Inland Naturopathic
WELLNESS CENTER
Regenerate Optimize Heal

Adult Intake Form

Last Name: _____ **First Name:** _____ **Age:** _____
DOB:_____
Date: _____

Describe the Reason(s) for Your Visit: _____
_____

What is Your Greatest Health Concern?_____
How Does It Limit You the Most? _____
How Committed Are You Towards Making Valuable Changes:
☐ Little ☐ Moderately ☐ Very

MEDICAL HISTORY:
List Your Medical Diagnoses:
1) _____
2) _____
3) _____
4) _____
5) _____
Last Time You Had Blood Work Done and With What Doctor: _____

List All Surgeries, Hospitalizations & Traumas — Including Date Occurred:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

When and What Were the Results of the Following:
Electrocardiogram (ECG): _____
Echocardiogram: _____
Colonoscopy: _____
Mammogram: _____

Please List All Sensitivities/Allergies/Reactions:
Drugs: _____
Foods: _____
Environment: _____

***Please Check ALL that Apply**: **LEAVE BLANK** if you've never had the disease.*
***Check DISEASE** if you had the **DISEASE. Check IMMUNIZED** if **IMMUNIZED** with vaccinations.*

CONDITION	DISEASE	IMMUNIZED
COVID-19	☐	☐
Measles	☐	☐
Mumps	☐	☐

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CONDITION	DISEASE	IMMUNIZED
Rubella	☐	☐
Chickenpox	☐	☐
German measles	☐	☐
Influenza	☐	☐
Diptheria	☐	☐
Tetanus	☐	☐
Whooping Cough	☐	☐
Hemophylis (Hib)	☐	☐
Hepatits B	☐	☐
Penumonia	☐	☐

Any Vaccination Reactions?:

_____

SUBSTANCES:

Mark ALL that Apply*: LEAVE BLANK if you've never had the symptom.*
Check C *if you* ***CURRENTLY*** *use the following substances.* ***Check P*** *if you have in the* ***PAST.***

SUBSTANCE	***C***	***P***
Antacids:	☐	☐
Steroids:	☐	☐
Analgesics:	☐	☐
Laxatives:	☐	☐
Coffee:	☐	☐
Cups per day:	_____	
Soda:	☐	☐
Ounces per day:	_____	
Energy drinks:	☐	☐
Tobacco:	☐	☐
Packs per day:	_____	

SUBSTANCE	***C***	***P***
E-cigarette:	☐	☐
Marijuana/CBD:	☐	☐
Recreational drugs:	☐	☐
Drug addiction:	☐	☐
Recreational drug treatment:	☐	☐
Type of drugs:		
_____		
Alcohol:	☐	☐
How much per day:	_____	
Alcohol addiction:	☐	☐
Alcohol treatment:	☐	☐

List all CURRENT Prescription Medicines, Supplements, & Herbs You Take:

Name of Supplement/Medication	Dosage	Reason(s) for Taking Supplement/Medication	Does It Help? (Yes or No)

HEALTH HABITS

EXERCISE:

How often?:_____ What type(s)?:_____

How long?:_____

HOBBIES: _____

SLEEP:

How long per night (hours): _____ Work: ☐ Day Shift OR ☐ Night Shift

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

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***Mark ALL that Apply**: LEAVE BLANK if you've never had the symptom.*

SLEEP	***C***	***P***	***SLEEP***	***C***	***P***
Trouble falling asleep:	☐	☐	Have you had a sleep study:	☐	☐
Trouble staying asleep:	☐	☐	Tired/Fatigued/Sleepy		
Wake unrefreshed:	☐	☐	during the day:	☐	☐
Snore loudly:	☐	☐	Stop breathing during sleep:	☐	☐
Sleep apnea:	☐	☐	Grind teeth:	☐	☐

MEALS:

Meals per day: _____ How much water do you drink per day?: _____

Other beverages?: _____

What do you eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

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?_____

_____

DENTAL HYGIENE:

When was your last dental cleaning?: _____

How often do you have dental cleanings?: _____

Do you have root canals?: ☐ Yes ☐ No If so, how many?: _____

Do you have Amalgam fillings?: ☐ Yes ☐ No If so, how many?: _____

SOCIAL LIFE:

Enjoy job?: ☐ Yes ☐ No Active spiritual practice: ☐ Yes ☐ No

Satisfaction with where you are in life: _____

_____

Stress Level: ☐ High ☐ Medium ☐ Low

Quality of most Significant Relationship: _____

Who do you live with by relationship: _____

Do you have a network of supportive family/friends?: ☐ Yes ☐ No

History of sexual, mental/emotional/physical abuse?: ☐ Yes ☐ No

If so, at what age and by whom?: _____

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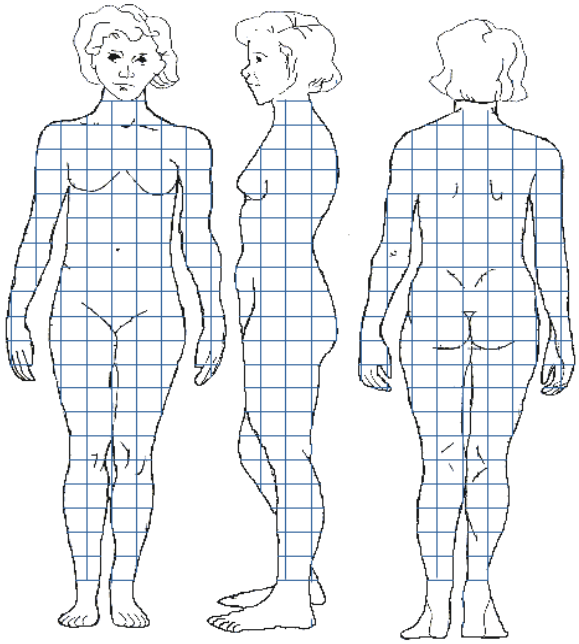
PAIN CHART
Please Mark (X) the Location of Your Pain Including Any Radiation.



FAMILY HISTORY:

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age (Living)	_____	_____	_____	_____	_____	_____
Age (Deceased)	_____	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer (Type)	_____	_____	_____	_____	_____	_____

Check Y** for **YES. CHECK N** for **NO.

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
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
Alzheimer's	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Tuberculoses (TB)	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N

Any other conditions?: _____

REVIEW OF SYSTEMS

Present weight: _____
Weight one year ago: _____ Recent weight gain, when & why: _____
Ideal weight: _____ Recent weight loss, when & why: _____

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***Please Mark ALL Symptoms that Apply**: LEAVE BLANK if you've never had the symptom.*
Check C** if you have the problem **CURRENT**. **Check P** if you had the problem in the **PAST.
Check Y** for **YES. Check N** for **NO.

Good energy: ☐Y ☐N
Fatigue: ☐Y ☐N
If fatigued, when is it the worst? ☐ Morning ☐ Afternoon ☐ Evening
If fatigued, can you do what you need to during the day?: ☐Y ☐N

SKIN

Rash:	☐ C	☐ P
Hives:	☐ C	☐ P
Lump:	☐ C	☐ P
Itchy:	☐ C	☐ P
Psoriasis/Eczema:	☐ C	☐ P
Skin cancer:	☐ C	☐ P

HEAD

Hair loss:	☐ C	☐ P
Headache:	☐ C	☐ P
Head injury:	☐ C	☐ P
Migraine:	☐ C	☐ P
TMJ	☐ C	☐ P

NECK

Stiffness:	☐ C	☐ P
Swollen glands:	☐ C	☐ P
Tension:	☐ C	☐ P

EYES

Blurry vision:	☐ C	☐ P
Glaucoma:	☐ C	☐ P
Styes:	☐ C	☐ P
Discharge:	☐ C	☐ P
Cataracts:	☐ C	☐ P
Double vision:	☐ C	☐ P
Dark under eyelids:	☐ C	☐ P
Itchy eyes:	☐ C	☐ P
Sensitivity to light:	☐ C	☐ P

EARS

Ear pain:	☐ C	☐ P
Decreased hearing:	☐ C	☐ P
Drainage:	☐ C	☐ P
Ringing:	☐ C	☐ P
Dizziness:	☐ C	☐ P

NOSE

Frequent colds:	☐ C	☐ P
Congestion:	☐ C	☐ P
Postnasal drip:	☐ C	☐ P
Nasal polyps:	☐ C	☐ P
Seasonal allergies:	☐ C	☐ P
Nosebleeds:	☐ C	☐ P

MOUTH/THROAT

Canker sores:	☐ C	☐ P
Cold sores:	☐ C	☐ P
Sore throat:	☐ C	☐ P
Loss of taste:	☐ C	☐ P
Hoarseness:	☐ C	☐ P
Dryness	☐ C	☐ P

DENTAL HYGIENE :

Gum disease:	☐ C	☐ P
Dentures:	☐ C	☐ P
Cavities:	☐ C	☐ P

RESPIRATORY

Cough:	☐ C	☐ P
Tuberculosis:	☐ C	☐ P
Bronchitis:	☐ C	☐ P
Pneumonia:	☐ C	☐ P
Asthma:	☐ C	☐ P
Wheezing:	☐ C	☐ P
Painful breathing:	☐ C	☐ P
Shortness of breath: lying down:	☐ C	☐ P
Shortness of breath sitting:	☐ C	☐ P
Shortness of breath with exertion:	☐ C	☐ P

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CARDIOVASCULAR

High blood pressure:	☐ C	☐ P
Low blood pressure:	☐ C	☐ P
Murmurs:	☐ C	☐ P
Arrhythmias:	☐ C	☐ P
Palpitations:	☐ C	☐ P
Chest pain:	☐ C	☐ P
Leg/Feet swelling:	☐ C	☐ P
Rheumatic fever:	☐ C	☐ P

HEMATOLOGIC

Anemia:	☐ C	☐ P
Easy bruising:	☐ C	☐ P
Easy bleeding:	☐ C	☐ P
Transfusions:	☐ C	☐ P

ENDOCRINE

Change in appetite:	☐ C	☐ P
Heat intolerance:	☐ C	☐ P
Cold intolerance:	☐ C	☐ P
Thyroid problems:	☐ C	☐ P
Difficulty maintaining weight:	☐ C	☐ P
Diabetes:	☐ C	☐ P

GASTROINTESTINAL

Abdominal pain	☐ C	☐ P
Bowel movement (BM) frequency:	_____	
Diarrhea:	☐ C	☐ P
Constipation:	☐ C	☐ P
Indigestion:	☐ C	☐ P
Recent change in BM:	☐ C	☐ P
Heartburn:	☐ C	☐ P
Bloating:	☐ C	☐ P
Burping/Belching:	☐ C	☐ P
Excess gas:	☐ C	☐ P
Nausea:	☐ C	☐ P
Vomiting:	☐ C	☐ P
Hemorrhoids:	☐ C	☐ P
Gall bladder disease:	☐ C	☐ P
Liver disease:	☐ C	☐ P
Ulcer:	☐ C	☐ P
Pancreatitis:	☐ C	☐ P
Change in appetite:	☐ C	☐ P

URINARY

Frequent urination	☐ C	☐ P
Incontinence:	☐ C	☐ P
Pain with urination:	☐ C	☐ P
Frequent infections:	☐ C	☐ P
Urgency:	☐ C	☐ P
Discharge/Blood:	☐ C	☐ P
Kidney stones:	☐ C	☐ P

MUSCULOSKELETAL

Weakness:	☐ C	☐ P
Arthritis:	☐ C	☐ P
Stiffness:	☐ C	☐ P
Leg cramps:	☐ C	☐ P
Tremors:	☐ C	☐ P
Joint pain:	☐ C	☐ P
Muscle pain:	☐ C	☐ P

NERVOUS

Paralysis:	☐ C	☐ P
Tingling/Numbness:	☐ C	☐ P
Seizures:	☐ C	☐ P
Radiculopathy:	☐ C	☐ P
Carpal tunnel syndrome:	☐ C	☐ P
Fainting:	☐ C	☐ P
Nerve pain:	☐ C	☐ P

MENTAL/EMOTIONAL

Forgetfulness or memory loss	☐ C	☐ P
Sadness:	☐ C	☐ P
High-strung/Tense:	☐ C	☐ P
Anger/Irritability:	☐ C	☐ P
Suicidal:	☐ C	☐ P
Anxiety:	☐ C	☐ P
Fear/Panic:	☐ C	☐ P

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FEMALE

Age periods began: _____
Sexual active: ☐ C ☐ P
Healthy libido: ☐ C ☐ P
Hot flashes: ☐ C ☐ P
Insomnia: ☐ C ☐ P
Pain with intercourse: ☐ C ☐ P
Vaginal dryness: ☐ C ☐ P
Vaginitis: ☐ C ☐ P
Sexual orientation:
☐ Hetero ☐ Homo ☐ Bi
Date of last pap smear: _____
Diagnosis: _____
Abnormal paps: ☐ C ☐ P
When: _____
Birth control (BC): ☐ C ☐ P
Types and ages used:
_____
Use of hormones: ☐ C ☐ P
Sexually transmitted infections: ☐ C ☐ P
Dexa scan: ☐ C ☐ P
Results: _____

Menopausal:

Since what age: _____
Any changes in menstrual cycle: ☐ C ☐ P
Hysterectomy: ☐ Yes ☐ No
How were/are they being treated:
_____

If still having period:

Date of last cycle: _____
How often periods occur: _____
How long periods last: _____
Periods:
☐ Light ☐ Medium ☐ Heavy
Bleeding:
☐ Regular ☐ Irregular
Cramping: ☐ C ☐ P
Pain: ☐ C ☐ P
PMS: ☐ C ☐ P
Food cravings: ☐ C ☐ P

Pregnancy:

Times pregnant: _____
How many births: _____
Caesarian: _____
Vaginal: _____
Miscarriages: _____
Abortions: _____

Breast:

Lumps: ☐ C ☐ P
Nipple discharge: ☐ C ☐ P
Self examination: ☐ C ☐ P
Breast pain: ☐ C ☐ P

MALE

Testicular pain or swelling: ☐ C ☐ P
Hernia: ☐ C ☐ P
Discharge: ☐ C ☐ P
Difficulty achieving erection: ☐ C ☐ P
Difficulty maintaining erection: ☐ C ☐ P
Waking erection regularly: ☐ C ☐ P
Sexually active: ☐ C ☐ P
Healthy libido: ☐ C ☐ P
Prostate disease or symptoms: ☐ C ☐ P
Sexual orientation:
☐ Hetero ☐ Homo ☐ Bi
Sexually transmitted infections: ☐ C ☐ P
Impaired fertility: ☐ C ☐ P
Last prostate exam:
_____

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