Naturopathic Patient Intake

Hawthorn
NATUROPATHY • ACUPUNCTURE • MASSAGE THERAPY

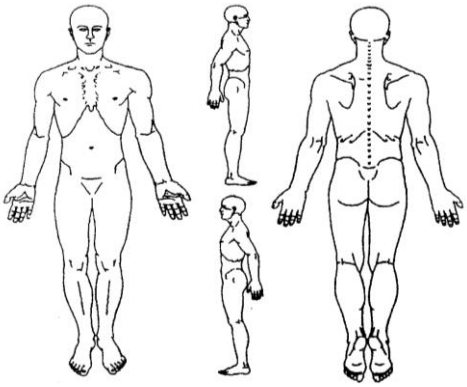
Patient Name: _____ Date: _____
Age: _____ Date of Birth: _____ Sex: M F
Address: _____ Phone: (H)_____
_____ (W)_____
_____ (C)_____
E-mail: _____ Occupation: _____
Marital Status: _____ Children: ___ M.D.: _____
Referred by: _____

Insurance Co.: _____ Policy#: _____ ID#: _____

Chief health concerns, in order of importance to you:

1. _____
2. _____
3. _____
4. _____

Please mark any problem area(s)



Are you taking any pharmaceutical medications? (Please list)

_____
_____
_____

Are you currently taking any natural remedies? (Please list)

_____
_____

Do you have any allergies (known or suspected)?

_____
_____

Please list any serious health conditions, illnesses or injuries and any hospitalizations along with the year it occurred:

_____ _____
_____ _____

Do you:
Drink Alcohol: Y / N
Exercise regularly: Y / N
Smoke tobacco or use recreational drugs: Y / N
Drink coffee, tea, or caffeinated beverages: Y / N
Use OTC medication regularly (such as aspirin, antacids or laxatives): Y / N
Have regular screening tests (Pap, blood tests, prostate exam, etc.): Y / N

Indicate if you or a close relative (parent, sibling, aunt, uncle) has had any of the following:

	Relation?		Relation?
Allergies		Thyroid problems	
Diabetes		Depression	
Arthritis		Drug/Alcohol abuse	
Heart disease		Auto-immune disease	
High BP/cholesterol		Cancer	