Welcome!

*Our intake forms are quite extensive. Be prepared to answer a lot of questions! Naturopathic doctors like to get to know the **whole** person and the entire picture of health before initiating treatment. This is a **confidential** record of your medical history and will be kept in this office. Information contained here will not be released without your consent.*

Full name:

Birthdate:

Address:

Home phone number:

Cell phone number:

Email address:

Emergency contact's name and relationship to you:

Emergency contact's phone number:

Family doctor's name:

Insurance Provider: Policy #: ID #:

Main Health Concerns

List your main heath concerns (or reasons for visiting the clinic) in order of importance

1.	
2.	
3.	
4.	
5.	

Past Medical Conditions

Condition	Symptoms	Year of Diagnosis	Diagnosed by whom?	Still present today?

Allergies and Sensitivities

Substance that causes the reaction	Allergy or a sensitivity?	Symptoms you experience during a flare up?

Current Medications/Supplements

Please list all CURRENT medications/supplements that you are taking

Medication or Supplement Name	Prescribing physician (if applicable)	Condition or symptoms it is treating	Dosage	How long?	Brand (if applicable)

Medical History

Please circle any condition(s) you currently have or have previously experienced

Acne	Anemia	Angina or heart attack	Appendicitis	Arthritis	Asthma	Bleeding disorder	Cancer
Cervical dysplasia	Chicken pox	Chlamydia	Chronic bronchitis	Crohn's	Diabetes	Ectopic pregnancy	Eczema
Emphysema	Endo-metriosis	Enlarged prostate	Epilepsy	Gallstones	Glaucoma	Gonorrhea	Gout
Head injury	Headaches /migraines	Heart disease	Hemorrhoids	Hepatitis	High blood pressure	High cholesterol	HIV
Hives disease	HPV	Kidney disease	Kidney stones	Lupus	Measles	Memory loss	Meningitis
Mental illness	Miscarriage	Mono-nucleosis	Multiple sclerosis	Nasal polyps	Nerve damage	Osteo-porosis	Parasites
Pelvic inflammatory disease	Pneumonia	Polycystic ovaries	Psoriasis	Rheumatic fever	Rubella	Sexual abuse	Sickle cell anemia
Strep throat	Stroke	Thalassemia	Tuberculosis	Ulcerative Colitis	Varicose veins	Other: _____	Other: _____

Final Questions

Is there anything else you'd like the doctor to know about your health that you weren't able to express or include already in this intake form?

How did you hear about Dr. Amy Florian, ND and/or this clinic?

Did someone refer you? If so, who can we thank?

Thank you for taking the time to complete this intake form! ☺