Inland Naturopathic
WELLNESS CENTER
Regenerate Optimize Heal

Adult Evaluation & Intake Form

Last Name: _____ **First Name:** _____ **Age:** _____

DOB:_____ **Today's Date:** _____

Describe the Reason(s) for Your Visit: _____

_____

_____

What is Your Greatest Health Concern?_____

How Does It Limit You the Most? _____

_____

_____

What have you tried doing to resolve this problem that DID NOT work?

Have you become discouraged or stressed about handling this problem?

When your problem is at its worst, how does it make you feel?

_____

Please mark all that apply:

What are you afraid this might be or will be affecting without change?

- ☐ Career/Job
- ☐ Your Children
- ☐ Marriage
- ☐ Sleep
- ☐ Freedom
- ☐ Future abilities
- ☐ Finances
- ☐ Time

Are there any health conditions you are afraid this might turn into?

- ☐ Diminished Future Abilities
- ☐ Dependency on others
- ☐ Weight Gain
- ☐ Heart disease
- ☐ Depression
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____

Where do you picture yourself in the next 3-5 years if this problem is not taken care of? Please be specific.

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What would be different or better without this problem? Please circle:

- ☐ Diminished Stress
- ☐ More energy
- ☐ Self-esteem
- ☐ Confidence
- ☐ Sleep
- ☐ Work
- ☐ Life
- ☐ Family

If we were to sit down and discuss your life <u>1 year</u> from now and look back at today, what would have to have happened for you to be happy with your progress?
(Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

How Committed Are You Towards Making Valuable Changes:

☐ Little ☐ Moderately ☐ Very

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?
_____ Do you feel that you are coachable and would value a mentor in helping you?
_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

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: _____

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***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	☐	☐
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 Prescriptions, Supplements, & Herbs You Take: **(Turn to page 8 for additional space)**

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

HEALTH HABITS
EXERCISE:
How often?:_____ What type(s)?:_____
How long?:_____

HOBBIES:

_____

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SLEEP:

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

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

***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 during the day:	☐	☐
Wake unrefreshed:	☐	☐	Stop breathing during sleep:	☐	☐
Snore loudly:	☐	☐	Grind teeth:	☐	☐
Sleep apnea:	☐	☐			

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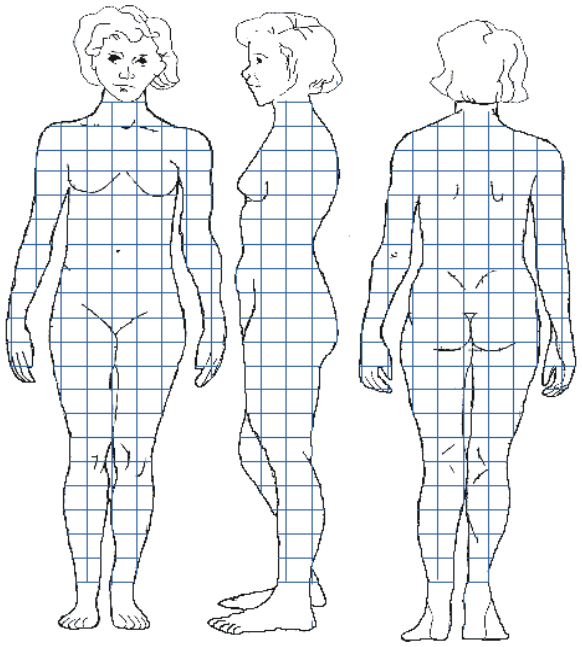
PAIN CHART
Please Mark (X) the Location of Your Pain Including Any Radiation.



FAMILY HISTORY:

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

FAMILY HISTORY contd.: ***Check Y** for **YES. CHECK N** for **NO.***

	Father	Mother	Siblings	Grandparents	Spouse	Children
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
sitting:	☐ C	☐ P
with exertion:	☐ C	☐ P

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

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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 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

MALE

- Testicular pain or swelling: ☐ C ☐ P
- Hernia: ☐ C ☐ P
- Discharge: ☐ C ☐ P
- Difficulty:
  - achieving erection: ☐ C ☐ P
  - 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:

_____

FEMALES continue to next page >>>

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FEMALE

Age periods began: _____
Sexually 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 & 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

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MEDICATION LIST

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

SUPPLEMENT LIST

Name of Supplement	Brand	Dosage	Frequency	Reason for Taking	Does It Help? (Yes or No)

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