

**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      | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Home address                                      |               |                   |  |
| City  | State         | Zip code          |  |
| Home phone #                                      | Cell phone #  | Email address     |  |
| Occupation  | Work phone #  | Social security # |  |
| Employer name and address                         |               | Insurance         | <input type="checkbox"/> PPO<br><input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify: |   |
| Have you ever smoked cigarettes? <input type="checkbox"/> Current smoker <input type="checkbox"/> Past smoker  | # of cigarettes per day: _____ # of years: _____  |
| How many alcoholic beverages do you drink per week?  | Do you use recreational drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes |

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

| Meal  | Time | Description |
|---|------|-------------|
| <b>Breakfast</b>  |      |             |
| Morning snack   |      |             |
| <b>Lunch</b>  |      |             |
| Afternoon snack   |      |             |
| <b>Dinner</b>   |      |             |
| 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:**

|   |  |
|---|--|
| <b>Stress:</b> Rate your stress level on a scale of 1-10 (10 = most stress) | <b>1 2 3 4 5 6 7 8 9 10</b>                      |
| What are your current sources of stress?                                    |  |
| <b>Energy:</b> Rate your energy level on a scale of 1-10 (10 = most energy) | <b>1 2 3 4 5 6 7 8 9 10</b>                      |
| <b>Sleep:</b> 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?         |
| <b>Exercise:</b> Describe your exercise activity, frequency and duration    |  |

Date reviewed with patient \_\_\_\_\_ Doctor Signature \_\_\_\_\_ Maya Roth, ND

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**Review of systems:** Please check all ongoing or recurrent problems

|   |
|---|
| <b>General:</b><br><input type="checkbox"/> Weight change <input type="checkbox"/> Fever/chills <input type="checkbox"/> Fatigue/weakness <input type="checkbox"/> Sweats/night sweats <input type="checkbox"/> Sensitivity to heat or cold   |
| <b>Skin/hair :</b><br><input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Acne or pimples <input type="checkbox"/> Hives <input type="checkbox"/> Rough or scaly skin <input type="checkbox"/> Changes in hair or nails   |
| <b>Head:</b><br><input type="checkbox"/> Headaches <input type="checkbox"/> Head injury <input type="checkbox"/> TMJ problems   |
| <b>Eyes:</b><br><input type="checkbox"/> Changes in vision <input type="checkbox"/> Glasses/contacts <input type="checkbox"/> Blurring <input type="checkbox"/> Pain <input type="checkbox"/> Discharge <input type="checkbox"/> Dryness  |
| <b>Ears:</b><br><input type="checkbox"/> Earache <input type="checkbox"/> Ringing in the ear <input type="checkbox"/> Hearing problems <input type="checkbox"/> Discharge from ears   |
| <b>Nose/sinuses:</b><br><input type="checkbox"/> Sinus congestion <input type="checkbox"/> Bleeding <input type="checkbox"/> Discharge <input type="checkbox"/> Postnasal drip  |
| <b>Mouth/throat:</b><br><input type="checkbox"/> Cracks in corners of the mouth <input type="checkbox"/> Cold sores <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore throat   |
| <b>Respiratory/chest:</b><br><input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest tightness <input type="checkbox"/> Phlegm/mucus <input type="checkbox"/> Cough <input type="checkbox"/> Breast mass <input type="checkbox"/> Breast pain <input type="checkbox"/> Nipple discharge<br><input type="checkbox"/> Snoring <input type="checkbox"/> Apnea or holding breath at night   |
| <b>Cardiovascular:</b><br><input type="checkbox"/> Palpitations/fluttering <input type="checkbox"/> Swelling/Edema <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Chest pain <input type="checkbox"/> Leg pain when walking <input type="checkbox"/> Hypertension   |
| <b>Gastrointestinal:</b><br># of bowel movements per day _____ <input type="checkbox"/> Loss of or excess appetite <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloating <input type="checkbox"/><br>Indigestion <input type="checkbox"/> Belching <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood, mucus or undigested food in stool <input type="checkbox"/> Hepatitis <input type="checkbox"/> Fatty liver  |
| <b>Genitourinary:</b><br><input type="checkbox"/> Urinary pain/urgency/frequency <input type="checkbox"/> Urination at night <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Frequent UTIs <input type="checkbox"/> Kidney stones <input type="checkbox"/><br>Kidney disease   |
| <b>Musculoskeletal:</b><br><input type="checkbox"/> Muscle stiffness/pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Joint pain/stiffness <input type="checkbox"/> Trauma/swelling   |
| <b>Endocrine:</b><br><input type="checkbox"/> Goiter <input type="checkbox"/> Hormone therapy <input type="checkbox"/> Thyroid condition <input type="checkbox"/> Blood sugar imbalance   |
| <b>Blood/lymphatic:</b><br><input type="checkbox"/> Anemia <input type="checkbox"/> Easy bleeding/bruising <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Varicose veins <input type="checkbox"/> Bleeding or clotting problems <input type="checkbox"/> Transfusion   |
| <b>Neurological:</b><br><input type="checkbox"/> Convulsions <input type="checkbox"/> Fainting <input type="checkbox"/> Loss of balance <input type="checkbox"/> Dizziness/vertigo <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Paralysis/weakness <input type="checkbox"/> Tremor   |
| <b>Psychological:</b><br><input type="checkbox"/> Anxiety/nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Poor concentration <input type="checkbox"/> Memory problems <input type="checkbox"/> Changeable mood <input type="checkbox"/> Drug or alcohol abuse <input type="checkbox"/><br>Considered/attempted suicide   |
| <b>Sexual health information:</b><br>Are you currently sexually active? <input type="checkbox"/> yes <input type="checkbox"/> no Do you practice safe sex? <input type="checkbox"/> yes <input type="checkbox"/> no<br>Low libido? <input type="checkbox"/> yes <input type="checkbox"/> no Method of birth control currently used? _____<br>STDs: <input type="checkbox"/> HIV <input type="checkbox"/> Herpes <input type="checkbox"/> HPV/genital warts <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Syphilis  |
| <b>Male health information:</b><br><input type="checkbox"/> Testicular pain/swelling/mass <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Prostate problems <input type="checkbox"/> Discharge or genital sores   |
| <b>Female health information:</b><br>Age of first menses: _____ Age of last menses (if menopausal): _____<br>Length of cycle: _____ days Duration of flow: _____ days<br>Date of last menstrual cycle: _____ Have you ever had an abnormal PAP? _____<br><input type="checkbox"/> Cycles regular <input type="checkbox"/> Heavy flow <input type="checkbox"/> Bleeding between cycles <input type="checkbox"/> Painful menses <input type="checkbox"/> Clotting <input type="checkbox"/> PMS<br><input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Fertility issues <input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Menopausal symptoms<br><input type="checkbox"/> Vaginal bleeding since menopause<br>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