Sky Valley Healing Arts

Medicine with Purpose

PATIENT INTAKE FORM
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360-863-2152, FAX 360-863-2364

PATIENT INFORMATION

First Name: _____ Last Name: _____ MI: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Telephone: (please circle which one is best to reach you at)

HM: _____ Work: _____ Cell: _____

Email: _____ Can we email you regarding your file/care with us? Y / N

Employer: _____

Emergency Contact: _____ Contact's Phone: _____

Do you have special needs? _____

Mother's Name: (minors only) _____

Father's Name: (minors only) _____

How did you hear about us? _____

Financial Terms: *I have reviewed all Naturopathic/Nutritional/NCR fees payable and have agreed to make prompt payment of the same. I understand that I am solely responsible for all charges at the time of service. I understand that finance charges will begin accruing on all delinquent accounts that are thirty (30) days past due at a rate of one percent per month. The undersigned agrees that excessively overdue accounts may be forwarded to an outside collection agency and agrees to reimburse all collection and attorney's fees and costs incurred or generated as a result of these collection efforts.*

Records Privacy: *Records are kept of Naturopathic/Nutritional/NCR services provided. Applicable state and federal privacy laws protect the confidentiality of your medical information and grant patients the right to see your medical records. You may also request a copy of your medical information, subject to payment of applicable file copying costs. If you believe any information in your record is inaccurate, you may request a correction. Your medical information will not be disclosed to others unless you direct us to do so, in writing, or applicable laws or legal duress compels us to do so.*

Patient's signature: _____ Date: _____

Patient's Legal Guardian Signature (under age 18): _____

HEALTH HISTORY

Name: _____Date Filled Out: _____ Date of Birth: _____
Sex: M / F Ethnicity: _____ Current weight: _____ Current height: _____

Present Health Concerns: in order of most significant to least significant

Symptom	Severity	Current Treatment	Success

Please check any of the below that have had in the past or that you currently experience:

(Please mark present conditions with a **P)**

- O Acne
- O Addiction
- O Anemia
- O Anorexia
- O Anxiety
- O Arthritis (RA or OA)
- O Asthma
- O Bladder Infections
- O Bleeding Disorders
- O Bloating, gas
- O Blood sugar problems
- O Bronchitis
- O Cancer _____
- O Colds/flu's (frequent)
- O Cold sores
- O Chronic fatigue/Fibromyalgia
- O Constipation
- O Dandruff
- O Depression
- O Diabetes I/Diabetes II
- O Diarrhea
- O Difficulty Losing weight
- O Difficulty Gaining Weight
- O Emotional problems
- O Emphysema
- O Eczema
- O Fainting
- O Gall bladder problems
- O Gout
- O Hair loss or poor growth
- O Headaches/Migraines
- O Hypoglycemia
- O Heart disease or problems
- O Heartburn
- O Hemorrhoids
- O Herpes Simplex I or II
- O High Blood Pressure
- O High Cholesterol
- O HIV
- O Hot flashes
- O Insomnia
- O Intestinal Problem
- O Kidney Stones
- O Liver problems
- O Loose stools
- O Memory loss or confusion
- O Nail, poor growth
- O Panic Attacks
- O Parasites
- O Pregnant or nursing
- O Psoriasis
- O Respiratory problems
- O Ringing in ears
- O Seizures
- O Severe mood swing
- O Stroke
- O Suicidal tendencies
- O Thyroid condition
- O Ulcers
- O Yeast infection

Please list all your current health care providers:

Name	Type	What For	Phone number

Please list ALL medication and over the counter medications you take:

Name	Dose	For what?	How long?	Prescribed by?

(Please add to the back if needed)

Please list ALL supplements you take:

Name	Dose	For what?	How long?	Prescribed by?

(Please add to the back if needed)

Please list all hospitalizations or serious illness:

Family History	Mother	Father	Sibling	Grandmother	Grandfather
Alcoholism					
Cancer					

Diabetes					
Heart Dz					
High Blood Press					
Kidney Dz					
Mental Dz					
Stroke					
Osteoporosis					

Female: please check any that apply

- ☐ Irregular Periods
- ☐ Painful Periods

- ☐ Loss of Periods
- ☐ PMS
- ☐ Ovarian cysts
- ☐ Tubal ligation
- ☐ Fibroids
- ☐ Menopause
- ☐ Painful intercourse
- ☐ C-section births
- ☐ Loss of libido
- ☐ Hysterectomy

Male: please check any that apply

- ☐ Frequent urination
- ☐ Difficult urination

- ☐ Erectile dysfunction
- ☐ Prostate enlargement
- ☐ Vasectomy
- ☐ Prostectomy
- ☐ Loss of libido

Date of most recent Physical Exam: _____

Recent labs: Please bring any current labs with you to your appointment.

Lipids/Cholesterol	**Date:**	**#:**
Glucose/Blood Sugar	**Date:**	**#:**
PSA	**Date:**	**#:**

Recent Imaging: Please bring any x-rays, MRI, ultrasound, or CT scan reports to appointment.

X-rays	**Date:**	**?**
MRI	**Date:**	**?**
Ultrasound	**Date:**	**?**
CT scan	**Date:**	**?**

Please give the most current dates/or your age upon receiving the below tests.

Breast Exam:	**Prostate Exam:**
Mammogram:	**Colonoscopy:**
Pelvic Exam:	
DEXA/Bone Density:	

CRANIAL HEALTH INTAKE

Please describe your birth process:

_____

Were forceps or suction cups a part of your birth?	**Y / N / Not sure**
If so, do you have scarring?	**Y / N**
Did you wear braces as a child?	**Y / N ages ____**
Do you wear braces now?	**Y / N Yrs ____**
Have you been wearing your retainer?	**Y / N**
Have you had your wisdom teeth removed?	**Y / N age_____**
Have you had your adenoids/tonsils removed?	**Y / N age_____**
Did you have tubes in your ears as child?	**Y / N**
Did or do you presently have chronic ear infections?	**Y / N**
Have you ever sustained a concussion?	**Y / N**
Have you ever had a diagnosed Traumatic Brain Injury?	**Y / N**
Do currently experience dizziness, vertigo, or poor balance?	**Y / N**
Do you have a history of headaches and/or migraines?	**Y / N**
Do you experience frequent head/neck/back pain?	**Y / N**
Do you have a history of TMJ disfunction?	**Y / N**
Have you ever had facial plastic surgery or reconstruction?	**Y / N**

If yes please describe: _____

Do you have any bridges in your mouth that are older than 10 years?	**Y / N**
Have you ever had a root canal?	**Y / N**
Do you have chronic sinus issues?	**Y / N**
Can you breath through your nose efficiently?	**Y / N**

If not please describe when this started: _____

Please list any significant falls, traumas, dental work, athletic injuries, or motor vehicle accidents prior to the age of 18:

_____
_____
_____
_____
_____

Please list any significant falls, traumas, dental work, athletic injuries, or motor vehicle accidents after the age of 18:

_____
_____
_____
_____
_____
_____

If applicable, please describe any severe emotional events in your life and your health afterwards:

_____
_____
_____

When do you believe many of your problems started?

QUALITY OF LIFE INTAKE

SLEEP

How many hours per night do you sleep? 1-4 4-6 6-8 8-10
Is it easy for you to fall asleep? Y / N
Are you able to stay asleep? Y / N
Do you wake feeling rested? Y / N / Sometimes
Do you snore? Y / N / don't know
Do you have sleep apnea? Y / N / don't know
If so, do you wear a CPAP? Y / N / Not like I should
How many times per night do you wake to urinate? _____

ENERGY and EXERCISE

What is your energy on a scale of 1-10 (1 being GREAT, and 10 being HORRIBLE)? _____
What is your daily stress level? Low Medium High Very High
How much per week do you exercise? 0 1-2 3-4 5-7
What types of exercise do you do?

_____

How long do you work out at each session? 20-30 min 30 min-1hr 1-2 hrs
How do you feel AFTER exercise? Better Worse No change
What hobbies do you have? _____
How much time do you spend outside with work or hobbies per day? _____

MOOD

How would you describe your day-to-day mood? _____
Do you suffer with depression? Never Rarely Sometimes Always
Do you suffer with anxiety? Never Rarely Sometimes Always
What type of relaxation activities do you practice? _____

SOCIAL SUPPORT

What type of work do you do? _____
Are you satisfied with your work? Y / N
How would you rate your:
Relationship with Partner/Spouse Poor Fair Good Excellent N/A
Relationship with Children Poor Fair Good Excellent N/A
Relationship with Parents Poor Fair Good Excellent N/A
Relationships with Friends Poor Fair Good Excellent N/A
Is Spirituality/ Religion important to you? Y / N
Do you have a daily practice? _____

LIBIDO

Please rate your libido: Poor Fair Good Excellent N/A
How many times per week are you sexually active? 1-2 3-4 4-6 7 or higher N/A
Are you satisfied with your sex life? Y / N

NUTRITION INTAKE

Blood Type: _____ / Don't Know

Please list what you eat on a typical day for:

Breakfast	
Lunch	
Dinner	
Snacks	

How much of the following do you consume?

	Per day		Per week
Coffee		**Red Meat**	
Black/Green Tea		**Chicken**	
Water		**Fatty fish**	
Diet Soda		**Eggs**	
Regular Soda		**Dairy products**	
Fruit Juice		**Fast food**	
Milk		**Chocolate**	
Alcohol (beer, liquor)		**Candy**	
Wine			
Vegetables			
Fruit			

Do you consume: O Butter O Margarine O Olive Oil O Vegetable Oil
O Coconut Oil O Flaxseed Oil O Canola Oil O Other _____

Do you have any food allergies/sensitivities? _____
Do you eat any organic foods? _____
What foods do you crave? _____
Do you eat late at night? _____
Do you have a reaction to MSG and/or Aspartame? _____

How would you rate your appetite?	**Poor Normal**	**Excessive**
Do you have gas and bloating after eating?		**Y / N**
Do you have mucous after eating?		**Y / N**
Do you experience worsened depression/anxiety/fatigue after eating?		**Y / N**
How many bowel movements do you have per day?		**# _____**
Do you use tobacco?		**Y / N # _____**

Recreational Drugs? **Y / N**