**Patient Intake Form Holistic Healing Naturopathic**

Name:

Date of Birth:

Phone Number:

Home Address:

Please answer below--how did you hear about *Holistic Healing Naturopathic*?

If through internet search please mention search terms

Please complete and email this form to dr.tim@drsalotto.com a minimum of 48 hours prior to initial visit to ensure information has been received and reviewed in time.

**Reminder to please bring all relevant lab work and imaging or ensure digital access**

**Important**

List any **allergies** to -**medications-** OR **-foods-** that you have or feel you may have below, if none please write “none”**:**

-List all medications & supplements you are currently taking in the table below-

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| --- | --- | --- |
| Name of Supplement or Medication |  Amount |  Frequency (times per day) |
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-Chief Complaints-

Please list all health conditions and/or concerns you would like to address in order of priority

Be aware that there may only be time to fully address 2 to 3 within the first visit:

What are your expectations, if any, for your first visit?

For **each** condition/concern, please answer the following:

When did you first notice the signs and/or symptom(s) of this concern? Was there any initiating event associated with its onset or significant and/or stressful life events at the time?

If you have any pain(s) associated with any of your conditions, how would you describe it? (sharp, dull, burning, throbbing, radiating, etc., or any combination)

Do your symptoms appear to be specific to any location?

Do you experience symptoms elsewhere in the body that occur at the same time or began at the same time?

How often do you experience symptoms?

Are there any particular circumstances or settings that appear to trigger or worsen symptoms?

Please rate the severity of your symptoms on a 1-10 scale with 10 being the worst. (May not apply to all problems)

What have you or your doctor(s) used to treat this condition? Was anything helpful? Hurtful? If so, please describe below:

Have you had this problem in the past? (I.e. it resolved previously or appeared to, but has since returned) If so, did anything seem to help before?

-Past Medical History-

Have you been taking any medications for a period of longer than two months?

Did you begin any medications shortly (days to weeks) before current symptoms began?

When was your last annual blood work?

Any history of major surgeries, silver/amalgam fillings, or root canals?

Have you ever done any designated detoxification programs or juice fasting in the past?

-Social History-

Do you currently smoke cigarettes or do you have a history of smoking? If so, for how long and how many packs per day?

Are you currently employed? If so, what is your occupation?

Have you worked in any settings previously where you may have been exposed to chemicals by skin or by inhalation for a period of days, weeks, or years? If yes, please explain below

-Family History-

Is there a family history of any of your chief complaints or similar symptoms to what you are experiencing that you are aware of? If so, please include the condition or symptoms and family member in relation to you.

Any family history of autoimmune disorders, fibromyalgia, gluten sensitivity, or chronic fatigue syndrome? If so, please list the relative(s) and condition(s)

-Diet and Beverage Consumption-

Please describe what you eat on a typical day:

Breakfast:

Lunch:

Dinner:

Snacks:

Please include typical daily beverage consumption **and amounts** for both a typical weekday and a typical weekend (includes water, juices, alcohol, etc.). If you do not know the amount, please estimate to the best of your ability.

Weekday –

Weekend –

-Exercise-

Do you exercise currently? If so, what kind of exercise, how long, and how many times per week on average?

-Systems Review-

For this section there is no need to repeat anything you have already described above.

If you do experience any of the following, please describe severity, frequency, and when symptoms began.

Recent or constant fever, fatigue, large daily fluctuations in energy, or night sweats?

Unintended weight gain/loss? If there has been weight loss, how much over how long of a period of time?

Frequent or constant feelings of being too hot or too cold?

Sudden changes in vision, difficulty seeing at night, double vision, or visual floaters?

Recent or constant runny or stuffy nose, congestion, or sore throat?

Recent or constant cough, difficulty breathing, shortness of breath, or coughing up blood?

Heart palpitations, skipped beats, or chest pain?

Upset stomach or stomach pains, gas, bloating, diarrhea, constipation, abnormally colored or bloody stools, nausea, vomiting, food avoidance?

How many bowel movements do you have per day, on average?

Red, orange, or brown colored urine, frequent urination, painful urination, urinary discharge, or difficulty urinating?

Easy bruising or poor/slow clotting/healing?

Muscle or joint pain, or recent injuries/physical trauma?

Frequent or occasional numbness, tingling, tremors, dropping things, headache or migraine, or difficulty balancing?

Anxiety or depression (if present, is this something you would like help with?)

Mood swings, trouble remembering things or difficulty concentrating?

Recent or sudden itching, rashes, changes in skin coloration, or odd skin patches?

Trouble sleeping or snoring that you are aware of, or according to a partner?

On average how many hours of sleep do you get per night, and do you feel this is enough sleep for you to feel well rested?

Please rate your average daily energy level from 1 to 10 here:

1= barely having the energy to get out of bed

5= feeling fatigued somewhat often or on most days of the week, but still capable of getting through the day

10= having as much energy as you could ask for or would want

**Please only answer the remaining questions if you intend to address any potential hormone-related women’s health concerns**

(includes Fibrocystic breasts, PMDD/PMS, Uterine fibroids, acne, infertility, PCOS, endometriosis, menstrual irregularities, early menopause, etc.)

If you experience any of the following, please describe severity, frequency, and when symptoms began

Persistently decreased sex drive

Bloating (water retention)

Breast swelling and tenderness

Fibrocystic breasts

Headaches (especially premenstrually)

Mood swings

Weight and/or fat gain (particularly around the abdomen and hips)

Cold hands and feet (a symptom of thyroid dysfunction)

Hair loss

Thyroid dysfunction

Sluggish metabolism

Foggy thinking, memory loss

History of PMDD/PMS

History of heavy menstrual flow or passing clots (heavy is defined as enough blood to soak a pad or tampon every hour for several consecutive hours)

History of irregular menstrual cycles? (shorter than 21 days or longer than 35 from the start of one menstrual cycle to the next, or a period lasting longer than 7 days)

Thank you greatly for taking the time to fill out this form. I look forward to seeing you soon and will do my best to get you feeling better as soon as possible!

-In health, Dr. Salotto