Good News Naturopathic Clinic
83 East Ave STE 209, Norwalk CT 06851
203-450-6463(Tel) 203-900-8747(Fax)

New Patient Intake Form

Date: _____

Last Name: _____ First Name: _____

DOB: _____ Age: _____ Sex: M F SSN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Insured? Y N Insurance Provider: _____

Occupation: _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred number to reach you: _____ OK to leave voicemail? Y N

Email address: _____

Relationship Status: Single Married Partnership Separated Divorced Widowed

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

How did you hear about us?

- Referral from Health Care Provider – Name: _____
- Patient Referral – Name: _____
- Nutrition Workshop Internet Search Other (please specify): _____

When did you last receive health care, and for what reason?

_____
_____
_____

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Reason for today's visit: _____

Please list your primary health concerns/goals (in order of importance):

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

Please list all MEDICATIONS you are currently taking, including over-the-counter medications.

 I currently do not take any medications.

Medication	Reason	Date/year started?	Dose/Frequency	Helpful? Y or N
1.				
2.				
3.				
4.				
5.				

Please list all SUPPLEMENTS you are currently taking, including vitamins, minerals, herbal, and others.

 I do not currently take any supplements.

Supplement Name (ex: Vitamin B12)	Supplement Brand (ex: Nature's Way)	Date/year started?	Dose/Frequency	Helpful? Y or N
1.				
2.				
3.				
4.				
5.				

Please list any known drug, food or environmental allergies:

_____

_____

PAST MEDICAL HISTORY Yes (Y), Past (P), No (N)
Have you been immunized? Y N
If yes, please specify:

Immunization	Y or N	Date(s) Received
Polio	Y N	
Measles, Mumps, Rubella	Y N	
Diptheria	Y N	
Hepatitis B	Y N	
Pertussis	Y N	
Tetanus	Y N	
Chickenpox	Y N	
Influenza	Y N	
Herpes Zoster (Shingles)	Y N	
Tuberculosis	Y N	
Pneumonia	Y N	
Meningitis	Y N	
Other (specify):	Y N	

Have you had any adverse reactions to immunizations? Y N
If yes, which one(s) and describe the adverse reaction: _____

_____

Have you served in the military? Y N Branch: _____ Status: Active Veteran

Have you recently traveled outside of the US? Y N
If yes, where? _____ Length of visit: _____

Hospitalizations: Y N
If yes, please list:

Date	Reason	Length of Stay
1.		
2.		
3.		

Surgeries: Y N
If yes, please list:

Date	Procedure	Complications
1.		
2.		
3.		

History of antibiotic use? Y P N If yes, what reason: _____

_____

FAMILY HISTORY

Please indicate whether you or family member(s) has or had any of the following illnesses:

Family Member	**Autoimmune Disease** (specify)	**Cancer** (specify)	**Cardiovascular Disease** (specify)	**Diabetes**	**Mood Disorders** (specify)	**Neurological Disorders** (specify)	**Thyroid Disease**
Self	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Mother	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Father	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Sibling(s)	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Child(ren)	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Maternal Grandmother	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Maternal Grandfather	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Paternal Grandmother	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Paternal Grandfather	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N

If death directly resulted from any of the illnesses listed above, please note family member(s) and age of death: _____

_____

_____

_____

_____

REVIEW OF SYSTEMS

General:

Weakness	Y P N	Chills	Y P N
Fatigue	Y P N	Night sweats	Y P N
Fever	Y P N		

Have you had a weight gain or loss of 5 or more pounds within the past month? Y N
If yes, how much many pounds gained or lost? _____

Have you experienced any changes in appetite? Y N
If yes, describe the changes: _____

_____

Have you noticed any changes in sleeping habits: Y N
If yes, describe the changes: _____

_____

Head:

Trauma	Y P N	Dizziness	Y P N
Headaches	Y P N	Lightheadedness	Y P N
Migraines	Y P N	Hair Loss	Y P N

Eyes:

Double vision	Y P N	Glaucoma	Y P N
Blurriness	Y P N	Photophobia	Y P N
Cataracts	Y P N	Vision changes	Y P N
Dryness	Y P N	Eye pain	Y P N

Date of last eye exam: _____

Ears:

Earache	Y P N	Ringing ears	Y P N
Discharge	Y P N	Vertigo	Y P N
Hearing loss	Y P N	Trauma to ear	Y P N

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Nose:

Sinusitis	Y	P	N	Congestion	Y	P	N
Loss of smell	Y	P	N	Nosebleeds	Y	P	N
Discharge	Y	P	N	Nasal fracture	Y	P	N
Polyps	Y	P	N				

Mouth and Throat:

Oral lesions	Y	P	N	Difficulty swallowing	Y	P	N
Bleeding/sore gums	Y	P	N	Sore throat	Y	P	N
Cavities	Y	P	N	Teeth grinding	Y	P	N
Hoarseness	Y	P	N	Impaired speech	Y	P	N

Date of last dental exam: _____

Neck:

Trauma	Y	P	N	Swollen glands	Y	P	N
Pain or stiffness	Y	P	N	Lumps	Y	P	N
Goiter	Y	P	N				

Respiratory:

Asthma	Y	P	N	Bronchitis	Y	P	N
Chronic cough	Y	P	N	Pneumonia	Y	P	N
Wheezing	Y	P	N	Sputum	Y	P	N
Emphysema	Y	P	N	Blood in sputum	Y	P	N
Tuberculosis	Y	P	N	Shortness of breath	Y	P	N
Difficulty breathing	Y	P	N	with lying down	Y	P	N
Rapid breathing	Y	P	N	with exertion	Y	P	N
Painful breathing	Y	P	N	at night	Y	P	N

Cardiovascular:

High blood pressure	Y	P	N	Angina	Y	P	N
Murmur	Y	P	N	Chest pain	Y	P	N
Palpitations	Y	P	N	Dizziness	Y	P	N
Heart disease	Y	P	N	Swollen ankles/feet	Y	P	N
Leg pain (walking)	Y	P	N	Rheumatic fever	Y	P	N

Peripheral Vascular:

Coldness of hands/feet	Y	P	N	Varicose veins	Y	P	N
Numbness of hands/feet	Y	P	N	Spider veins	Y	P	N
Deep leg pain	Y	P	N	Thrombophlebitis	Y	P	N

Gastrointestinal:

Heartburn	Y P N	Belching	Y P N
Bloody stool	Y P N	Gas/bloating	Y P N
Gallbladder disease	Y P N	Hemorrhoids	Y P N
Liver disease	Y P N	Jaunice/yellow skin	Y P N
Vomiting	Y P N	Nausea	Y P N
Vomiting of blood	Y P N	Ulcers	Y P N
Rectal pain/itching	Y P N	Loose stool	Y P N

How often are you having a bowel movement? _____

Do you notice the following in your stool?

Blood	Y P N
Mucous	Y P N
Undigested food	Y P N

Skin:

Acne	Y P N	Boils	Y P N
Itching	Y P N	Rashes	Y P N
Lesions	Y P N	Hives	Y P N
Bruising/color changes	Y P N	Moles	Y P N
Eczema	Y P N	Dryness	Y P N

Genitourinary:

Urge to urinate	Y P N	Frequent urination	Y P N
Blood in urine	Y P N	Painful urination	Y P N
Difficulty urinating	Y P N	Kidney stones	Y P N
Frequent infections	Y P N	Incontinence	Y P N
Urethral discharge	Y P N		

Male Reproductive System:

Hernia	Y P N	STDs	Y P N
Testicular Pain	Y P N	Testicular masses	Y P N
Sexual/penile dysfunction	Y P N	Prostate disease/pain	Y P N
Discharges/sores	Y P N	Genital warts	Y P N
Infertility	Y P N		

Are you sexually active? Y P N

If yes, please list safe sex practices: _____

Have you had a prostate exam? Y P N

If yes, please note date of last prostate exam: _____

List abnormal findings, if any: _____

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Female Reproductive System:

Age of first menses: _____ Normal puberty? Y N
Length of cycle: _____ Days of bleeding: _____ Regular cycle? Y P N
LMP: _____
Birth control? Y P N What type? _____
# of Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____
Pregnancy complications? Y N
If yes, please explain: _____
_____

Do you have:

Painful menses	Y P N	Painful intercourse	Y P N
PMS	Y P N	Heavy bleeding	Y P N
Missed periods	Y P N	Sexual dysfunction	Y P N
Menopause symptoms	Y P N	STDs	Y P N
Pelvic pain	Y P N	Vaginal itching/burning	Y P N
Spotting	Y P N	Vaginal discharge/sores	Y P N
Genital warts	Y P N		

Are you sexually active? Y P N
If yes, please list safe sex practices: _____

Have you had a Pap smear? Y P N
If yes, please note date of last Pap: _____
List abnormal findings, if any: _____

Please list menopausal or perimenopausal symptoms: _____
_____

Breast:

Nipple discharge	Y P N	Enlargement	Y P N
Breast pain	Y P N	Tenderness	Y P N
Lumps/mass	Y P N	Skin discoloration	Y P N
Self-breast exams	Y P N		

Have you had a mammogram? Y P N If yes, reason? _____
Date of last mammogram? _____
Abnormal findings? Y P N If yes, please explain: _____
_____

Musculoskeletal:

Joint pain/stiffness	Y P N	Broken bones	Y P N
Joint swelling	Y P N	Muscle cramps/spasms	Y P N
Arthritis	Y P N	Weakness	Y P N
Tenderness	Y P N	Muscle aches	Y P N

Neurological:

Numbness/tingling	Y P N	Seizures	Y P N
Fainting	Y P N	Paralysis	Y P N
Tremors	Y P N	Memory loss	Y P N
Loss of sensation	Y P N	Loss of coordination	Y P N

Endocrine:

Hot/cold intolerance	Y P N	Excessive thirst	Y P N
Excessive hunger	Y P N	Excessive urination	Y P N
Easy bleeding/bruising	Y P N	Anemia	Y P N
Low energy/fatigue	Y P N		

Mental/Emotional:

Anxiety/nervousness	Y P N	Excessive fears	Y P N
Depression	Y P N	Mood swings	Y P N
Easily angered	Y P N	Restlessness	Y P N
Suicidal thoughts	Y P N	Tension/Stress	Y P N

HEALTH HABITS:

Drink alcohol? Y P N If yes, how many drinks a day or week? _____

Smoke? Y P N If yes, how many cigarettes a day? _____

Recreational drug use? Y P N If yes, please list: _____

_____

Have you ever been treated for alcohol or substance abuse? Y N

If yes, please explain: _____

_____

_____

Chemical or environmental exposures? Y P N

Please list type of exposure and any symptoms you have experienced before, during or after exposure: _____

_____

_____

Do you currently exercise? Y N
If so, how frequently and what activities? _____
_____
_____

How many hours do you sleep? _____
Insomnia? Y N Difficulty falling asleep or staying asleep? (circle one)
Do you feel well-rested when you wake up? Y N

Describe your energy on a scale of 1-10 (1=low; 10=high): _____
Best time of day? _____ Worst time of day? _____

Please list any hobbies/interests: _____
_____
_____

Please list any concerns that have not been addressed on this form.
_____
_____
_____