

# NATURAL MEDICINE CENTER OF LAKELAND

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315 Doris Drive  
Lakeland, Florida 33813

## Intake Form

Please answer the following questions to the best of your ability to enable a more complete assessment of your condition.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

*(circle one)*

Sex: M      F                      Marital Status: M      S      D      W

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Profession: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

How were you referred to Natural Medicine Center?

Friend: \_\_\_\_\_ Relative: \_\_\_\_\_ Seminar: \_\_\_\_\_ Internet: \_\_\_\_\_ Other: \_\_\_\_\_

### Physician:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

ILLNESS	FATHER	MOTHER	SIBLING(S)	SPOUSE	CHILDREN
Cancer					
Diabetes					
High Blood Pressure/Heart Disease					
Allergies (food, dust, etc.)					
Drug Abuse					
Mental Illness					
Other					

1. Please describe in detail the main problem(s) you would like to address. Include the onset, progression, and aggravating and alleviating factors. How does this condition effect your life? Please rank your problem on a scale of 1 to 10 where 1 is mild and 10 is severe):
  
2. On a scale of 1 to 10, how is your energy level (1 being the worst and 10 being the best)? Do you experience an energy slump at any particular time of day?
  
3. Urination: Do you experience any frequency, urgency, burning, dribbling? Do you notice any abnormal coloration? Do you have a history of urinary tract infections or other urinary dysfunction?
  
4. Bowel Movement: Are they regular, once a day, twice a day, every other day, etc? Do you ever experience diarrhea, constipation, alternation of the two, etc.? Any history of large intestine problems?
  
5. Do you experience any sensations of heat or cold? Do yo prefer warmth, lots of sweaters and blankets? Or are you comfortable wearing T-shirts during colder weather?

6. How is your appetite? Are you hungry only at mealtimes? Or, more or less often?
7. Do you have any abnormal thirst, dry mouth or throat?
8. Do you experience night sweats? Sweating upon slight exertion?
9. Please describe in general what you eat. Do you eat a lot of sweets or any other particular foods? Do you crave salty foods? Sweets?
10. Do you experience digestive difficulties? Do you experience any bloating, reflux, gas, ulcers?
11. Do you have any known heart problems? Do you experience heart palpitations or fluttering?
12. Do you have any respiratory problems such as asthma, etc.? Do you experience shortness of breath?
13. Do you have ringing in the ears, low or high-pitched? Stuffy sensation in the ears?
14. Do your eyes ever burn, itch or tear? Do they feel gritty or dry? Do you have floaters (spots) before your eyes?

15. Do you fall asleep easily or have initial insomnia? Do you wake up in the middle of the night and have difficulty falling asleep again? Do you wake up feeling rested? Do you have vivid dreams or nightmares? Do your dreams center around any particular themes and if so, what?

16. Do you have any propensity to catch colds or get sick frequently?

17. If you smoke, consume alcoholic or caffeinated beverages, and/or engage in any other recreational drugs, please describe frequency and amount.

18. Please list all herbs and supplements you are currently taking along with dosage.

19. Females:

When was the first day of your last period \_\_\_\_\_

Are your periods regular? Yes \_\_\_ No \_\_\_

Age first period? \_\_\_ #Days between periods? \_\_\_ # Days bleeding \_\_\_

Amount of bleeding: Light \_\_\_ Medium \_\_\_ Heavy \_\_\_

Have you ever needed medication to bring on your period? Yes \_\_\_ No \_\_\_

Pain with menstruation? Yes \_\_\_ No \_\_\_

Degree of pain: Mild \_\_\_ Moderate \_\_\_ Severe \_\_\_

Pain relieved by over the counter medication? Yes \_\_\_ No \_\_\_

Starts with the onset of bleeding? Yes \_\_\_ No \_\_\_

Begins a few days prior to the onset of bleeding? Yes \_\_\_ No \_\_\_

Persists more than 48 hours? Yes \_\_\_ No \_\_\_

Do you have pain with ovulations? Yes \_\_\_ No \_\_\_

Do you experience pain with sexual intercourse? Yes \_\_\_ No \_\_\_

Pain is mostly on the exterior? Yes \_\_\_ No \_\_\_

Pain is mostly internal (deep penetration)? Yes \_\_\_ No \_\_\_

Do you experience painful ovulation? Yes \_\_\_ No \_\_\_

Are you experiencing a vaginal discharge? Yes \_\_\_ No \_\_\_

Associated with itching or burning? Yes \_\_\_ No \_\_\_

Associated with an unusual odor? Yes \_\_\_ No \_\_\_

Do you have a Gynecologist? Yes \_\_\_ No \_\_\_

When was your last Pap Smear? \_\_\_\_\_

Result? \_\_\_\_\_

Have you ever had an abnormal Pap Smear? Yes \_\_\_ No \_\_\_

If yes, what follow up was needed? \_\_\_\_\_

Have you ever had a Mammogram? Yes \_\_\_ No \_\_\_

Have you ever had a sexually transmitted disease? Yes \_\_\_ No \_\_\_

Chlamydia, Gonorrhea, Syphilis, Herpes, Other \_\_\_\_\_

When? \_\_\_\_\_ Was it treated? Yes \_\_\_ No \_\_\_  
 Have you ever had Pelvic Inflammatory Disease (PID)? Yes \_\_\_ No \_\_\_  
 When? \_\_\_\_\_  
 Were you Hospitalized? Yes \_\_\_ No \_\_\_  
 Do you experience milk or discharge from your breasts? Yes \_\_\_ No \_\_\_  
 Have you ever used an IUD? Yes \_\_\_ No \_\_\_  
 Have you ever used the Oral Contraceptive Pill? Yes \_\_\_ No \_\_\_  
 How many years? \_\_\_\_\_  
 When did you last use it? \_\_\_\_\_  
 Number of inseminations \_\_\_\_\_  
 Dates \_\_\_\_\_  
 Number of IVF \_\_\_\_\_  
 Dates \_\_\_\_\_  
 Next procedure scheduled \_\_\_\_\_

**PREVIOUS SURGERIES**

Have you ever had surgery?

PROCEDURE	DATE	INDICATION	OUTCOME

Are you currently pregnant: Yes \_\_\_ No \_\_\_ Don't Know (maybe) \_\_\_

**OBSTETRICAL HISTORY**

How long have you been trying to have a baby? \_\_\_\_\_ years

Have you ever been pregnant before? Yes \_\_\_ No \_\_\_

Date	Current/ Prior Partner	Live Birth (Y/N)	Miscarriage Abortion/ Ectopic	Wks	Fetal Heart (Y/N)	D&C (Y/N)	Mode of Delivery	Sex	Wt.	Complications/ Comments

**MEDICAL CONDITIONS**

Do you have a history of any of the following conditions?

<b>Condition</b>	<b>Yes/No</b>	<b>Comments</b>
German measles (Rubella)	Yes No	
Migraine	Yes No	
Prolonged dizziness	Yes No	
Glasses / contact lenses	Yes No	
Thyroid problems	Yes No	
Pneumonia	Yes No	
Tuberculosis	Yes No	
Asthma	Yes No	
Bronchitis	Yes No	
Other lung conditions	Yes No	
Heart attack	Yes No	
Heart murmur	Yes No	
Rheumatic fever	Yes No	
Other heart conditions	Yes No	
High blood pressure	Yes No	
Gastric/duodenal ulcer	Yes No	
Hepatitis	Yes No	
Cirrhosis	Yes No	
Intestinal bleeding	Yes No	
Bleeding tendency	Yes No	
Problems with anesthesia	Yes No	
Diabetes	Yes No	
Kidney stones	Yes No	
Kidney infection	Yes No	
Other kidney disorder	Yes No	
Bladder infection	Yes No	
Rheumatoid arthritis	Yes No	
Other forms of arthritis	Yes No	
Lupus erythematosus	Yes No	
Paralysis	Yes No	
Neurologic disorders	Yes No	
Thrombophlebitis	Yes No	
Varicose veins	Yes No	
Breast tumor (benign)	Yes No	
Breast Cancer	Yes No	
Ovarian cancer	Yes No	
Uterine cancer	Yes No	
Other	Yes No	

**DRUG ALLERGIES**

Are you allergic to any medications that you know of? Yes \_\_\_\_\_ No \_\_\_\_\_

<b>Medication</b>	<b>Reaction</b>

## **CURRENT MEDICATIONS**

Are you currently taking any medications? Yes \_\_\_\_\_ No \_\_\_\_\_

Medication	Dose	Frequency

## **FAMILY HISTORY**

Is there a history of any of the following conditions in the family?

Condition	Yes/No	Comments
Diabetes	Yes No	
Heart Disease	Yes No	
High Blood Pressure	Yes No	
Kidney Disease	Yes No	
Multiple Births	Yes No	
Mental Retardation	Yes No	
Birth Defects	Yes No	
Inherited Diseases	Yes No	
Rheumatoid Arthritis	Yes No	
Thyroid Disease	Yes No	
Lupus Erythematosis	Yes No	
Blood Disorders	Yes No	
Breast Cancer	Yes No	
Ovarian Cancer	Yes No	
Uterine Cancer	Yes No	
Other Cancer	Yes No	
Sickle Cell Disease	Yes No	
Cystic Fibrosis	Yes No	
Tay Sachs	Yes No	
Thalassemia	Yes No	
Other	Yes No	