

Confidential Health Intake Form

Name _____ Date _____

Occupation _____ Hrs/wk _____ Retired _____

Married/Partnership _____ Separated _____ Divorced _____ Widowed _____ Single _____

Live with: Spouse/Partner _____ Children _____ Parents _____ Friends _____ Alone _____

What are your most important health concerns? List in order of importance.

How do you feel about the state of your health? What/How would you like that to change?

How does your condition(s) affect you?

What do you think is happening and why? _____

What do you most enjoy in your life?

Medications Use (P) for past or (C) for currently used:

laxatives _____ sleeping pills _____ anti-inflammatories _____ anti-depressants _____ pain relievers _____

antacids _____ thyroid medication _____ heart/cholesterol/circulation meds. _____

anti-biotics _____ birth control _____ menopausal _____

Other medications, vitamins or supplements you are taking and at what dose.

Childhood Illnesses:

Mumps _____ Measles _____ Chickenpox _____ German Measles _____ Rheumatic fever _____ Diphtheria _____

Other _____

Significant trauma (falls, injuries, auto accidents) _____

Surgeries and Hospitalizations

Have any major events impacted your life? How? _____

Family History: (please indicate member and (F) for father's side or (M) for mother's side.)

Cancer_____ Diabetes_____ Heart Disease___ High Blood Pressure_____ Stroke_____
 Seizures___ Asthma/Hives/Hay fever___ Anemia___ Kidney Disease_____ T.B._____
 Depression_____ Schizophrenia_____ Dementia___ Other_____

Diet and Lifestyle Information

Do you buy organically grown fruits and vegetables _____ dairy and meat _____

Check all that apply to your diet:

<input type="checkbox"/> raw foods	<input type="checkbox"/> vegan	<input type="checkbox"/> vegetarian	<input type="checkbox"/> eggs/dairy
<input type="checkbox"/> whole foods	<input type="checkbox"/> meat	<input type="checkbox"/> processed/fast foods	

Describe your daily liquid intake in ounces (e.g. 8 oz. of water):

water (filtered?)	soda	herbal Tea	alcohol
juice	coffee	black Tea	other:

Describe your **daily** intake of the following:

flour products	sugar	artificial sweeteners	soy products
dairy products	meats	fried foods	fast food

Describe any known reactions or allergies to foods/drugs/environmental factors: _____

Describe your exercise habits: _____

Rate on a scale (1-10) the stress in your life and describe: _____

Describe history of alcohol/tobacco/recreational drug use: _____

Describe your sleep habits: _____

Do you wake rested? _____ How long does it take you to fall asleep? _____
 How often do you have bowel movements? _____
 How would you characterize them? _____

What is your current height and weight? _____
 How has your weight fluctuated over the past 5 years? _____

Please indicate past symptoms with a (P), < 6months/Acute (A). > 6months/Chronic (C).

Poor sleep	Headaches	High blood pressure	Excessive hair loss
Poor appetite	Head injuries	Low blood pressure	Ulcerations
Chills	Glasses/contacts	Phlebitis	Itching
Fevers	Night blindness	Fainting	Eczema/Hives
Cravings	Color blindness	Swollen feet	Lumps/growths
Night sweats	Glaucoma	Swollen hands	Moles
Sweat easily	Ringling in the ears	Murmurs	Rashes
Strong thirst	Nose bleeds	Chest pain	Boils/acne
Weight gain	Teeth grinding	Heart disease	
Weight loss	Copious saliva	Irregular heart beat	
Sudden energy drops	Jaw clicks	Rheumatic fever	Gonorrhea
Bleed/bruise easily	Goiter	Cold hands/feet	Syphilis
Peculiar taste/smells	Head/neck problems	Fainting	Condyloma
Fatigue	Jaw/TMJ problems	Blood clots	Herpes
Change in appetite	Spots in eyes	Dizziness	Chlamydia
	Double vision	Angina	
Depression	Tearing/dryness	Palpitations	Male:
Mood swings	Earaches		Hernias
Poor memory	Stiffness	Indigestion	Impotency
Seizures	Loss of smell	Constipation	Prostate disease
Lack of co-ordination	Gum problems	Vomiting	Testicular pain
Anxiety/nervousness	Sore tongue/lips	Hemorrhoids	Premature ejaculation
Loss of balance	Facial pain	Trouble swallowing	Discharge or sores
Dizziness	Migraines	Liver disease	Testicular masses
Numbness/tingling	Eye strain	Gall bladder disease	
Tension	Blurriness	Bloating/gas	Female:
Quick temper	Cataracts	Abdominal pain/cramps	Age of 1 st menses
Concussion	Eye pain	Blood in stool	Duration of menses
Susceptible to stress	Poor hearing	Black stools	Length of cycle
Considered suicide	Sinus problems	Heartburn	Menstrual cramps
	Frequent sore throat	Ulcer	Heavy menses
Hypothyroid	Dental cavities	Bad breath	Light menses
Heat/cold intolerance	Hoarseness	Nausea	Irregular periods
Seasonal depression		Rectal pain	Vaginal discharge
Hypoglycemic	Frequent urination	Diarrhea	Vaginal sores
Diabetes	Wake to urinate	Yellow skin	Endometriosis
Thyroid disease	Urgency to urinate	Appetite change	Ovarian cysts
Excessive thirst	Inability to hold urine	Rectal cuts	Cervical dysplasia
Excessive hunger	Blood in urine		Sexual difficulties
	Pain on urination	Joint pain/stiffness	Bleeding between cycles
Anemia	Kidney stones	Muscle cramps	Pain during intercourse
Deep leg pain		Broken bones	PMS
Varicose veins	Persistent cough	Arthritis	# of pregnancies
Thrombophlebitis	Asthma	Sciatica	# of live births
	Emphysema	Foot/ankle pain	Miscariages
Slow wound healing	Short of breath	Knee pain	# of abortions
Swollen glands	Bronchitis	Hip pain	Abnormal PAP
Muscle weakness	Coughing blood	Back pain	Menopausal symptoms
Lingering infections	Pneumonia	Shoulder pain	Breast lumps
	Pain on breathing	Neck pain	Nipple discharge
	Wheezing	Hand/wrist pain	Date of last PAP

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Quality of Life: Please rate the following from 0 (not at all satisfied) to 10 (very satisfied)

Your overall level of health	_____	Your relationship with friends	_____
The health of your family	_____	The amount of love in your life	_____
How often you feel fatigued	_____	How connected you feel to others	_____
The amount of medication you take	_____	The size of your social network	_____
Your satisfaction with your work	_____	Level of stress in your personal life	_____
Your financial security	_____	Your overall level of energy	_____
The amount you work	_____	Your sense of vitality	_____
The amount of money you make	_____	Your physical presentation	_____
How much you stress about money	_____	Your creativity	_____
Level of stress at work	_____	Sense of fulfillment in your life	_____
Your daily routine outside of work	_____	How good you feel about yourself	_____
Time for yourself/enough down time	_____	A sense of playfulness	_____
Your ability to relax	_____	Your level of frustration	_____
The amount you recreate	_____	Your level of fear	_____
Your home environment	_____	Your level of anger	_____
Your intimate relationships	_____	Your level of optimism	_____
Your ability to communicate	_____	Your level of patience	_____
Your relationships with family	_____	How much you cry	_____

Thank you for your patience with such a lengthy intake. As we begin to work together it helps me to have a broad view of how you feel about different areas of your life. It also provides a reference point from which to evaluate treatment and changes that may occur over time. Please feel free to use the space below for any additional comments you may have. I look forward to sharing with you on your journey to optimum health and well-being. Thank you for choosing me for your health care needs.

How did you hear about me? _____
If it was a personal referral please provide me with their name so I may send a thank you.