

THE NATUROPATHIC OFFICE OF DR. MAYA ROTH
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NEW PATIENT INTAKE FORM

Please fill out this form as completely as possible. It will help us to uncover the cause of your health concerns.

Name	Date of birth	Today's date	<input type="checkbox"/>	<input type="checkbox"/> Male
<input type="checkbox"/> Female				
Home address				
Home phone #	Cell phone #	Email Address		
Occupation	Work phone #	Employer		
Employer address				
Insurance				
Emergency contact name	Relationship	Phone #		
Who referred you to our office?				

Chief complaints:

What are your current health concerns? Describe treatment received: Describe obstacles encountered:

1.		
2.		
3.		
4.		
5.		

Allergies: Have you ever had an adverse reaction to food, medication, vaccination, or supplement? No Yes

Please list names of allergic foods, drugs, vaccines or supplements:

Reaction:

1.	
2.	
3.	

Medications: What medications are you currently taking? Please include prescription, OTC & herbal medications:

Name of medication or supplement:

Daily dose:

Indication:

Example: Selenium	200 mcg	Hypothyroidism
1.		
2.		
3.		
4.		
5.		

Patient Name _____ Date of birth _____ Today's date _____

Are you currently under the care of a primary care doctor? Yes No (If yes, please specify)

Name _____ Reason _____ Tel: _____

Are you currently under the care of any other health professional? Yes No (If yes, please specify)

Name _____ Reason _____ Tel: _____

Past medical history:

Have you ever had a major illness, sustained an injury, been hospitalized, or had surgery or a procedure done? No Yes

Illness, injury, hospitalization, surgery or procedure	Date	Illness, injury, hospitalization, surgery or procedure	Date
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Procedures: Please list the dates and results of your most current check up, lab test and procedures:

Procedure/exam	Date	Result	Procedure/exam	Date	Result
Annual physical or complete check up			Bone density scan		
Last blood test			Colonoscopy		
PAP smear			Chest X-ray		
Mammogram			EKG or stress test		
CT, MRI or ultrasound			Other (please specify)		

Immunization history:

	Date(s)	Vaccination	Date(s)
<input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus)		<input type="checkbox"/> HBV (Hepatitis B Vaccine)	
<input type="checkbox"/> Booster (Diphtheria, Tetanus)		<input type="checkbox"/> Polio	
<input type="checkbox"/> MMR (Measles, Mumps, Rubella)		<input type="checkbox"/> Seasonal flu shot	
<input type="checkbox"/> Hemophilus (Hib)		<input type="checkbox"/> Other (Please specify)	

Family history: Please describe your family's health including illnesses such as autoimmune disease, cancer, heart disease, diabetes, depression, allergies & thyroid disease.

Family Member: _____ Age if living: _____ Age at death: _____ Major illnesses or chronic conditions: _____

Mother			
Father			
Maternal grandmother			
Maternal grandfather			

Patient Name _____ Date of birth _____ Today's date _____

Paternal grandmother			
Paternal grandfather			

Social History:

Family unit: <input type="checkbox"/> Single <input type="checkbox"/> In a committed relationship <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other:	
How many children do you have?	What are their names and ages?
Do you have a religious orientation or a spiritual practice that is important to you? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify:	
Have you ever smoked cigarettes? <input type="checkbox"/> Current smoker <input type="checkbox"/> Past smoker	# of cigarettes per day: _____ # of years: _____
How many alcoholic beverages do you drink per week?	Do you use recreational drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes

Diet and nutrition: Please describe your typical daily food and beverage intake.

Meal	Time	Description
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Dinner		
After dinner snack		
Before bed		

How many ounces of water do you drink per day?

How many servings of caffeinated beverages (soda, black tea, coffee) do you have per day? (8oz = 1 serving)

Which foods do you crave the most (sweets, salt, chocolate, starch, ice cream, coffee)?

Please check dietary practices that you adhere to:

Mostly natural Organic Vegan Vegetarian Kosher Halal Gluten free Dairy free Other (please specify)

Sleep: How many hours do you sleep per night?

What time do you go to sleep?

What time do you wake up in the morning?

How many times do you wake up during the night?

Do you wake up well rested? Yes No

How do you feel when you wake up?

Patient Name _____ Date of birth _____ Today's date _____

Exercise: Do you exercise? Yes No If yes, please, describe your exercise activity, frequency and duration

Physical activity	How many times per week do you perform this activity?	How many minutes?

Lifestyle: Please rate your stress level on a scale of 1-10 (10 = most stress)		1 2 3 4 5 6 7 8 9 10
What are your current primary sources of stress?		
Please describe how you cope with stress in your life?		
How many hours do you work per week?	Number of relaxation hours per week:	
Please list your top three stressful events in life:		
Please list your three happiest life events:		
Energy: Please rate your energy level on a scale of 1-10 (10 = most energy)		1 2 3 4 5 6 7 8 9 10
What time of the day do you have the most energy?	What time of the day do you feel most fatigued?	
Do you feel tired after meals?	Do you feel more energetic after eating?	
Do you feel better after exercise?	Do you have a hard time waking up in the morning?	

Review of systems:

Please check all ongoing or recurrent problems	Doctor use only
General: <input type="checkbox"/> Weight change <input type="checkbox"/> Fever/chills <input type="checkbox"/> Fatigue/weakness <input type="checkbox"/> Sweats/night sweats	
Skin/hair : <input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Acne or pimples <input type="checkbox"/> Hives <input type="checkbox"/> Brown spots or bronzing of skin <input type="checkbox"/> Rough or scaly skin <input type="checkbox"/> Hair loss or thinning <input type="checkbox"/> Dry brittle hair	
Head: <input type="checkbox"/> Headaches <input type="checkbox"/> Head injury <input type="checkbox"/> TMJ problems	
Eyes: <input type="checkbox"/> Changes in vision <input type="checkbox"/> Glasses/contacts <input type="checkbox"/> Blurring <input type="checkbox"/> Pain <input type="checkbox"/> Discharge <input type="checkbox"/> Dryness	
Ears: <input type="checkbox"/> Earache <input type="checkbox"/> Ringing in the ear <input type="checkbox"/> Hearing problems <input type="checkbox"/> Discharge from ears	
Nose/sinuses: <input type="checkbox"/> Sinus congestion <input type="checkbox"/> Bleeding <input type="checkbox"/> Discharge <input type="checkbox"/> Postnasal drip	
Mouth/throat: <input type="checkbox"/> Cracks in corners of the mouth <input type="checkbox"/> Cold sores <input type="checkbox"/> Sores <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore throat <input type="checkbox"/> Dental cavities <input type="checkbox"/> Dental fillings composite (white) /amalgam (silver)	
Respiratory/chest: <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest tightness <input type="checkbox"/> Sputum/mucus <input type="checkbox"/> Cough persistent/dry/productive/bloody <input type="checkbox"/> Breast mass <input type="checkbox"/> Breast pain <input type="checkbox"/> Nipple discharge	
Cardiovascular: <input type="checkbox"/> Palpitations/fluttering <input type="checkbox"/> Edema <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Chest pain	

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Gastrointestinal: # of bowel movements per day _____ <input type="checkbox"/> Loss of or excess appetite <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloating <input type="checkbox"/> Indigestion <input type="checkbox"/> Belching <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood, mucus or undigested food in stool <input type="checkbox"/> Hepatitis <input type="checkbox"/> Fatty liver	
Genitourinary: <input type="checkbox"/> Pain on urination <input type="checkbox"/> Urgency <input type="checkbox"/> Frequency <input type="checkbox"/> Urination at night <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Frequent UTIs <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney disease	
Musculoskeletal: <input type="checkbox"/> Muscle pain <input type="checkbox"/> Joint pain/stiffness <input type="checkbox"/> Trauma/swelling	
Endocrine: <input type="checkbox"/> Goiter <input type="checkbox"/> Hormone therapy <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Blood sugar imbalance	
Blood/lymphatic: <input type="checkbox"/> Anemia <input type="checkbox"/> Easy bleeding/bruising <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Fluid retention <input type="checkbox"/> Varicose veins <input type="checkbox"/> <input type="checkbox"/> Cold hands and feet <input type="checkbox"/> Deep leg pain <input type="checkbox"/> Transfusion	
Neurological: <input type="checkbox"/> Convulsions <input type="checkbox"/> Fainting <input type="checkbox"/> Loss of balance <input type="checkbox"/> Dizziness/vertigo <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> <input type="checkbox"/> Paralysis/weakness <input type="checkbox"/> Tremor	
Psychological: <input type="checkbox"/> Anxiety/nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Poor concentration <input type="checkbox"/> Memory problems <input type="checkbox"/> Changeable mood <input type="checkbox"/> Drug or alcohol abuse <input type="checkbox"/> Considered/attempted suicide	
Sexual health information: Are you currently sexually active? <input type="checkbox"/> yes <input type="checkbox"/> no Do you practice safe sex? <input type="checkbox"/> yes <input type="checkbox"/> no Low libido? <input type="checkbox"/> yes <input type="checkbox"/> no Method of birth control currently used? _____ STDs: <input type="checkbox"/> HIV <input type="checkbox"/> Herpes <input type="checkbox"/> HPV/genital warts <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Syphilis	
Male health information: <input type="checkbox"/> Testicular pain/swelling/mass <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Prostate problems <input type="checkbox"/> Discharge or genital sores	
Female health information: Age of first menses: _____ Age of last menses (if menopausal): _____ Length of cycle: _____ days Duration of flow: _____ days Date of last menstrual cycle: _____ Have you ever had an abnormal PAP? _____ <input type="checkbox"/> Cycles regular <input type="checkbox"/> Heavy flow <input type="checkbox"/> Bleeding between cycles <input type="checkbox"/> Painful menses <input type="checkbox"/> Clotting <input type="checkbox"/> PMS <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Fertility issues <input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Menopausal symptoms <input type="checkbox"/> Vaginal bleeding since menopause How many times were you pregnant? _____ # living children _____ # miscarriages _____ # abortions	

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM.

Date reviewed with patient _____ Doctor Signature _____ Maya Roth, ND