



GREENHOUSE

NATUROPATHIC MEDICINE

Adult Intake Form

This is a confidential record of your medical history. It will not be released except with your authorization. Please complete this questionnaire as thoroughly as possible. Mark anything you do not understand with a question mark.

If mailing please return to **P.O. Box 985, Hollis, New Hampshire 03049**

Date _____ Social Security Number _____

Name _____
Last First MI

Address _____ Date of Birth _____
_____ Age _____

Phone _____ it's ok to leave message about my care

Email _____ Occupation _____

Employment Status:

Please circle: Married Divorced Single Widowed Significant Partnership

Emergency Contact Person _____ Relation _____

Address _____ Phone _____

How did you hear about us?

Referral/Friend Yellow pages Lecture Walk or Drive-by Article Internet

If a personal referral who can we thank?

Would you like to receive our quarterly newsletter by email? Y N

What are your main health concerns?

1. _____
2. _____
3. _____
4. _____

OPINIONS ABOUT YOUR HEALTH

How does your condition affect you?

What do you think is happening; why do you think you have this condition?

What do you feel needs to happen for you to get better?

How much change are you willing to make at this time for improving your health?

circle one: MINIMAL SOME COMPLETE

MEDICATIONS & ALLERGIES

Any allergies to medication, food or environmental influences: (Please specify reaction)

List all the **medications** that you are currently taking, including dosages:

List all **vitamins, minerals, herbs, homeopathic remedies and nutritional supplements** you are currently taking:

PERSONAL HABITS

Do you eat three meals per day?	Y	N		
Do you wake feeling rested?	Y	N		
Do you have a supportive relationship?	Y	N		
Have you had any major traumas?	Y	N		
Do you have a history of abuse?	Y	N	(physical, emotional or sexual)	
Do you drink coffee?	Y	N		
Do you drink sodas or energy drinks?	Y	N		
Do you consume alcohol?	Y	N		
Number of drinks per day/week/month _____				
Do you smoke?	Y	N	Current or Past	Yr started _____ Yr stopped _____
Do you now or have you ever used recreational drugs?	Y	N		
Do you have a religious or spiritual practice?	Y	N		
Do you enjoy your job?	Y	N		

Sleep

Usual bedtime _____ Hours slept _____

Problems with falling asleep? Y N Waking up after your fall asleep? Y N Dreams and/or nightmares: Y N

Energy Level when waking up, throughout the day. (1 = low, 10 = high)

Exercise

How often do you exercise and what type of exercise?

Do you experience any symptoms during exercise (pain in any particular place in your body, shortness of breath, extreme fatigue beyond what is normal for the activity, heart palpitations, dizziness, abnormally high or low perspiration, etc.)?

Current Health Status and History

What is your blood type? _____
 Weight _____ Weight 1 year ago _____
 Maximum Weight _____ when?
 What do you think should be your desired weight _____ Height _____

*Please circle any of the following conditions/symptoms you have had, **Yes-I** have this now; **Never-I**'ve never had it; **Past-I**'ve had it in the past but not now.*

Head, Eyes, Ears, Nose & Throat

Headaches	Y N P	Migraines	Y N P
Lightheadedness	Y N P	Dizziness	Y N P
Bell's Palsy	Y N P	Head injury or trauma	Y N P
Concussion	Y N P	Jaw/TMJ problems	Y N P
Spots in eyes	Y N P	Impaired vision	Y N P
Blurriness	Y N P	Color blindness	Y N P
Double vision	Y N P	Eye pain	Y N P
Swollen eyes	Y N P	Eyestrain	Y N P
Cataracts	Y N P	Glasses/contacts	Y N P
Tearing or dryness	Y N P	Glaucoma	Y N P
Night blindness	Y N P	Circles under eyes	Y N P
Impaired hearing	Y N P	Deafness	Y N P
Earaches	Y N P	Itching in ears	Y N P
Ringing in ears	Y N P	Excessive ear wax	Y N P
Frequent ear infections	Y N P	Frequent colds	Y N P
Stuffiness	Y N P	Post nasal drips	Y N P
Loss of Smell	Y N P	Nose bleeds	Y N P
Polyps	Y N P	Frequent sore throat	Y N P
Sores in mouth	Y N P	Hoarseness	Y N P
Difficulty swallowing	Y N P	Loss of taste	Y N P
Teeth grinding	Y N P	Sore lips	Y N P
Enlarged lymph nodes	Y N P	Sore tongue	Y N P
Gum problems	Y N P	Dental problems	Y N P
Difficulty speaking	Y N P	Dental cavities	Y N P
Copious saliva	Y N P	Dry mouth	Y N P

Respiratory

Coughing	Y N P	Spitting up blood	Y N P
Wheezing	Y N P	Difficulty breathing	Y N P
Pain with breathing	Y N P		
Shortness of breath	Y N P	while lying down? at night?	
Sputum	Y N P	Bronchitis	Y N P
Pleurisy	Y N P	Emphysema	Y N P
Pneumonia	Y N P	Asthma	Y N P
Positive TB Test	Y N P		

Cardiovascular

Heart disease	Y N P	High/Low blood pressure	Y N P
Blood Clots	Y N P	Phlebitis	Y N P
Rheumatic Fever	Y N P	Swelling in ankles	Y N P
Bleeding/clotting disorder	Y N P	High cholesterol	Y N P
Atherosclerosis	Y N P	Angina	Y N P
Heart murmurs	Y N P	Fainting	Y N P
Palpitations	Y N P	Heart Flutters	Y N P
Chest Pain	Y N P	Stroke	Y N P
Heart attack	Y N P		

Circulation

Cold hands/feet	Y N P	Deep leg pain	Y N P
Easy bleeding/bruising	Y N P	Varicose veins	Y N P
Thrombophlebitis	Y N P		

Gastrointestinal

Trouble swallowing	Y N P	Jaundice	Y N P
Nausea	Y N P	Vomiting blood	Y N P
Blood in stool	Y N P	Abdominal pain/cramps	Y N P
Belching or passing gas	Y N P	Gallbladder disease	Y N P
Ulcers	Y N P	Liver disease	Y N P
Hepatitis	Y N P	Heartburn	Y N P
Acid Reflux	Y N P	Change in appetite	Y N P
Diarrhea	Y N P	Constipation	Y N P
Bloating	Y N P	Stomach pain	Y N P
Black Stools	Y N P	Diverticulitis/losis	Y N P
Crohn's disease	Y N P	Irritable Bowel Syndrome	Y N P
Hemorrhoids	Y N P	Change in thirst	Y N P
Colitis	Y N P	Hiatal Hernia	Y N P
Vomiting	Y N P	Other? _____	
Frequency of bowel movements (number per day)	_____		
Quality of stools (small and hard, loose, etc.)	_____		

Urinary

Pain during urination	Y N P	Frequency at night	Y N P
Bladder infections	Y N P	Unable to urinate	Y N P
Increased frequency	Y N P	Unable to hold urine	Y N P
Kidney stones	Y N P	Blood in urine	Y N P
Approximate number of times you urinate per day	_____		
Waking up at night to urinate:	Y N	Pain or other symptoms during urination, etc.	Y N

Skin

Rashes	Y N P	Hives	Y N P
Acne, boils	Y N P	Moles	Y N P
Lumps	Y N P	Ulceration	Y N P
Shingles	Y N P	High cholesterol	Y N P
Atherosclerosis	Y N P	Eczema	Y N P
Psoriasis	Y N P	Itching	Y N P
Dryness	Y N P	Perpetual hair loss	Y N P
Night sweats	Y N P	Sores	Y N P
Infections	Y N P	Change in hair/nails	Y N P

Neck

Pain or stiffness	Y N P	Swollen Glands	Y N P
Pinched nerve	Y N P	Lumps	Y N P
Herniated disk	Y N P		

Musculoskeletal

Joint pain or stiffness	Y N P	Muscle spasms	Y N P
Muscle weakness	Y N P	Arthritis	Y N P
Bursitis	Y N P	Osteoporosis	Y N P
Osteopenia	Y N P	Broken Bones	Y N P
Back Pain	Y N P	Herniated disk	Y N P
Back surgery	Y N P		

Neurological

Seizures	Y N P	Muscle weakness	Y N P
Loss of memory	Y N P	Vertigo	Y N P
Dizziness	Y N P	Trembling hands/feet	Y N P
Mood swings	Y N P	Epilepsy	Y N P
Paralysis	Y N P	Numbness or tingling	Y N P
Loss of balance	Y N P	Lightheaded	Y N P
Poor concentration	Y N P	Slurred speech	Y N P
Neuralgia	Y N P	Loss of coordination	Y N P
Easily stressed	Y N P		

Mental / Emotional

Excess Stress	Y N P	Anxiety	Y N P
Panic Attacks	Y N P	Depression	Y N P
Mood swings	Y N P	Memory loss	Y N P
Suicidal thoughts	Y N P	Treated for emotions	Y N P

Nervousness	Y N P	Seasonal depression	Y N P
Endocrine			
Hypothyroidism	Y N P	Hyperthyroidism	Y N P
Hypoglycemia	Y N P	Excessive thirst	Y N P
Unexplained weight loss	Y N P	Fatigue	Y N P
Hormonal problems	Y N P	Heat or cold intolerance	Y N P
Diabetes	Y N P	Excessive hunger	Y N P
Seasonal depression	Y N P	Easy weight gain	Y N P
Pituitary disorder	Y N P	Adrenal problem	Y N P
Immune			
Slow wound healing	Y N P	Chronic fatigue syndrome	Y N P
Chronic swollen glands	Y N P	Reaction to vaccinations	Y N P
Chronic infections	Y N P	Cancer	Y N P
Infectious Illnesses			
Scarlet Fever	Y N P	Diphtheria	Y N P
Rheumatic Fever	Y N P	Chicken Pox	Y N P
German Measles	Y N P	Mumps	Y N P
Measles	Y N P	Polio	Y N P
Meningitis	Y N P	Epstein-Barr	Y N P
Tick Bite	Y N P		