SONORAN NATUROPATHIC CENTER

9316 E. Raintree Dr. Suite #140
Scottsdale, AZ 85260
T: 480-614-2322
F: 480-614-2522

NEW PATIENT INTAKE

Name: _____

Date of Birth: _____ **Age** _____ **Gender** _____

Street Address _____

City_____ **State**_____ **Zip Code**_____

Phone: (Home) _____ (Cell) _____ (Work) _____

HIPPA compliance does not allow for email communication involving personal/identifying information, medical records, health information, or treatment recommendations. In order to communicate with your Provider via email and see medical documents such as lab results and treatment protocols, you will need to enroll in our Patient Portal. Please provide the email that you would like to use for the registration of your portal.
E-mail Address _____
(PLEASE NOTE, you cannot change the email once it has been registered)

Sonoran Naturopathic Center may use this email for appointment reminders and other communication not involving personal/medical information

YES_____**NO**_____

Social Security Number (used for insurance purposes) _____

Pharmacy: _____**Phone:**_____

How did you hear about us? * (If someone referred you here, please name them so that we may thank that person)

* **Friend Referral** (Please let us know who referred you to our office.)

_____

* **Social Media** (Please indicate which version you used to find out about our office)

❑ Facebook ❑ Twitter ❑ Youtube ❑ Other (If other please specify below)

_____

Name:_____ Date:_____

EMERGENCY CONTACT:

Name _____ **Phone** _____

Relationship to you _____

What are your main health concerns? (Please list your concerns in their order of importance to you. Give a brief history of when it started, other treatments or doctors/practitioners you have seen, etc.)

1. _____
   _____
   _____

2. _____
   _____
   _____

3. _____
   _____
   _____

4. _____
   _____
   _____

5. _____
   _____
   _____

PAST MEDICAL HISTORY:

- Significant previous Diagnoses or Illnesses:

- Major accidents or traumas:

- Hospitalizations/Surgeries: (Please list the date & the nature of the visit or procedure)

Family History (Please indicate if the following family members are alive or deceased – list their age, health concerns and/or cause of death)

- Mother:
    - Maternal Grandmother
    - Maternal Grandfather
- Father:
    - Paternal Grandmother
    - Paternal Grandfather
- Siblings:

- Children:

Medications/Supplements: (Please Include Dosage & Brand Name, if known)

- Medications (Including Prescription and Over-the-Counter)

- Supplements

Allergies: (Include Food and/or Drug Allergies – please also describe the type of reaction you have had)

Social/Lifestyle History:

- **Occupation:**

- **Sleep:**
  - Hours Per Night:
  - Quality of Sleep:
  - Wake feeling rested?

- **Energy Level:**
  - Scale of 1-10 (10 being the most energy)

- **Living Situation:**
  - Marital Status

- **Alcohol Consumption:**
  - Number of Drinks per week:

- **Cigarette Smoking:** (past or present)
  - Amount (packs per day):
  - Duration (in years):

- **Recreational Drug Use:** (past or present)
  - Type
  - Duration and Frequency

- **Exercise:**
  - Type
  - Duration & Frequency
  - Restrictions (any type of activity or exercise you are unable to do)

- **Stress Level:**
  - Current level of Satisfaction/Happiness with your life?

- **Typical Diet:**
  - Breakfast:
  - Lunch:
  - Dinner:
  - Snacks:

- **Beverages:** (please specify amounts and types of the following)
  - Caffeine:
  - Water:
  - Juice/Soda, etc:

ENVIRONMENTAL HISTORY

Please check the boxes below if you have current or past exposure to any of the following:

❑ Dental Amalgams (silver) ❑ Commercial hair coloring ❑ Home Fragrances (i.e. Sented Candles)

❑ Perfumes/Colognes ❑ Scented Lotions ❑ Commercial Dry Cleaning

❑ Nail or Hair Salons

Do you consume any of the following? If so, how often?

❑ Raw Fish/Sushi ❑ Farm Raised Fish ❑ Beef/ Red Meat

❑ Tuna ❑ Shellfish

Home/Office Environment

❑ New Paint ❑ New Carpeting

❑ New Furniture ❑ Home or office built before 1978

❑ Composite/Synthetic Wood Furniture

Do you use any of the following?

❑ Shower Filters ❑ Home Water Filtration ❑ HEPA Air Filters

❑ Bottled Water ❑ Non-toxic Hair and Body Care ❑ Organic Fruits and Vegetables

❑ Organic Dairy Products ❑ Organic Meats

What city and town were you born in?

How long did you live there?

Have you ever had a job where you had known and/or documented chemical exposure?

Have you had any reactions or known sensitivities to chemicals?

Have you lived near any industrial plants or factories? If so, what type of industry and how long did you live there?

Have you ever been tested for heavy metals, solvents, or other environmental medicine panels? If so, were there any significant findings?

REVIEW OF SYSTEMS:

(Please review the following list and check the box to indicate if you currently experience or have previously experienced any of the following symptoms. Use the space in the right column to elaborate, if necessary)

(Check positive findings and chart to right)	Details/Specifics
General: ❑ Hot ❑ Cold ❑ Chills ❑ Fever ❑ Sweats ❑ Night sweats ❑ Weight loss ❑ Weight gain ❑ Fatigue ❑ Restless legs ❑ Snoring ❑ Difficulty staying awake ❑ Difficulty falling asleep ❑ Difficulty staying asleep **Current Weight**:_____ **Weight One year ago**:_____ **Ideal Weight:** _____	
Skin, Hair, Nails: ❑ Dry Skin ❑ Frequent or Easy Bruising ❑ Rashes ❑ Hair Loss or Thinning Hair ❑ Fungal Infections of the skin or nails ❑ Eczema ❑ Poor Wound Healing ❑ Psoriasis ❑ Itching ❑ Jaundice ❑ Breaking Nails **Any abnormal skin lesions?** _____ **Do you see a dermatologist regularly?** _____ **Most recent Dermatological Exam:** _____	
HEENT: **Head:** ❑ Headache ❑ History of head injury ❑ Migraines **Eyes**: ❑ Double vision ❑ Blurred Vision ❑ Cataracts ❑ Vision changes ❑ Pain ❑ Redness ❑ Itching	

Most recent visit to eye doctor?

Wear glasses or contacts?

Ears:

- ❑ Discharge
- ❑ Hearing changes
- ❑ Ringing in the ears
- ❑ Pain
- ❑ Dizziness

Nose:

- ❑ Sinusitis
- ❑ Decreased smell
- ❑ Discharge/mucus
- ❑ Nose bleeds
- ❑ Congestion
- ❑ Seasonal allergies

Mouth/Throat:

- ❑ Canker sores
- ❑ Sore throats
- ❑ Persistent hoarseness
- ❑ Difficulty swallowing
- ❑ Toothache
- ❑ Bleeding gums
- ❑ Gingivitis

Most recent dental visit?

Any fillings or dentures?

NECK:

- ❑ Injuries
- ❑ Masses
- ❑ Pain
- ❑ Stiffness

CHEST:

- ❑ Asthma
- ❑ Bronchitis
- ❑ COPD
- ❑ Chronic cough
- ❑ Coughing up blood
- ❑ Shortness of breath
- ❑ Sleep apnea
- ❑ Pain
- ❑ Wheezing
- ❑ Pneumonia

CARDIOVASCULAR:

- ❑ Palpitations
- ❑ Murmurs
- ❑ Arrhythmias
- ❑ Chest pain/Angina
- ❑ Congestive Heart Failure
- ❑ Claudication (pain in the legs with exercise)
- ❑ Heart Attack
- ❑ Coronary Artery Disease
- ❑ Cyanosis (blue hands or feet)

❑ Dizziness
❑ Shortness of Breath with exercise
❑ High Blood Pressure
❑ Difficulty Breathing while lying flat
❑ Phlebitis
❑ Varicose Veins
❑ Stroke or TIA

GASTROINTESTINAL:

❑ Constipation ❑ Diarrhea
❑ Blood in the stool ❑ Gallbladder problems
❑ Nausea ❑ Vomiting
❑ Gas or Bloating ❑ Hemorrhoids
❑ Undigested food or mucus in the stool
❑ Indigestion ❑ Belching
❑ Acid Reflux ❑ Ulcers
❑ Abdominal Pain or Cramping
❑ Irritable Bowel Syndrome

Bowel Movement frequency?

Do you have to strain or do you experience any pain with passing stool?

Most Recent Colonoscopy:

GENITOURINARY:

❑ Pain with Urination ❑ Blood in the urine
❑ Frequent Urination ❑ Discharge
❑ Waking frequently at night to urinate
❑ Change in frequency
❑ Difficulty initiating stream
❑ Decreased force of urine stream
❑ Incontinence
❑ Chronic or Frequent UTI's
❑ Kidney Stones ❑ Interstitial Cystitis

SEXUAL HEALTH

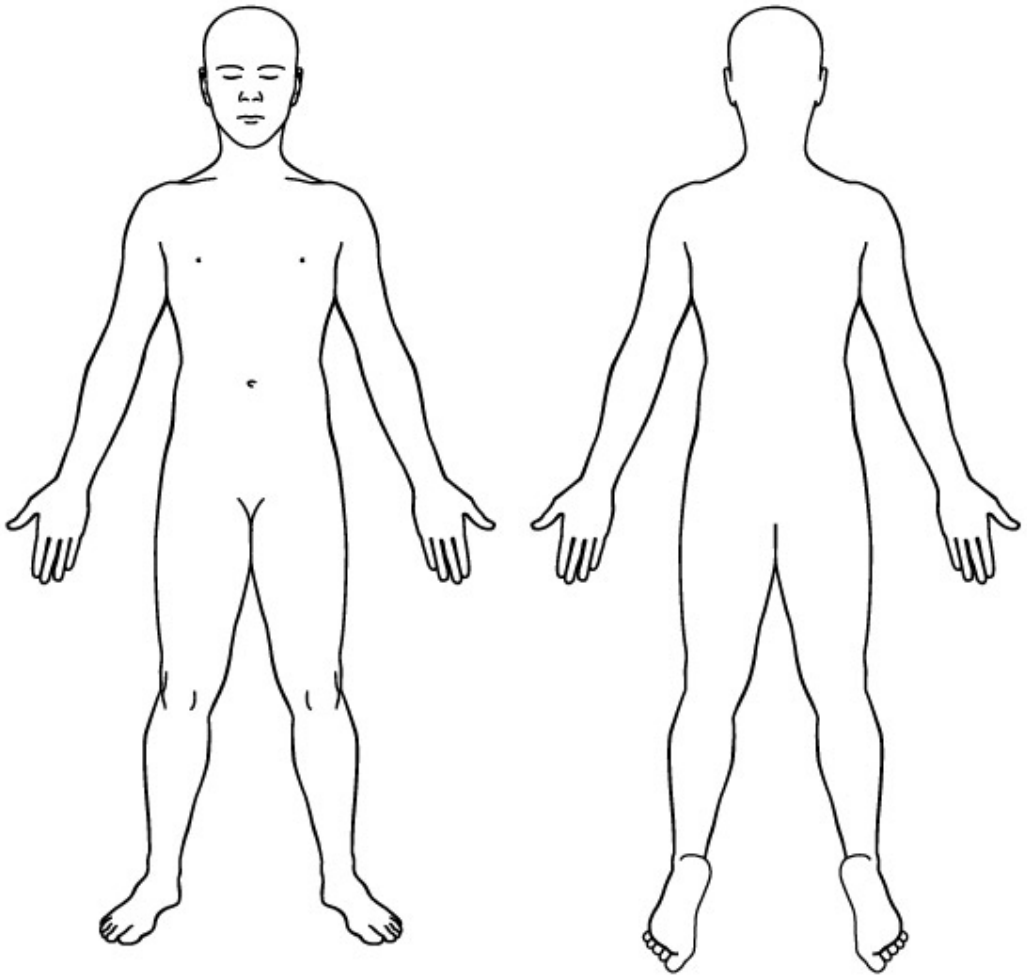
❑ Genital Pain ❑ Itching
❑ Pain During Intercourse
❑ Discharge ❑ Decreased Libido
❑ Difficulty with arousal
❑ Inability to achieve orgasm

Have you ever been diagnosed or treated for an

STD? (please specify when & which STD) Number of sexual partners in the past year: Most recent testing for STD's Method of Contraception:	
BREASTS: ❑ Discharge ❑ Enlargement ❑ Pain ❑ Tenderness ❑ Prior surgery or biopsy **Most Recent Mammogram:**	
FEMALE/GYN: • **Number of Pregnancies:** • **Number of Live Births:** • **Abortions or Miscarriages:** • **Date of Last Menstrual Period**: • **Length of Cycle:** ❑ Discharge ❑ Short ❑ Long ❑ Irregular ❑ Regular ❑ Clots ❑ Painful ❑ Discharge ☐ Foul Odor • **PMS Symptoms:** • **Menses started at age:** • **Menses stopped at age:** • **Last Pap Smear:** • **History of Abnormal Paps?** **Gynelocial Surgeries or Procedures (date & type)**	
MALE: ❑ Prostatitis ❑ Lesions ❑ Benign Prostatic Hypertrophy ❑ Erectile Dysfunction ❑ Testicular Trauma	
NEUROMUSCULAR:	

❑ Numbness ❑ Tingling ❑ Joint Pain ❑ Arthritis ❑ Joint Swelling ❑ Muscle Pain ❑ Syncope (fainting) ❑ Vertigo ❑ Weakness ❑ Tremors ❑ Poor Balance ❑ Loss of Consciousness	
ENDOCRINE: ❑ Heat intolerance ❑ Cold intolerance ❑ Increased Thirst ❑ Increased Appetite ❑ Anemia ❑ Excessive bruising ❑ Easy bleeding ❑ Diabetes ❑ Thyroid Problems ❑ Fatigue	
MENTAL/EMOTIONAL: ❑ Depression ❑ Anxiety ❑ Panic Attacks ❑ Bipolar Disorder ❑ Phobias ❑ Anger/Rage ❑ PTSD ❑ Schizophrenia ❑ Poor Memory ❑ Brain Fog ❑ Behavioral or Conduct Disorders ❑ ADHD/ADD Have you ever had suicidal thoughts or attempted suicide? Were you ever emotionally or physically abused? Have you ever been hospitalized for Psychiatric Reasons?	

Please circle, highlight, or indicate any areas of pain, numbness, tingling, or other concerns. Be as specific and descriptive as possible.



Better with: (check all that apply)

❑ Hot ❑ Cold ❑ Motion ❑ Rest ❑ Pressure ❑ No pressure

Anything else make it feel better?

- Severity _____
  - (on a scale of 1-10, 10 being the worst pain you've ever experienced)
- Worst Time of Day:
  ❑ Mornings ❑ Evenings ❑ Afternoons ❑ Night-time
- Are these Symptoms:
  ❑ Constant ❑ Random ❑ Increasing in Severity
- Any known triggers?