Dr. Kat, Naturopathic Physician - LLC
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Be Well

Intake Form

Today's Date: ___________________

Name: ____ S.S.#: ____________________
Age: ______ Date of Birth: _______________ Sex at birth: ______ Gender: _______
Address: ____
____
City: _____________________________________ State: ____________________ Zip: _______________

Email: ____
May we email you with medical information? (circle one) Yes No

Home phone: ________________________ Cell phone: ___________________________
Work phone: _________________________ Best time to call: _______________________
Preferred Number? (circle one) Home Work Cell
May we leave a message? (circle one) Yes No
May we send you mobile notifications? (circle one) Yes No

Employer: ____
Occupation: _________________________ Full or Part time (circle one)
Address: ____
Education: ____

Are you (circle all that apply): Married Separated Divorced Single Cohabitating

Live with (circle all that apply): Spouse Partner Parents Relatives Friends Pets Alone

Emergency Contact: ____
Relationship: ____
Address: ____
____
City: ______________________ State: ____________________ Zip: ___________
Home phone: ____
Cell phone: ____
Work phone: ____

Referred to Dr. Kaitlyn N. Staal by:____

A NOTE TO CLIENTS: Holistic and Preventive healthcare require a complete picture of the patient physically, mentally and emotionally. Please complete this health questionnaire accurately, and find the necessary space & time to answer the more personal questions at the end as honestly as possible.

ALLERGIES

Are you hypersensitive or allergic to:
Any drugs? ______________________________
Any foods? ______________________________
Any chemicals or environmental toxins? ______________________________
____

What happens to you when you have an allergic reaction?
____
____

How severe are the reactions? (circle all that apply, list allergen)
MILD: ______________________________
MODERATE: ______________________________
SEVERE: ______________________________

What prior types of allergy testing have you had?

_____Intradermal	_____Blood IgE inhalant	_____Cytotoxic
_____Scratch	_____Blood IgE food	_____Food Intolerance
_____Blood IgG food	_____Electroacupuncture	_____None
_____Blood IgA food	_____Kinesiology	Other: _______________

CURRENT HEALTH CONDITION

When, where and from whom did you last receive medical or health care?
____
____
Primary Physician: ______________________________
City, State: ______________________________
Other current providers (including specialists, therapists, and other wellness services):
____
____

Past providers (former providers in the past 7 years):
____
____

Reason for discontinuation of care:
____
____

What are your most important health concerns?

1. ____________________	5. ____________________
2. ____________________	6. ____________________
3. ____________________	7. ____________________
4. ____________________	8. ____________________

Which of the listed problems are of most immediate concern?
____

Do you have any contagious diseases at this time (circle one) YES NO
If yes, what? ____

CURRENT MEDICATIONS

Do you take or use (check all that apply):

_____Antacids	_____Cortisone	_____Pain relievers
_____Antibiotics	_____Hormones	_____Sleeping pills
_____Appetite suppressants	_____Laxatives	_____Thyroid medication
_____Birth control pills	_____Nasal decongestants	_____Tranquilizers

Please list any PRESCRIPTION medications you are taking and include dosages:

1. ________________________	5. ________________________
2. ________________________	6. ________________________
3. ________________________	7. ________________________
4. ________________________	8. ________________________

Please list any over-the-counter medications, vitamins or other supplements you are taking and include dosages:

1. ________________________	5. ________________________
2. ________________________	6. ________________________
3. ________________________	7. ________________________
4. ________________________	8. ________________________
9. ________________________	12. ________________________
10. ________________________	13. ________________________
11. ________________________	14. ________________________

FAMILY HISTORY

	Age or Age at death	State of Health -or-	Cause of Death
Mother	______	Good Fair Poor	______________
Maternal	______	Good Fair Poor	______________
Grandmother	______	Good Fair Poor	______________
Maternal	______	Good Fair Poor	______________
Grandfather	______	Good Fair Poor	______________
Father	______	Good Fair Poor	______________
Paternal	______	Good Fair Poor	______________
Grandmother	______	Good Fair Poor	______________
Paternal	______	Good Fair Poor	______________
Grandfather	______	Good Fair Poor	______________
Sibling: M F	______	Good Fair Poor	______________
Sibling: M F	______	Good Fair Poor	______________
Sibling: M F	______	Good Fair Poor	______________
Child: M F	______	Good Fair Poor	______________
Child: M F	______	Good Fair Poor	______________
Child: M F	______	Good Fair Poor	______________

Check any that a family member has or has had and state which relative:

_____Allergies: ______________________________
_____Anemia: ______________________________
_____Arthritis: ______________________________
_____Asthma: ______________________________
_____Cancer (specify type): __________________
_____Diabetes (&type): ______________________
_____Glaucoma: ______________________________
_____Gout: ________________________________
_____Hayfever/Hives: ______________________

_____Heart Dz/High cholesterol: _____________
_____High Blood Pressure: __________________
_____Kidney Disease: _______________________
_____Mental Illness (&type): ________________
_____Seizure/Epilepsy: _____________________
_____Stroke: ______________________________
_____Thyroid Problem: ______________________
(Hypo/Hyper? Hashi's?): ___________________
_____Other: _______________________________

PERSONAL HEALTH HISTORY

For the following, please mark:
YES = a current condition; **PAST** = something you've had before; **NEVER** = something you've never had

Head	**YES**	**PAST**	**NEVER**
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Head injury	☐	☐	☐
Double vision	☐	☐	☐
Jaw/TMJ problems	☐	☐	☐
Dizziness	☐	☐	☐
Fainting spells	☐	☐	☐
Eyes			
Glasses or contacts	☐	☐	☐
Impaired vision	☐	☐	☐
Spots in eyes	☐	☐	☐
Cataracts	☐	☐	☐
Blurriness	☐	☐	☐
Eye pain/strain	☐	☐	☐
Color blindness	☐	☐	☐
Tearing or dryness	☐	☐	☐
Sensitivity to light	☐	☐	☐
Glaucoma	☐	☐	☐
Ears			
Discharge from ears	☐	☐	☐
Pain in ears	☐	☐	☐
Hearing problems	☐	☐	☐
Sensitivity to noise	☐	☐	☐
Ringing in ears	☐	☐	☐
Many ear infections	☐	☐	☐

Nose and Sinuses	**YES**	**PAST**	**NEVER**
Frequent colds	☐	☐	☐
Stuffiness	☐	☐	☐
Nosebleeds	☐	☐	☐
Hay fever	☐	☐	☐
Sinus problems	☐	☐	☐
Loss of smell	☐	☐	☐
Mouth and Throat			
Frequent sore throat	☐	☐	☐
Copious saliva	☐	☐	☐
Teeth grinding	☐	☐	☐
Mouth ulcers	☐	☐	☐
Bleeding gums	☐	☐	☐
Hoarseness	☐	☐	☐
Speech difficulties	☐	☐	☐
Loss of voice	☐	☐	☐
Neck			
Lumps	☐	☐	☐
Swollen glands	☐	☐	☐
Goiter	☐	☐	☐
Pain or stiffness	☐	☐	☐

Cardiovascular	YES	PAST	NEVER
Angina	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Blood clots	☐	☐	☐
Fainting	☐	☐	☐
Phlebitis	☐	☐	☐
Palpitations	☐	☐	☐
Rheumatic fever	☐	☐	☐
Chest pain	☐	☐	☐
Swelling in ankles	☐	☐	☐
Heart murmurs	☐	☐	☐

Urinary			
Pain on urination	☐	☐	☐
Increased frequency	☐	☐	☐
Frequency at night	☐	☐	☐
Inability to hold urine	☐	☐	☐
Problems starting urine	☐	☐	☐
Blood in urine	☐	☐	☐
Kidney Stones	☐	☐	☐
Many urinary infections	☐	☐	☐

Gastrointestinal			
Trouble swallowing	☐	☐	☐
Heartburn	☐	☐	☐
Bad breath	☐	☐	☐
Bad taste in mouth	☐	☐	☐
Change in thirst	☐	☐	☐
Change in appetite	☐	☐	☐
Nausea	☐	☐	☐
Vomiting	☐	☐	☐
Vomiting blood	☐	☐	☐
Constipation	☐	☐	☐
Blood in stool	☐	☐	☐
Diarrhea	☐	☐	☐
Pain or cramps	☐	☐	☐
Gall bladder disease	☐	☐	☐
Belching	☐	☐	☐
Ulcers	☐	☐	☐
Passing gas	☐	☐	☐

Gastrointestinal Cnt'd	YES	PAST	NEVER
Hemorrhoids	☐	☐	☐
Eating disorder	☐	☐	☐
Distress from eating	☐	☐	☐
fats	☐	☐	☐
Black stools	☐	☐	☐
Jaundice	☐	☐	☐
Liver disease	☐	☐	☐
Bad body odor	☐	☐	☐

Bowel movements: #____________

How often? (circle one) Per week / Per day

Is this a change? (circle one) Yes / No

Respiratory			
Cough	☐	☐	☐
Sputum production	☐	☐	☐
Spitting up blood	☐	☐	☐
Wheezing	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Pneumonia	☐	☐	☐
Pleurisy	☐	☐	☐
Emphysema	☐	☐	☐
Difficulty breathing	☐	☐	☐
Pain on breathing	☐	☐	☐
Shortness of breath	☐	☐	☐
" " lying down	☐	☐	☐
" " at night	☐	☐	☐
Night sweats	☐	☐	☐
Tuberculosis	☐	☐	☐

Sexual Health			
Sexually Active	☐	☐	☐
Chlamydia	☐	☐	☐
Gonorrhea	☐	☐	☐
Condyloma	☐	☐	☐
Discharge or sores	☐	☐	☐
Herpes	☐	☐	☐
Syphilis	☐	☐	☐
Nipple discharge	☐	☐	☐
Breast lumps	☐	☐	☐
Breast tenderness	☐	☐	☐

Female Reproduction	YES	PAST	NEVER
Age at first menses	_______ years old		
Length of cycle	Every _____ days		
Cycles regular?	Yes No		
Duration of menses	_______ days long		
Pain during intercourse	◻	◻	◻
Bleeding between cycles	◻	◻	◻
Clotting with menses	◻	◻	◻
Painful menses	◻	◻	◻
PMS	◻	◻	◻
If yes, please list your symptoms:	__________________		
Birth control	◻	◻	◻
If yes, Type:	__________________		
# of pregnancies:	__________________		
# of miscarriages:	__________________		
# of live births:	__________________		
# of abortions:	__________________		
Endometriosis	◻	◻	◻
Ovarian cysts	◻	◻	◻
Difficulty conceiving	◻	◻	◻
Menopausal symptoms	◻	◻	◻
Cervical dysplasia	◻	◻	◻
Abnormal PAP smear	◻	◻	◻
Sexual difficulties	◻	◻	◻
Vaginal discharge	◻	◻	◻
Dryness	◻	◻	◻
Pelvic pain	◻	◻	◻
Breast pain	◻	◻	◻
Self-breast exams	◻	◻	◻

Male Reproduction

Hernias	◻	◻	◻
Testicular Mass	◻	◻	◻
Testicular pain	◻	◻	◻
Prostate disease	◻	◻	◻
Premature ejaculation	◻	◻	◻

Male Reproduction Cnt'd	YES	PAST	NEVER
Impotence	◻	◻	◻
Vasectomy	◻	◻	◻
Painful erections	◻	◻	◻

Musculoskeletal

Joint pain or stiffness	◻	◻	◻
Arthritis	◻	◻	◻
Broken bones	◻	◻	◻
Weakness	◻	◻	◻
Muscle spasms or cramps	◻	◻	◻
Back pain	◻	◻	◻

Blood/peripheral vascular

Easy bleeding	◻	◻	◻
Easy bruising	◻	◻	◻
Anemia	◻	◻	◻
Deep leg pain	◻	◻	◻
Cold hands/feet	◻	◻	◻
Varicose veins	◻	◻	◻
Thrombophlebitis	◻	◻	◻
Fluid retention	◻	◻	◻
Bleeding in unusual places	◻	◻	◻

Emotional

Treated for emotional problems	◻	◻	◻
Anxiety	◻	◻	◻
Nervousness	◻	◻	◻
Mood swings	◻	◻	◻
Depression	◻	◻	◻
Considered suicide	◻	◻	◻
Attempted suicide	◻	◻	◻
Tension	◻	◻	◻
Excessive worry	◻	◻	◻
Panic attacks	◻	◻	◻

Neurologic	YES	PAST	NEVER
Seizures/epilepsy	□	□	□
Paralysis	□	□	□
Muscle weakness	□	□	□
Numbness or	□	□	□
tingling	□	□	□
Loss of memory	□	□	□
Vertigo or dizziness	□	□	□
Easily stressed	□	□	□
Loss of balance	□	□	□
Endocrine			
Hypothyroid	□	□	□
Heat/cold intolerance	□	□	□
Hypoglycemia	□	□	□
Diabetes	□	□	□
Excessive thirst	□	□	□
Excessive hunger	□	□	□
Fatigue	□	□	□
Seasonal depression	□	□	□
Unexplained weight loss/gain	□	□	□
Change in sexual desire	□	□	□

Immune & Integumentary	YES	PAST	NEVER
Reactions to vaccinations	□	□	□
Chronic fatigue syndrome	□	□	□
Chronic infections	□	□	□
Chronically swollen glands	□	□	□
Slow wound healing	□	□	□
Skin Rashes	□	□	□
Eczema/hives	□	□	□
Acne/boils	□	□	□
Itching	□	□	□
Color changes	□	□	□
Hair loss	□	□	□
Lumps	□	□	□
Warts	□	□	□

GENERAL INFORMATION

Current Weight: ____________
Current Height: _____ft. _____ in.

Weight 1 year ago:__________
Maximum weight: __________lbs.
When: _____________________

At what time is your energy the best? _____________________
At what time is your energy the worst? ____________________

CHILDHOOD ILLNESSES (write the age you had each illness next to the applicable illnesses):

_____Rubella (German 3-day measles)
_____Measles (2 weeks)
_____Mumps
_____Chickenpox
_____Whooping cough
_____Rheumatic fever
_____Polio
_____Scarlet fever
_____Roseola
_____Asthma
_____Others: __________________

IMMUNIZATIONS (check all that you've received)

_____ Pertussis
_____ Tetanus
_____ Polio
_____ Diphtheria
_____ Measles/Mumps/Rubella
_____ Hepatitis
_____ Others: _________________________

IMAGING AND SPECIAL STUDIES (list age at which you've received applicable test)

____ Electrocardiogram (EKG)
____ Electroencephalogram (EEG)
____ Intravenous Pyelogram (IVP)

What x-rays, CAT scans, other imaging, or other special health studies have you had & when?

____
____
____
____

HOSPITALIZATION AND SURGERY

What hospitalizations or surgeries have you had, when, & why?

____
____
____
____

LIFESTYLE

Main interests and hobbies:

____
____
____

Do you exercise? ___Y ___N If yes, what kind? ______________________________

Do you have a religious/spiritual practice? ___Y ___N If yes, what kind? ______________
____

Do you eat 3 meals a day? ___Y ___N If no, how many & why? ____________________
____

Do you average 6-8 hours sleep? ___Y ___N If no, how many & why? ______________
____

Do you sleep well? ___Y ___N If no, what is the problem? _______________________
____

Do you awaken rested? ___Y ___N If no, what is the problem? ____________________
____

Do you enjoy your work? ___Y ___N If no, why not? ___________________________
____

Do you spend time outside? ___Y ___N If yes, how much and in what form? ___________
____

Do you watch television? ___Y ___N If yes, what & how much? ______________________________

____

Do you read? ___Y ___N If yes, what & how much? ______________________________________

____

Do you take vacations? ___Y ___N If yes, how long and what kind? ____________________________

____

Do you have a supportive relationship? ___Y ___N If no, why not? ___________________________

____

Do you have a history of abuse/trauma? ___Y ___N If yes, please describe: ______________________

____

Additional Comments:

____

____

HABITS

For the following, please mark: **CURRENTLY**, **IN THE PAST**, or **NEVER** as appropriate.

	CURRENTLY	**IN THE PAST**	**NEVER**
Use medical painkillers	☐	☐	☐
Use medical marijuana	☐	☐	☐
Use recreational drugs	☐	☐	☐
Treatment for drug dependence	☐	☐	☐
Treatment for alcoholism	☐	☐	☐
Smoke tobacco products	☐	☐	☐
Chew tobacco products	☐	☐	☐
Use alcoholic beverages	☐	☐	☐
Drink coffee	☐	☐	☐
Drink black tea	☐	☐	☐
Drink cola/soda	☐	☐	☐
Eat out often	☐	☐	☐
Go on diets often	☐	☐	☐
Eat excessive sugar	☐	☐	☐
Eat excessive salt	☐	☐	☐

TYPICAL FOOD INTAKE	What time?	Typical foods
Breakfast		
Snacks		
Lunch		
Dinner		
Dessert		

CURRENT ILLNESS OR CONDITION

How does your condition affect you?

What do you think is happening?

Why?

What do you feel needs to happen for you to get better?

What do you enjoy most in life?

How much change are you willing to make at this time for improving your health?