Patient Intake Form
Seattle Nature Cure Clinic

Patient Name:_____ DOB:_____

Healthcare Team

Present PCP (Name, Credentials, Phone):

_____

Other healthcare practitioners:

_____

Last physical exam: Date_____ Doctor_____
Last blood work: Date_____ Doctor_____

Present Health Concerns

What is the main reason for your visit today? Please describe in detail, including date of onset and any factors that may have contributed to its onset or continuation.

_____
_____
_____

Is this concern getting (circle one): BETTER WORSE SAME

List types of treatments (including home care) and who treated you for this condition:

_____
_____
_____

List other health concerns and dates of onset in order of importance:

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Past Medical History

General childhood health (circle one): GOOD FAIR POOR

Childhood Illnesses:

❑ Scarlet Fever ❑ Rheumatic Fever ❑ German measles ❑ Chicken pox
❑ Whooping cough ❑ Diphtheria ❑ Asthma ❑ Mumps
❑ Mono ❑ Other_____

Hospitalizations and Surgeries (Type, Year):

_____
_____

Serious Illnesses and Injuries (Type, Cause, Year):

_____
_____

Medications (Prescription, non-prescription and supplements, including dosages):

1._____ 2._____
3._____ 4._____
5._____ 6._____

Known Allergies:

Drugs_____ Foods_____
Animals_____ Other_____

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Past Medical History, Cont.

Current	*Past*		*Current*	*Past*	
❑	❑	Allergies	❑	❑	Stroke
❑	❑	Arthritis	❑	❑	Ulcers
❑	❑	Gout	❑	❑	Herpes
❑	❑	Alcoholism	❑	❑	Candida
❑	❑	Bleeding disorder	❑	❑	Rheumatism
❑	❑	Cancer	❑	❑	Hypoglycemia
❑	❑	Heart murmur	❑	❑	Sinus problems
❑	❑	Asthma	❑	❑	High blood pressure
❑	❑	Kidney disease	❑	❑	Pneumonia
❑	❑	Liver disease	❑	❑	Thyroid problems
❑	❑	Diabetes	❑	❑	Tonsillitis
❑	❑	Anemia	❑	❑	HIV/AIDS
❑	❑	Hepatitis	❑	❑	Tuberculosis
❑	❑	Eczema	❑	❑	Venereal disease

Family Health History

❑ Heart disease	❑ Cancer	❑ Diabetes	❑ Stroke
❑ Bleeding disorder	❑ Seizures	❑ Allergies	❑ Sickle Cell Anemia
❑ Asthma	❑ Osteoporosis	❑ High Blood Pressure	❑ Congenital Heart Defects

Lifestyle and Habits

Rank each on a scale of 1 to 10 (10 being optimal):

___Energy	___Nutrition	___Digestion
___Sleep	___Exercise	___Weight
___Work	___Family	___Well-being

How many hours a day of…

Sleep____ Relaxation ____ *What form?* _____

Work____ Exercise____ *What form?* _____

Do you smoke? ❑ Yes ❑ No

Have you ever smoked? ❑ Yes ❑ No

If yes, for how long? _____ *How much per day?* _____

Do you use recreational or illicit drugs? ❑ Yes ❑ No

If yes, what type? _____

How much coffee, tea or cola do you drink a day? _____ a week? _____

How much alcohol do you drink a day? _____ a week? _____

Nutrition

Number of meals per day: _____

Foods restricted from diet, and for how long:

_____

_____

Describe any bad reactions you get from food:

_____

_____

Do you crave sugar? ❑ Yes ❑ No Starches? ❑ Yes ❑ No

Chocolate? ❑ Yes ❑ No Salt? ❑ Yes ❑ No

Fat? ❑ Yes ❑ No Other? _____

How much water do you drink per day? _____ Is it filtered? ❑ Yes ❑ No

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Review of systems

Please indicate symptoms that you have experienced in the last six months, or that have recurred throughout your life.

General
- ❑Weight change
- ❑Fever/chills
- ❑Weakness
- ❑Fatigue
- ❑Sweating/night sweats
- ❑Fainting
- ❑Dizziness
- ❑Forgetfulness
- ❑Hair/nail changes

Skin
- ❑Itching
- ❑Rashes
- ❑Bruise easily
- ❑Hives
- ❑Athlete's foot
- ❑Eczema/psoriasis
- ❑Change in moles
- ❑Sores that won't heal

Muscle/Joint/Bone
- ❑Pain
- ❑Numbness
- ❑Swelling
- ❑Bursitis/tendonitis
- ❑Broken bones
- ❑Sprains/strains
- ❑Spasms/cramps
- ❑Headaches/head injuries
- ❑Low back, hip, leg pain
- ❑Neck, shoulder, arm pain
- ❑Jaw pain/TMJ
- ❑Arthritis

Eyes
- ❑Glasses/contacts
- ❑Blurring
- ❑Pain
- ❑Double vision
- ❑Discharge
- ❑Floaters
- ❑Glaucoma
- ❑Cataracts

Ears
- ❑Ringing
- ❑Earache/discharge
- ❑Loss of hearing

Nose
- ❑Sinusitis
- ❑Bleeding
- ❑Discharge
- ❑Obstruction
- ❑Postnasal drip
- ❑Nasal polyps

Mouth/Throat
- ❑Sores
- ❑Bleeding gums
- ❑Teeth
- ❑Hoarseness
- ❑Difficulty swallowing
- ❑Taste

Pulmonary
- ❑Shortness of breath
- ❑Wheezing
- ❑Chronic cough
- ❑Coughing blood
- ❑Sputum

Cardiovascular
- ❑High blood pressure
- ❑Low blood pressure
- ❑Irregular heartbeat
- ❑Murmurs
- ❑Calf pain with walking
- ❑Edema
- ❑Palpitations
- ❑Chest pain
- ❑Varicose veins

Gastrointestinal
- ❑Poor appetite
- ❑Constipation/diarrhea
- ❑Indigestion/heartburn
- ❑Gas/bloating
- ❑Bowel changes
- ❑Excessive hunger
- ❑Excessive thirst
- ❑Nausea/vomiting
- ❑Hemorrhoids
- ❑Blood in stool
- ❑Hernia
- ❑Anal discomfort

Genitourinary
- ❑Low back pain
- ❑Painful urination
- ❑Blood in urine
- ❑Frequent/urgent urination
- ❑Loss of bladder control
- ❑Nighttime urination
- ❑Recurrent infections

Male Only
- ❑Breast lumps
- ❑Erection difficulties
- ❑Lump/pain in testicles
- ❑Penis discharge
- ❑Sores on penis
- ❑Infertility

Sexual History
- ❑Syphilis
- ❑Gonorrhea
- ❑Chlamydia
- ❑Sores/discharge
- ❑Herpes
- ❑Sexual/physical abuse

Female Only
- ❑Breast lumps
- ❑Nipple discharge
- ❑Bleeding after menopause
- ❑Hot flashes
- ❑Painful intercourse
- ❑Hysterectomy
- ❑Infertility
- ❑Fibroids
- ❑Vaginal infections
- ❑Abnormal PAP smears
- ❑LMP_____

Endocrine
- ❑Goiter
- ❑Heat/cold intolerance
- ❑Excessive thirst/hunger
- ❑Hormone therapy

Allergic
- ❑Drug/Vaccination allergy
- ❑Asthma
- ❑Eczema
- ❑Rhinitis
- ❑Hay fever
- ❑Hives
- ❑Post-nasal drip
- ❑Itchy/watery nose/eyes

Blood/Lymph
- ❑Anemia
- ❑Transfusions
- ❑Bleeding tendency
- ❑Lymph node enlargement
- ❑Lymph node pain

Neurological
- ❑Fainting
- ❑Convulsions
- ❑Sensations
- ❑Gait/coordination
- ❑Speech
- ❑Numbness/tingling
- ❑Paralysis/weakness

Psychological
- ❑Memory loss
- ❑Mood
- ❑Sleep pattern
- ❑Anxiety/depression
- ❑Phobias
- ❑Drug/alcohol abuse

Other
- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____