NDSource.com
1736 Ariana Dr
Bartlett, Illinois, US - 60103

New Patient Adult Intake_copy

Health History

How did you hear about us (please be specific)?

Reason for office visit:

Context of Care Review

Successful heath care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your, time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from our clinic?

What long term expectations do you have from working with our clinic?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0-5, 5 being very committed.

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

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

What do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

How often do you do these things?

Current Living Situation

Highest Education Level: _____

Occupational status: _____

Marital status: _____

Name of spouse: _____

Years married: _____

Spouse's age: _____

Spouse's occupation: _____

Spouse's education level: _____

Spouse's present health: _____

Total number of children: _____

Names and ages of children:

Names of children and relationship (None, Distant, Conflicted, Warm or Very Close)

Please list names and ages of all persons currently residing in your home:

Prior marriage(s)? ☐ Yes ☐ No

If yes, provide date and length of marriage(s):

Spouse's prior marriage(s)? ☐ Yes ☐ No

If yes, provide date and length of marriage(s):

Are there currently any significant marital stressors? ☐ Yes ☐ No

If yes, briefly explain:

Have you served in the military? ☐ Yes ☐ No

If yes, specify what branch and when?

Have you ever been accused or convicted of any crime? ☐ Yes ☐ No

If yes, please explain in detail the nature of the crime or accusation:

Childhood/Family History

Where were you born?

Was your birth: ☐ Normal ☐ Premature ☐ Long Labor ☐ Complications

Did you begin walking and talking: ☐ On time ☐ Early ☐ Late ☐ Do no know

List any traumatic event(s) or abusive situation(s) that occurred during your child:

List any significant accidents, illnesses, or injuries that occurred during your childhood:

How would you characterize your family life growing up?

Were you adopted? ☐ Yes ☐ No

If yes, at what age?

Father

If living: age and health:

If deceased: age, year, and cause of death:

Occupation:

Relationship: ☐ Distant ☐ Conflicted ☐ Warm ☐ Very Close

Mother

If living: age and health:

If deceased: age, year, and cause of death:

Occupation:

Relationship: ☐ Distant ☐ Conflicted ☐ Warm ☐ Very Close

Parents' marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Names of brother(s)/sister(s), ages and relationship (None, Distant, Conflicted, Warm or Very Close):

What is your family heritage?

Personal HIstory

Please list your strengths:

Are you currently receiving healthcare? ☐ Yes ☐ No

If yes, where and from whom?

If no, when and where did you last receive healthcare?

Do you have any known contagious diseases at this time? ☐ Yes ☐ No

If yes, what?

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

When did you first notice your problems?

What things did you first notice?

Was the onset of your problem sudden or gradual? ☐ Sudden ☐ Gradual

Has this problem affected other areas of your life? ☐ Yes ☐ No

Have you been treated for this problem before? ☐ Yes ☐ No

Was there any event or action that you or others think that might have contributed to your symptoms (be as detailed as possible)?

List any accidents, illnesses injuries, hospitalizations/surgeries or imaging (X-ray, CAT scan, MRI etc):

General

Height: _____

Weight: _____

Weight one year ago: _____

Maximum Weight: _____

When: _____

When during the day is your energy the best? _____

Worst?

Main interests and hobbies:

Watch T.V.? ☐ Yes ☐ No

If yes, how many hours?

Read? ☐ Yes ☐ No

If yes, what and how often?

Do you use any illegal drugs including marijuana? ☐ Yes ☐ No

If yes, what and how often?

Have you ever been in treatment for alcohol or drug use? ☐ Yes ☐ No

If yes, please explain:

Do you use tobacco? ☐ Yes ☐ No

If yes, how much?

Do you drink alcohol? ☐ Yes ☐ No

If yes, please specify: ☐ Rarely ☐ Occasionally ☐ Daily ☐ Past

How many drinks do you usually have? _____

Current Medications and Supplements

Are you hypersensitive or allergic to:

Any drugs/medications?

Any foods:

Any environmental chemicals?

List all medications (from drugstore or prescription) you are taking and dosages if known:

List all supplements are taking and dosages if known:

Nutrition

Please list what you eat during a typical day and at what time:

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Do you use caffeine products (soda, coffee, tea, etc)? ☐ Yes ☐ No

If yes, how much? _____

What foods/drinks do you regularly crave?

Do you cook for yourself/your family? ☐ Yes ☐ No

How many meals per day do you usually eat?

How many snacks do you have in a day? Please list.

Adult Mental Health

Have you received previous counseling? ☐ Yes ☐ No

Please specify: ☐ Psychiatrist ☐ Psychologist ☐ School Counselor ☐ Clergy

If yes, when and why?

Was it helpful?

If yes:

Have you ever been admitted to a psychiatric hospital? ☐ Yes ☐ No

If yes, when and where?

Have you ever had thoughts of, planned, or attempted suicide? ☐ Yes ☐ No

If yes, please explain:

Are you currently having any thoughts of harming yourself? ☐ Yes ☐ No

Are you currently having any thoughts of harming someone else? ☐ Yes ☐ No

Have you ever taken psychiatric medications? ☐ Yes ☐ No

If yes, please list (include problem, medication, dose, start/stop date, side effects and response):

Spiritual Orientation

Please list your spiritual orientation or religion:

How active are these beliefs in your life? ☐ Very active ☐ Somewhat active ☐ Not very active

If you like, share some of your thoughts on your spiritual practice/religion:

How much do your beliefs help you when times are difficult?

Environmental Exposures

Have you ever lived near a refinery, polluted area or in a home with leaded paint? ☐ Yes ☐ No

If yes, what sort of pollution where you exposed to?

Have you ever lived in a house that had new carpeting, paint, cabinets, or any other refurbishing that seemed to affect your health?

Do you seem particularly sensitive to ro perfumes, gasoline or other vapors?

Do you spray pesticides, herbicides or other chemicals around your home? ☐ Yes ☐ No

What year was your home/apartment built? _____

Do you have vinyl blinds, and if so, what year were they put in? _____

Water: ☐ City ☐ Well

H20 Purification System: ☐ Yes ☐ No

Air Purifiers: ☐ Yes ☐ No

Type of Heat: ☐ Gas ☐ Electric

If other, please describe:

Do you live near any bodies of water?	☐ Swamp	☐ River	☐ Ocean
	☐ None		
If other, please describe:			
Do you live near any of the following:	☐ High Voltage Power Lines	☐ Refinery	☐ Woods
		☐ Industrial area	
Describe your bedroom (curtains, blinds, carpet, feather pillows, etc)			
Flooring in other rooms you spend time in:			

Other

Please list any other concerns or comments:	

Health History

For the following section, please read the question and select from the following responses: Yes, No, or In Past. If No, move on to the next question. If Yes or In past, please specify the severity in the "Others" box, choosing from the following: Mild, Moderate, or Severe.

Endocrine

Do you sleep well?	☐ Yes	☐ No	☐ In Past
Average 6-8 hours?	☐ Yes	☐ No	☐ In Past
Awake rested?	☐ Yes	☐ No	☐ In Past
Cannot stay asleep?	☐ Yes	☐ No	☐ In Past
Cannot fall asleep?	☐ Yes	☐ No	☐ In Past
Insomnia?	☐ Yes	☐ No	☐ In Past
Afternoon Fatigue?	☐ Yes	☐ No	☐ In Past
Wake up tired even after 6 or more hours of sleep?	☐ Yes	☐ No	☐ In Past
Tired or sluggish?	☐ Yes	☐ No	☐ In Past
Dizziness when standing up quickly?	☐ Yes	☐ No	☐ In Past
Hyperthyroid/Hypothyroid?	☐ Yes	☐ No	☐ In Past

Hypoglycemia (low blood sugar)?	☐ Yes	☐ No	☐ In Past
Difficulty losing weight?	☐ Yes	☐ No	☐ In Past
Gain weight easily?	☐ Yes	☐ No	☐ In Past
Feel cold - hands, feet, all over?	☐ Yes	☐ No	☐ In Past
Thinning of hair on scalp, face, or genitals or excessive falling hair?	☐ Yes	☐ No	☐ In Past
Under high amounts of stress?	☐ Yes	☐ No	☐ In Past

Neurologic

Seizures?	☐ Yes	☐ No	☐ In Past
Muscle weakness?	☐ Yes	☐ No	☐ In Past
Loss of memory	☐ Yes	☐ No	☐ In Past
Vertigo or dizziness?	☐ Yes	☐ No	☐ In Past
Paralysis?	☐ Yes	☐ No	☐ In Past
Numbness or Tingling?	☐ Yes	☐ No	☐ In Past
Easily Stressed?	☐ Yes	☐ No	☐ In Past
Loss of balance?	☐ Yes	☐ No	☐ In Past

Neck

Pain or stiffness in neck?	☐ Yes	☐ No	☐ In Past
Difficulty swallowing?	☐ Yes	☐ No	☐ In Past
Lumps in neck?	☐ Yes	☐ No	☐ In Past
Goiter?	☐ Yes	☐ No	☐ In Past

Immune

Reactions to immunizations?	☐ Yes	☐ No	☐ In Past
Chronically swollen glands?	☐ Yes	☐ No	☐ In Past
Slow would healing?	☐ Yes	☐ No	☐ In Past
Chronic fatigue syndrome?	☐ Yes	☐ No	☐ In Past

Chronic infections?	☐ Yes	☐ No	☐ In Past
Night sweats?	☐ Yes	☐ No	☐ In Past

Ears

Ringing in ears?	☐ Yes	☐ No	☐ In Past
Ear aches?	☐ Yes	☐ No	☐ In Past
Impaired hearing?	☐ Yes	☐ No	☐ In Past

Eyes

Impaired vision?	☐ Yes	☐ No	☐ In Past
Cataracts?	☐ Yes	☐ No	☐ In Past
Glaucoma?	☐ Yes	☐ No	☐ In Past
Tearing or dryness?	☐ Yes	☐ No	☐ In Past
Spots in vision?	☐ Yes	☐ No	☐ In Past
Color blindness?	☐ Yes	☐ No	☐ In Past
Eye pain or strain?	☐ Yes	☐ No	☐ In Past

Head?

Headaches?	☐ Yes	☐ No	☐ In Past
Migraines?	☐ Yes	☐ No	☐ In Past
Head injury?	☐ Yes	☐ No	☐ In Past
Jaw or TMJ problems?	☐ Yes	☐ No	☐ In Past

Nose and Sinus

Stuffiness?	☐ Yes	☐ No	☐ In Past
Sinus problems?	☐ Yes	☐ No	☐ In Past
Nose bleeds?	☐ Yes	☐ No	☐ In Past
Nasal polyps?	☐ Yes	☐ No	☐ In Past
Hay fever?	☐ Yes	☐ No	☐ In Past
Loss of smell?	☐ Yes	☐ No	☐ In Past

Mouth and Throat

Teeth grinding?	☐ Yes	☐ No	☐ In Past
Gum problems?	☐ Yes	☐ No	☐ In Past
Jaw clicks?	☐ Yes	☐ No	☐ In Past
Frequent sore throat?	☐ Yes	☐ No	☐ In Past
Copious saliva?	☐ Yes	☐ No	☐ In Past
Sore tongue or lips?	☐ Yes	☐ No	☐ In Past
Hoarseness?	☐ Yes	☐ No	☐ In Past

Skin

Eczema or hives?	☐ Yes	☐ No	☐ In Past
Dryness of skin or scalp?	☐ Yes	☐ No	☐ In Past
Dry or flaky skin and/or scalp?	☐ Yes	☐ No	☐ In Past
Itching?	☐ Yes	☐ No	☐ In Past
Rashes?	☐ Yes	☐ No	☐ In Past
Acne/boils?	☐ Yes	☐ No	☐ In Past
Change in skin color?	☐ Yes	☐ No	☐ In Past
Lumps or bumps on skin?	☐ Yes	☐ No	☐ In Past
Perpetual hair loss?	☐ Yes	☐ No	☐ In Past
Weak nails?	☐ Yes	☐ No	☐ In Past

Respiratory/Cardiac

Shortness of breath?	☐ Yes	☐ No	☐ In Past
Pain in breathing?	☐ Yes	☐ No	☐ In Past
Cough?	☐ Yes	☐ No	☐ In Past
Coughing up blood?	☐ Yes	☐ No	☐ In Past
Asthma?	☐ Yes	☐ No	☐ In Past
Wheezing?	☐ Yes	☐ No	☐ In Past

Bronchitis?	☐ Yes	☐ No	☐ In Past
Emphysema?	☐ Yes	☐ No	☐ In Past
Shortness of breath when lying down?	☐ Yes	☐ No	☐ In Past
Hearth palpitations?	☐ Yes	☐ No	☐ In Past
Inward trembling?	☐ Yes	☐ No	☐ In Past

Musculoskeletal

Muscle spasms or cramps?	☐ Yes	☐ No	☐ In Past
Joint pain or stiffness?	☐ Yes	☐ No	☐ In Past
Arthritis?	☐ Yes	☐ No	☐ In Past
Sciatica?	☐ Yes	☐ No	☐ In Past
Weakness?	☐ Yes	☐ No	☐ In Past
Broken bones?	☐ Yes	☐ No	☐ In Past

Blood

Varicose veins?	☐ Yes	☐ No	☐ In Past
Anemia?	☐ Yes	☐ No	☐ In Past
Easy bleeding or bruising?	☐ Yes	☐ No	☐ In Past
Cold hands/feet?	☐ Yes	☐ No	☐ In Past

Gastrointestinal

Crave sweets during the day?	☐ Yes	☐ No	☐ In Past
Irritable if meals are missed?	☐ Yes	☐ No	☐ In Past
Depend on coffee to keep yourself going or started?	☐ Yes	☐ No	☐ In Past
Get lightheaded if meals are missed?	☐ Yes	☐ No	☐ In Past
Eating relieves fatigue?	☐ Yes	☐ No	☐ In Past
Change in thirst?	☐ Yes	☐ No	☐ In Past
Change in appetite?	☐ Yes	☐ No	☐ In Past

Greasy or high fat foods cause distress?	☐ Yes	☐ No	☐ In Past
Indigestion and fullness lasts 2-4 hours after eating?	☐ Yes	☐ No	☐ In Past
Heartburn?	☐ Yes	☐ No	☐ In Past
Abdominal pain or cramps?	☐ Yes	☐ No	☐ In Past
Excessive belching, burping, or bloating?	☐ Yes	☐ No	☐ In Past
Gas immediately following meals?	☐ Yes	☐ No	☐ In Past
Use antacids?	☐ Yes	☐ No	☐ In Past
Offensive breath?	☐ Yes	☐ No	☐ In Past
Nausea/vomiting?	☐ Yes	☐ No	☐ In Past
Ulcer?	☐ Yes	☐ No	☐ In Past
Gallbladder disease?	☐ Yes	☐ No	☐ In Past
History of gallbladder attacks or stones?	☐ Yes	☐ No	☐ In Past
Have you ever had your gallbladder removed?	☐ Yes ☐ No		
Liver disease?	☐ Yes	☐ No	☐ In Past
Hemorrhoids?	☐ Yes	☐ No	☐ In Past
Pancreatitis?	☐ Yes	☐ No	☐ In Past
Difficulty digesting fruits and vegetables; undigested foods found in stools?	☐ Yes	☐ No	☐ In Past
Feeling that bowels do not empty completely?	☐ Yes	☐ No	☐ In Past
Diarrhea?	☐ Yes	☐ No	☐ In Past
Constipation?	☐ Yes	☐ No	☐ In Past
Alternating diarrhea and constipation?	☐ Yes	☐ No	☐ In Past

Hard, dry, or small stool? Describe stool, check all that apply:	☐ Log like	☐ Pencil/ribbon like	☐ Sandy/not formed
	☐ Mushy/pudding like	☐ Watery	☐ Floats
		☐ Sinks	☐ Mucous in stool
	☐ Gas bubbles	☐ Gassy	☐ Food in stools
	☐ Foul smelling	☐ Stuck feeling	☐ Incomplete feeling
	☐ Frequent stools	☐ Urgency	
Black stools?	☐ Yes	☐ No	☐ In Past
Blood in stools?	☐ Yes	☐ No	☐ In Past
Use laxatives frequently?	☐ Yes	☐ No	☐ In Past
Bowel movements: How often?	_____		
Is this a change?	☐ Yes ☐ No		

Mental/Emotional

Treated for memory problems?	☐ Yes	☐ No	☐ In Past
History of abuse?	☐ Yes	☐ No	☐ In Past
Tension?	☐ Yes	☐ No	☐ In Past
Depression?	☐ Yes	☐ No	☐ In Past
Anxiety or nervousness?	☐ Yes	☐ No	☐ In Past
Poor concentration?	☐ Yes	☐ No	☐ In Past
Mood swings?	☐ Yes	☐ No	☐ In Past
Considered suicided?	☐ Yes	☐ No	☐ In Past
Attempted suicide?	☐ Yes	☐ No	☐ In Past
Treated for drug dependence?	☐ Yes	☐ No	☐ In Past
Behavioral issues?	☐ Yes	☐ No	☐ In Past
Sexuality issues?	☐ Yes	☐ No	☐ In Past
Self esteem/ growth issues?	☐ Yes	☐ No	☐ In Past
Mental sluggishness?	☐ Yes	☐ No	☐ In Past

Urinary

Increased frequency of urination?	☐ Yes	☐ No	☐ In Past

Inability to hold urine?	☐ Yes	☐ No	☐ In Past
Pain in urination?	☐ Yes	☐ No	☐ In Past
Frequency at night?	☐ Yes	☐ No	☐ In Past
Frequent UTI's?	☐ Yes	☐ No	☐ In Past
Kidney stones?	☐ Yes	☐ No	☐ In Past

Female Reproductive

Age of first menses? _____

Age of last menses? (if menopausal) _____

Length of cycle (in days) _____

Duration of menses (in days) _____

Are your cycles regular?	☐ Yes	☐ No	☐ In Past
Bleeding between cycles?	☐ Yes	☐ No	☐ In Past
Clotting?	☐ Yes	☐ No	☐ In Past
Scanty blood flow?	☐ Yes	☐ No	☐ In Past
Heavy blood flow?	☐ Yes	☐ No	☐ In Past
Pain and cramping during periods?	☐ Yes	☐ No	☐ In Past
Pelvic pain during menses?	☐ Yes	☐ No	☐ In Past
Irritable and depressed during menses?	☐ Yes	☐ No	☐ In Past
Acne breakouts?	☐ Yes	☐ No	☐ In Past
Facial hair growth?	☐ Yes	☐ No	☐ In Past
Hair loss/ thinning?	☐ Yes	☐ No	☐ In Past
Endometriosis?	☐ Yes	☐ No	☐ In Past
Ovarian cysts?	☐ Yes	☐ No	☐ In Past
Vaginal odor?	☐ Yes	☐ No	☐ In Past
Vaginal discharge?	☐ Yes	☐ No	☐ In Past

Date of last PAP? _____

Abnormal PAP?	☐ Yes	☐ No	☐ In Past
Are you sexually active?	☐ Yes	☐ No	☐ In Past
Sexual orientation?			
Increased sex drive?	☐ Yes	☐ No	☐ In Past
Diminished sex drive?	☐ Yes	☐ No	☐ In Past
Birth control? (if yes or in past, please specify in "other")	☐ Yes	☐ No	☐ In Past
Gonorrhea/Chlamydia?	☐ Yes	☐ No	☐ In Past
Herpes?	☐ Yes	☐ No	☐ In Past
Genital Warts?	☐ Yes	☐ No	☐ In Past
Syphilis?	☐ Yes	☐ No	☐ In Past
Difficulty conceiving?	☐ Yes	☐ No	☐ In Past
Number of pregnancies?			
Number of live births?			
Number of miscarriages?			
Number of abortions?			
Do you do self breast exams?	☐ Yes	☐ No	☐ In Past
Breast pain/tenderness?	☐ Yes	☐ No	☐ In Past
Breast lumps?	☐ Yes	☐ No	☐ In Past
Nipple discharge?	☐ Yes	☐ No	☐ In Past
Menopausal symptoms?	☐ Yes	☐ No	☐ In Past
Other symptoms?			

Male Reproductive

Are you sexually active?	☐ Yes	☐ No	☐ In Past
Sexual orientation?			
Increased sex drive?	☐ Yes	☐ No	☐ In Past

Diminished sex drive?	☐ Yes	☐ No	☐ In Past
Decrease in libido?	☐ Yes	☐ No	☐ In Past
Decrease in spontaneous morning erections?	☐ Yes	☐ No	☐ In Past
Decrease in fullness of erections?	☐ Yes	☐ No	☐ In Past
Premature ejaculation?	☐ Yes	☐ No	☐ In Past
Genital Warts?	☐ Yes	☐ No	☐ In Past
Chlamydia/Gonorrhea?	☐ Yes	☐ No	☐ In Past
Herpes?	☐ Yes	☐ No	☐ In Past
Impotence?	☐ Yes	☐ No	☐ In Past
Discharge or sores?	☐ Yes	☐ No	☐ In Past
Testicular masses?	☐ Yes	☐ No	☐ In Past
Testicular pain?	☐ Yes	☐ No	☐ In Past
Prostate disease?	☐ Yes	☐ No	☐ In Past
Hernias?	☐ Yes	☐ No	☐ In Past

Diet Survey

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages to you consume per week? _____

How many times do you eat out per week? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____

How many times a week do you work out? _____

List the three worst foods you eat during the average week:

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List the three healthiest foods you eat during the average week:

Do you smoke?(if yes or inpast, specify how many times a day)

☐ Yes ☐ No ☐ In Past

Rate your stress level on a scale of 1-10 during the average week:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please list any medications you are currently taking and for what conditions:

Please list any natural supplements you are currently taking and for what conditions: