Avena Naturopathic Center for Well-being, LLC
304 Delaware St.
Kansas City, MO 64106
816-471-7227

Patient Intake Form

Patient Name:_____ Date:_____Date of Birth:_____
Street Address:_____
City:_____ State:_____ Zip:_____
Home phone: _____Work Phone:_____Cell Phone:_____
Highest level of education:_____
Occupation:_____Employer_____Hours work per week:_____
Marital Status (circle):Single Married Separated Divorced With Partner Widow(er)
Insurance Company:_____Policy:_____Group #:_____
Name of Insured_____Relation to Insured_____
Social Security Number:_____
Person to call in case of Emergency:_____Relationship to you:_____
Phone number contact for them:_____
Regular Physician: _____ **E-mail_____**
How did you hear of the clinic:_____

List in Order of Importance what your problems are:
1.
2.
3.
4.
5.
Last time you had blood work done and with what doctor:_____

Family history

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	_____	____	_____	_____	_____	_____
Age when died	_____	____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer (type)	Y N	Y N	Y N	Y N	Y N	Y N
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-immune disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries and Hospitalizations—including date occurred:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please Note When and Why You Had Each of The Following:

X-rays: _____
MRI/Cat Scans:_____
Ultrasounds:_____
Accidents:_____

Please List All Sensitivities/Allergies/Reactions

Drugs: _____
Foods: _____
Environment: _____

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	D I N	Diptheria:	D I N
Mumps:	D I N	Tetanus:	D I N
Rubella:	D I N	Whooping Cough:	D I N
Chickenpox:	D I N	Hemophilus (Hib):	D I N
German Measles:	D I N	Hepatitis B:	D I N

Any vaccination reactions:_____

List Yes, No, or Past regarding use of the following:

Antacids:	Y N P	Steroids:	Y N P
Smoking:	Y N P	Packs per day if Yes/Past:	_____
Analgesics:	Y N P	Laxatives:	Y N P
Coffee:	Y N P	Cups per day if Yes/Past:	_____
Soda Pop:	Y N P	Ounces per day if Yes/Past:	_____
Alcohol:	Y N P	How often and how much if Yes/Past:	_____

Any alcohol addiction: Y N P
Any alcohol treatment: Y N P
Recreational drugs: Y N P
Any drugs addiction: Y N P
Any drug treatment: Y N P

List all Prescription Medicines and Nutrient Supplement/Herbs Taking:

_____
_____
_____
_____
_____
_____

Review Of Systems:

Present Weight:_____ Weight one year ago: _____
Height: _____ Maximum weight and when:_____
Minimum Weight as adult and when: _____
Ideal Weight:_____

REGARDING THE NEXT LONG SECTION: Please Circle Y if you have the problem **NOW**, **N** if you've **NEVER** had the problem, **P** if you had the problem in the **PAST**.

Good Energy: Y N P
Fatigue: Y N P
If you have fatigue, when in morning, afternoon, evening is it the worst?:_____
If you have fatigue, can you do what you need to during the day?: Y N

Skin:

Rash:	Y N P	Color Change:	Y N P
Hives:	Y N P	Lump:	Y N P
Psoriasis/eczema:	Y N P	Itchy:	Y N P
Dry:	Y N P	Warts/moles:	Y N P
Cancer:	Y N P	Perspiration:	Y N P

Head:

Headache:	Y N P	Migraine:	Y N P
Dandruff:	Y N P	Head Injury:	Y N P
Oil/dry hair:	Y N P	Hair loss:	Y N P

Eyes:

Dry/Watery:	Y N P	Blurry vision:	Y N P
Double vision:	Y N P	Cataracts:	Y N P
Glaucoma:	Y N P	Styes:	Y N P
Strain:	Y N P	Discharge:	Y N P
Itchy:	Y N P	Dark under eyelid:	Y N P

Nose:

Frequent colds:	Y N P	Nosebleeds:	Y N P
Congestion:	Y N P	Post nasal drip:	Y N P
Polyps:	Y N P	Seasonal allergies:	Y N P

Mouth/Throat:

Canker sores:	Y N P	Cold sores:	Y N P
Sore throat:	Y N P	Gum disease:	Y N P
Dentures:	Y N P	Cavities:	Y N P
Loss of taste:	Y N P	Hoarseness:	Y N P

Neck:

Stiffness:	Y N P	Swollen glands:	Y N P
Full movement:	Y N P	Tension:	Y N P

Respiratory:

Cough:	Y N P	TB:	Y N P
Shortness of breath with exertion:	Y N P	Bronchitis:	Y N P
Shortness of breath sitting:	Y N P	Pneumonia:	Y N P
Shortness of breath lying down:	Y N P	Asthma:	Y N P
Wheezing:	Y N P	Painful breathing:	Y N P

Cardiovascular:

High blood pressure:	Y N P	Rheumatic Fever:	Y N P
Low blood pressure:	Y N P	Murmurs:	Y N P
Arrhythmias:	Y N P	Palpitations:	Y N P
Edema:	Y N P	Chest pain:	Y N P

Gastrointestinal:

Heartburn:	Y N P	Bowel movement frequency:_____	
Indigestion:	Y N P	Recent change in BM:	Y N P
Bloating:	Y N P	Diarrhea or constipation:	Y N P
Nausea:	Y N P	Hemorrhoids:	Y N P
Vomiting:	Y N P	Gall bladder disease:	Y N P
Change in Appetite:	Y N P	Liver disease:	Y N P
Pancreatitis:	Y N P	Ulcer:	Y N P

Urinary Tract:

Incontinence:	Y N P	Pain with urination:	Y N P
Frequent infections:	Y N P	Kidney stones:	Y N P
Urgency:	Y N P	Discharge/blood:	Y N P

Male Genitalia:

Testicular pain/swelling:	Y N P	Sexually active:	Y N P
Hernia:	Y N P	Sexually transmitted disease:	Y N P
Discharge:	Y N P	Prostate disease/symptoms:	Y N P
Impotency:	Y N P	Sexual orientation:	Hetero Homo Bi

Female Genitalia:

Age periods began:_____
How long periods last: _____
Periods:
Heavy Bleeding: Y N P
Cramping: Y N P
Pain: Y N P
PMS: Y N P
Food Cravings: Y N P
Last Pap Smear:_____
Diagnosis: _____
Any abnormal paps: Y N P
When was abnormal: Y N P

How often periods occur:_____
Menopausal since what age:_____
Times Pregnant:_____
How many births:_____
Miscarriages:_____
Abortions:_____
Sexual Active: Y N P
Healthy Libido: Y N P
Pain With Intercourse: Y N P
Dry Vagina: Y N P
Vaginitis: Y N P

Any Birth Control (please list types and ages used):_____
Sexually Transmitted Diseases: Y N P
Mammography: Y N P
Dexa Scan: Y N P If Yes, what were the results:_____
Use of Hormones: Y N P

Musculoskeletal:

Weakness: Y N P
Stiffness: Y N P
Tremors: Y N P

Arthritis: Y N P
Leg cramps: Y N P
Pain: Y N P

Nervous:

Paralysis: Y N P
Tingling/numbness: Y N P
Seizures: Y N P

Sciatica: Y N P
Carpal tunnel syndrome: Y N P
Fainting: Y N P

Mental/Emotional:

Depression: Y N P
Suicidal: Y N P
Anxiety: Y N P

Anger/irritability: Y N P
High-strung/tense: Y N P
Fear/Panic: Y N P

Exercise:

How often:_____
What type(s):_____
For How long:_____

Hobbies:

_____

_____

Sleep:

How long per night: _____

If you wake up frequently, what is the reason: _____

Nightmares: Y N P

Wake refreshed:Y N P

Must Nap during the day: Y N P

Sleep walk: Y N P

Grind Teeth: Y N P

Snore: Y N P

Food:

Appetite Good?: Y N P

Foods crave: _____

Foods Dislike: _____

Foods that don't sit well:_____

Blood Type: _____

Toxin Exposure:

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:_____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:_____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?:_____

Are you particularly sensitive to perfumes, gasoline, or other vapors?:_____

Do you use pesticides, herbicides, other chemicals around your home?_____

_____

Social Life:

Enjoy job?: Y N P

Active Spiritual practice: Y N P

Quality of most significant relationship?_____

History of sexual, mental/emotional, physical abuse?: Y N

What is your greatest health concern?_____

How does it limit you the most? _____

How committed are you towards making valuable changes: Little Moderately Very