THE NATUROPATHIC OFFICE OF DR. MAYA ROTH

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NEW PATIENT INTAKE FORM

Please fill out this form as completely as possible. It will help us to uncover the cause of your health concerns.

Name	Date of birth	Today's date	□ Male □ Female
Home address			
City	State	Zip code	
Home phone #	Cell phone #	Email address	
Occupation	Work phone #	Social security #	
Employer name and address		Insurance	□ PPO □ HMO
Emergency contact name	Relationship	Phone #	
Who may we thank for referring you to our office?			

Chief complaints:

What are your current health concerns?	Describe treatment received, obstacles encountered and, if previously seen by a healthcare provider, the results of their evaluation:
1.	
2.	
3.	

Allergies: Have you ever had an adverse reaction to food, medication, vaccination, or supplement? □No □Yes

Please list names of allergic foods, drugs, vaccines or supplements:	Reaction:
1.	
2.	
3.	

Medications: What medications are you currently taking? Please include prescription, OTC & herbal medications:

Name and strength of medication or supplement:	Daily dose:	Indication:
Example: Selenium 200mcg	1 tablet	Hypothyroidism
1.		
2.		
3.		
4.		
5.		

Patient Name _____ Date of birth _____ Today's date_____

Are you currently under the care of a primary care doctor? □ Yes □ No (If yes, please specify)

Name Reason Tel:

Are you currently under the care of any other health professional? □ Yes □ No (If yes, please specify)

Name Reason Tel:

Past medical history:

Have you ever had a major illness, sustained an injury, been hospitalized, or had surgery or a procedure done? □No□Yes

Illness, injury, hospitalization, surgery or procedure	Date	Illness, injury, hospitalization, surgery or procedure	Date
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Screening tests: Please list the dates and results of your most current check up, laboratory and screening tests:

Procedure	Date	Results	Procedure	Date	Results
Annual physical or complete check up			Bone density scan		
Last blood test			Colonoscopy		
PAP smear			Chest X-ray		
Mammogram			EKG or stress test		
CT, MRI or ultrasound			Other (please specify)		

Family history: Please describe your family's health including illnesses such as autoimmune disease, cancer, heart disease, diabetes, anxiety, depression, eczema, allergies & thyroid disease.

Family Member:	Age if living:	Age at death:	Major illnesses or chronic conditions:
Mother			
Father			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			
Siblings			
Children			

Date reviewed with patient _____ Doctor Signature _____ Maya Roth, ND

Patient Name _____ Date of birth _____ Today's date_____

Social History:

Circle your family unit: Single /In a committed relationship/Married/Divorced/Widowed/Separated/Other
How many children do you have? What are their names and ages?
Do you have a religious orientation or a spiritual practice that is important to you? □Yes □No Please specify:
Have you ever smoked cigarettes? □ Current smoker □ Past smoker # of cigarettes per day: # of years:
How many alcoholic beverages do you drink per week? Do you use recreational drugs? □ No □ Yes

Diet and nutrition: Please describe your typical daily food and beverage intake.

Meal	Time	Description
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Dinner		
After dinner snack		
Before bed		
How many ounces of water do you drink per day?		
How many servings of caffeinated beverages (soda, black tea, coffee) do you have per day? (8oz = 1 serving)		
Which foods do you crave the most (sweets, salt, chocolate, starch, ice cream, coffee)?		
Please circle dietary practices that you adhere to: Vegan Vegetarian Kosher Halal Gluten-free Dairy-free Soy-free Other		

Lifestyle:

Stress: Rate your stress level on a scale of 1-10 (10 = most stress) **1 2 3 4 5 6 7 8 9 10**
What are your current sources of stress?
Energy: Rate your energy level on a scale of 1-10 (10 = most energy) **1 2 3 4 5 6 7 8 9 10**
Sleep: How many hours do you sleep each night? At what time(s) do you wake up during the night?
What time do you go to sleep? What time do you wake up in the morning?
Exercise: Describe your exercise activity, frequency and duration

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Patient Name _____ Date of birth _____ Today's date_____

Review of systems: Please check all ongoing or recurrent problems

General:
□ Weight change □ Fever/chills □ Fatigue/weakness □ Sweats/night sweats □Sensitivity to heat or cold

Skin/hair :
□ Rashes □ Itching □ Acne or pimples □ Hives □ Rough or scaly skin □ Changes in hair or nails

Head:
□ Headaches □ Head injury □ TMJ problems

Eyes:
□ Changes in vision □ Glasses/contacts □ Blurring □ Pain □ Discharge □ Dryness

Ears:
□ Earache □ Ringing in the ear □ Hearing problems □ Discharge from ears

Nose/sinuses:
□ Sinus congestion □ Bleeding □ Discharge □ Postnasal drip

Mouth/throat:
□ Cracks in corners of the mouth □ Cold sores □ Bleeding gums □ Hoarseness □ Sore throat

Respiratory/chest:
□ Shortness of breath □ Wheezing □ Chest tightness □ Phlegm/mucus □ Cough □ Breast mass □ Breast pain □ Nipple discharge □ Snoring □ Apnea or holding breath at night

Cardiovascular:
□ Palpitations/fluttering □ Swelling/Edema □ Arrhythmia □ Chest pain □ Leg pain when walking □ Hypertension

Gastrointestinal:
# of bowel movements per day _____ □ Loss of or excess appetite □ Nausea/vomiting □ Abdominal pain □ Bloating □ Indigestion □ Belching □ Gas □ Constipation □ Diarrhea □ Blood, mucus or undigested food in stool □ Hepatitis □ Fatty liver

Genitourinary:
□ Urinary pain/urgency/frequency □ Urination at night □ Blood in urine □ Incontinence □ Frequent UTIs □ Kidney stones □ Kidney disease

Musculoskeletal:
□ Muscle stiffness/pain □ Muscle weakness □ Joint pain/stiffness □ Trauma/swelling

Endocrine:
□ Goiter □ Hormone therapy □ Thyroid condition □ Blood sugar imbalance

Blood/lymphatic:
□ Anemia □ Easy bleeding/bruising □ Swollen lymph nodes □ Varicose veins □ Bleeding or clotting problems □ Transfusion

Neurological:
□ Convulsions □ Fainting □ Loss of balance □ Dizziness/vertigo □ Numbness/tingling □ Paralysis/weakness □ Tremor

Psychological:
□ Anxiety/nervousness □ Depression □ Poor concentration □ Memory problems □ Changeable mood □ Drug or alcohol abuse □ Considered/attempted suicide

Sexual health information:
Are you currently sexually active? □ yes □ no Do you practice safe sex? □ yes □ no
Low libido? □ yes □ no Method of birth control currently used? _____
STDs: □ HIV □ Herpes □HPV/genital warts □ Gonorrhea □ Chlamydia □ Syphilis

Male health information:
□ Testicular pain/swelling/mass □ Erectile dysfunction □ Premature ejaculation □ Prostate problems □ Discharge or genital sores

Female health information:
Age of first menses: _____ Age of last menses (if menopausal): _____
Length of cycle: _____ days Duration of flow: _____ days
Date of last menstrual cycle: _____ Have you ever had an abnormal PAP? _____
□ Cycles regular □ Heavy flow □ Bleeding between cycles □ Painful menses □ Clotting □ PMS
□ Vaginal discharge □ Fertility issues □ Pain with intercourse □ Menopausal symptoms
□ Vaginal bleeding since menopause
How many times were you pregnant? _____ # living children _____ # miscarriages _____ # abortions_____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM.

Date reviewed with patient _____ Doctor Signature _____ Maya Roth, ND