ Married ____ Partnership ____ Separated ____ Divorced

With whom do you live: ____ Spouse ____ Partner ____ Parents ____ Friends ____ Children ____ Alone

Spouse/Parent name: _____ Spouse/Parent birth date: _____

Spouse/Parent phone: _____Spouse/Parent address: _____

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**Emergency contact:** _____

**Relationship:** _____ **Telephone number:** _____

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**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, I am interested in a periodic newsletter

☐ Yes, I am interested in an invitation to our online natural pharmacy

Email : _____

**your email is never used for unauthorized marketing purposes and protected for your privacy

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)_____

☐ My symptoms have never been the same since_____(optional)

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 | Sibling | Sibling | G'Parent | G'Parent | Child |
|---|---|---|---|---|---|---|---|
| **Age (if living)** | | | | | | | |
| **Health ( G=good P=poor )** | | | | | | | |
| **Age at death (if deceased)** | | | | | | | |
| **Mark BELOW with a ✓** | | | | | | | |
| **Cancer (include type below)** | | | | | | | |
| **Diabetes** | | | | | | | |
| **Heart Disease** | | | | | | | |
| **High Blood Pressure** | | | | | | | |
| **Stroke** | | | | | | | |
| **Eating Disorder (include type below)** | | | | | | | |
| **Mental Illness (include type below)** | | | | | | | |
| **Asthma/Hayfever/Hives** | | | | | | | |
| **Anemia** | | | | | | | |
| **Kidney Disease** | | | | | | | |
| **Alcoholism/Drug Addiction** | | | | | | | |
| **Cause of Death (if deceased)** | | | | | | | |
| **Other** | | | | | | | |

Any other important family health history? _____
_____

## CHILDHOOD Health

| | | | | | |
|---|---|---|---|---|---|
| Chronic infections | Y N | Chicken pox | Y N | Mononucleosis | Y N |
| Ear infections | Y N | Strep throat | Y N | Pneumonia | Y N |

Antibiotic use as child: frequent / infrequent

Other childhood disease or recurring health condition:

_____

## 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_____

_____Year_____

## ALLERGIES

Are you hypersensitive or allergic to:

Any medications: _____

Any foods: _____

Other: _____

Describe reaction (if applicable):_____

## 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 |
| Anxiety medicines | 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 Hours per day_____ Per week_____

Screen usage: TV: _____ hours/day Smartphone/Tablet: _____ hrs/day

**go to the ***Settings*** feature on your device and choose *Screen Time* usage to find averages

How many **hours of sleep** do you get each night? _____

Bedtime: _____ Wake time:_____ Sleep schedule: Erratic / Routine

| | | | | | |
|---|---|---|---|---|---|
| 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 Yes(Y) No(N) Past(P)

### *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 |

### *GENERAL*

| | | | |
|---|---|---|---|
| Vaccinations up to date | Y P N | Reactions to vaccinations | Y P N |
| Chronic fatigue | 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 | History of 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 | Allergies | Y P N |
| Sinus problems | Y P N | Loss of smell | Y P N |

## ***MOUTH, NECK 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 |
| Lumps | Y P N | Swollen glands | Y P N |
| Goiter (Neck swelling) | 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 | Shortness of breath 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 |
| Bloating | Y P N | Gall Bladder disease | Y P N |
| Black stools | 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 |
| Frequent urination at night | Y P N | Inability to hold urine | Y P N |
| Frequent urinary infections | Y P N | Kidney stones | Y P N |

## ***MENS HEALTH***

| | | | |
|---|---|---|---|
| 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 |

## ***WOMENS HEALTH***

| | | | |
|---|---|---|---|
| Age of first menses: _____ | | | |
| Age of last mense: _____ | | Current 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, mail, or drop off this intake form **prior to your visit:**

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