

Avena Naturopathic Center for Well-being, LLC
 1810 Summit St #101
 Kansas City, MO 64108
 816-471-7227

Patient Intake Form

Patient Name: _____ Date: _____ Date of Birth: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Home phone: _____ Work Phone: _____ Cell Phone: _____
 Highest level of education: _____
 Occupation: _____ Employer _____ Hours work per week: _____
 Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)
 Insurance Company: _____ Policy: _____ Group #: _____
 Name of Insured _____ Relation to Insured _____
 Social Security Number: _____
 Person to call in case of Emergency: _____ Relationship to you: _____
 Phone number contact for them: _____
 Regular Physician: _____ **E-mail** _____
 How did you hear of the clinic: _____

List in Order of Importance what your problems are:

- 1.
- 2.
- 3.
- 4.
- 5.

Last time you had blood work done and with what doctor: _____

Family history

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	_____	_____	_____	_____	_____	_____
Age when died	_____	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer (type)	Y N	Y N	Y N	Y N	Y N	Y N
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-immune disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries and Hospitalizations—including date occurred:

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

Please Note When and Why You Had Each of The Following:

X-rays: _____

MRI/Cat Scans: _____

Ultrasounds: _____

Accidents: _____

Please List All Sensitivities/Allergies/Reactions

Drugs: _____

Foods: _____

Environment: _____

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	D I N	Diphtheria:	D I N
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Mumps:	D I N	Tetanus:	D I N
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Rubella:	D I N	Whooping Cough:	D I N
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Chickenpox:	D I N	Hemophilus (Hib):	D I N
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German Measles:	D I N	Hepatitis B:	D I N
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Any vaccination reactions: _____

List Yes, No, or Past regarding use of the following:

Antacids: Y N P

Steroids: Y N P

Smoking: Y N P

Packs per day if Yes/Past: _____

Analgesics: Y N P

Laxatives: Y N P

Coffee: Y N P

Cups per day if Yes/Past: _____

Soda Pop: Y N P

Ounces per day if Yes/Past: _____

Alcohol: Y N P

How often and how much if Yes/Past: _____

Any alcohol addiction: Y N P

Any alcohol treatment: Y N P

Recreational drugs: Y N P

Any drugs addiction: Y N P

Any drug treatment: Y N P

List all Prescription Medicines and Nutrient Supplement/Herbs Taking:

Review Of Systems:

Present Weight: _____ Weight one year ago: _____
Height: _____ Maximum weight and when: _____
Minimum Weight as adult and when: _____
Ideal Weight: _____

REGARDING THE NEXT LONG SECTION: Please Circle **Y** if you have the problem **NOW**, **N** if you've **NEVER** had the problem, **P** if you had the problem in the **PAST**.

Good Energy: Y N P
Fatigue: Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst?: _____
If you have fatigue, can you do what you need to during the day?: Y N

Skin:

Rash:	Y N P	Color Change:	Y N P
Hives:	Y N P	Lump:	Y N P
Psoriasis/eczema:	Y N P	Itchy:	Y N P
Dry:	Y N P	Warts/moles:	Y N P
Cancer:	Y N P	Perspiration:	Y N P

Head:

Headache:	Y N P	Migraine:	Y N P
Dandruff:	Y N P	Head Injury:	Y N P
Oil/dry hair:	Y N P	Hair loss:	Y N P

Eyes:

Dry/Watery:	Y N P	Blurry vision:	Y N P
Double vision:	Y N P	Cataracts:	Y N P
Glaucoma:	Y N P	Styes:	Y N P
Strain:	Y N P	Discharge:	Y N P
Itchy:	Y N P	Dark under eyelid:	Y N P

Nose:

Frequent colds:	Y N P	Nosebleeds:	Y N P
Congestion:	Y N P	Post nasal drip:	Y N P
Polyps:	Y N P	Seasonal allergies:	Y N P

Mouth/Throat:

Canker sores:	Y N P	Cold sores:	Y N P
Sore throat:	Y N P	Gum disease:	Y N P
Dentures:	Y N P	Cavities:	Y N P
Loss of taste:	Y N P	Hoarseness:	Y N P

Neck:

Stiffness: Y N P
Full movement: Y N P

Swollen glands: Y N P
Tension: Y N P

Respiratory:

Cough: Y N P
Shortness of breath with exertion: Y N P
Shortness of breath sitting: Y N P
Shortness of breath lying down: Y N P
Wheezing: Y N P

TB: Y N P
Bronchitis: Y N P
Pneumonia: Y N P
Asthma: Y N P
Painful breathing: Y N P

Cardiovascular:

High blood pressure: Y N P
Low blood pressure: Y N P
Arrhythmias: Y N P
Edema: Y N P

Rheumatic Fever: Y N P
Murmurs: Y N P
Palpitations: Y N P
Chest pain: Y N P

Gastrointestinal:

Heartburn: Y N P
Indigestion: Y N P
Bloating: Y N P
Nausea: Y N P
Vomiting: Y N P
Change in Appetite: Y N P
Pancreatitis: Y N P

Bowel movement frequency: _____
Recent change in BM: Y N P
Diarrhea or constipation: Y N P
Hemorrhoids: Y N P
Gall bladder disease: Y N P
Liver disease: Y N P
Ulcer: Y N P

Urinary Tract:

Incontinence: Y N P
Frequent infections: Y N P
Urgency: Y N P

Pain with urination: Y N P
Kidney stones: Y N P
Discharge/blood: Y N P

Male Genitalia:

Testicular pain/swelling: Y N P
Hernia: Y N P
Discharge: Y N P
Impotency: Y N P

Sexually active: Y N P
Sexually transmitted disease: Y N P
Prostate disease/symptoms: Y N P
Sexual orientation: Hetero Homo Bi

Female Genitalia:

Age periods began: _____
How long periods last: _____
Periods: _____
Heavy Bleeding: Y N P
Cramping: Y N P
Pain: Y N P
PMS: Y N P
Food Cravings: Y N P
Last Pap Smear: _____
Diagnosis: _____
Any abnormal paps: Y N P
When was abnormal: Y N P
Any Birth Control (please list types and ages used): _____
Sexually Transmitted Diseases: Y N P
Mammography: Y N P
Dexa Scan: Y N P If Yes, what were the results: _____
Use of Hormones: Y N P
How often periods occur: _____
Menopausal since what age: _____
Times Pregnant: _____
How many births: _____
Miscarriages: _____
Abortions: _____
Sexual Active: Y N P
Healthy Libido: Y N P
Pain With Intercourse: Y N P
Dry Vagina: Y N P
Vaginitis: Y N P

Musculoskeletal:

Weakness: Y N P
Stiffness: Y N P
Tremors: Y N P
Arthritis: Y N P
Leg cramps: Y N P
Pain: Y N P

Nervous:

Paralysis: Y N P
Tingling/numbness: Y N P
Seizures: Y N P
Sciatica: Y N P
Carpal tunnel syndrome: Y N P
Fainting: Y N P

Mental/Emotional:

Depression: Y N P
Suicidal: Y N P
Anxiety: Y N P
Anger/irritability: Y N P
High-strung/tense: Y N P
Fear/Panic: Y N P

Exercise:

How often: _____
What type(s): _____
For How long: _____

Hobbies:

Sleep:

How long per night: _____

If you wake up frequently, what is the reason: _____

Nightmares: Y N P

Wake refreshed: Y N P

Must Nap during the day: Y N P

Sleep walk: Y N P

Grind Teeth: Y N P

Snore: Y N P

Food:

Appetite Good?: Y N P

Foods crave: _____

Foods Dislike: _____

Foods that don't sit well: _____

Blood Type: _____

Toxin Exposure:

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?: _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?: _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?: _____

Are you particularly sensitive to perfumes, gasoline, or other vapors?: _____

Do you use pesticides, herbicides, other chemicals around your home? _____

Social Life:

Enjoy job?: Y N P

Active Spiritual practice: Y N P

Quality of most significant relationship? _____

History of sexual, mental/emotional, physical abuse?: Y N

What is your greatest health concern? _____

How does it limit you the most? _____

How committed are you towards making valuable changes: Little Moderately Very

