Gallatin Valley Natural Medicine

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Naturopathic Physician

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Patient Profile Intake Form

Please complete this confidential profile of your health history, so I can offer you more comprehensive naturopathic care.

Name _____ Age _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ is home cell work (circle one) Secondary Phone _____ h c w

Social Security # _____ Email address_____

Emergency Contact & Phone _____

Married Partnered Separated Divorced Widowed Single Children? Yes / No

How did you hear about me?_____

Where, when, from whom, and for what reason did you last receive any health care? _____

_____

_____

Please list, in order of importance, your health concerns and/or goals.

1. _____
2. _____
3. _____

Family Health History: Y = Yes N = No D = Caused Death (age of death) P = In the past

Please indicate if a **family member** has had any of the following. If yes, specify who.

Anemia	Y	N	D	P_____
Arthritis	Y	N	D	P_____
Asthma / Hay fever	Y	N	D	P_____
Cancer (type?)	Y	N	D	P_____
Cystic Fibrosis	Y	N	D	P_____
Diabetes	Y	N	D	P_____
Epilepsy	Y	N	D	P_____
Glaucoma	Y	N	D	P_____
Heart Disease (heart attacks)	Y	N	D	P_____
High blood pressure	Y	N	D	P_____
Kidney Disease	Y	N	D	P_____
Mental Illness	Y	N	D	P_____
Lung Disease	Y	N	D	P_____
Stroke	Y	N	D	P_____
Substance Abuse (drugs, alcohol)	Y	N	D	P_____
Venereal Disease	Y	N	D	P_____

Childhood Illnesses Please circle if you have had any of the following.

Scarlet fever Measles Diphtheria German measles Chicken pox Rheumatic fever

Mumps Others _____ Last Tetanus shot _____ Blood type_____

Allergies:

Drugs? _____

Foods? _____

Environmental? _____

Have you ever been hospitalized? Please list when and why.

Illnesses: _____

Surgeries:_____

Other: _____

Diagnosed illnesses for which you currently take medications: _____

Medications: Please indicate if you have used any of the following. (P = in the past)

Sleeping pills	Y	N	P	Birth Control Pill or Implant	Y	N	P
Antacids	Y	N	P	Thyroid Medicine	Y	N	P
Laxatives	Y	N	P	Cortisone/steroids	Y	N	P

Please list current prescription drugs and milligram dosages _____

_____

_____

Please list current herbal or nutritional supplements _____

_____

_____

Health Conditions Y = Yes N = No P = A condition you've had in the past

Skin							
Acne	Y	N	P	Skin Cancer	Y	N	P
Eczema	Y	N	P	Psoriasis	Y	N	P
Hives or Boils	Y	N	P	Itching	Y	N	P
Lumps	Y	N	P	Suspicious Moles	Y	N	P
Mouth and Throat							
Bleeding gums	Y	N	P	Difficulty swallowing	Y	N	P
Dental cavities	Y	N	P	Sore throat or tongue	Y	N	P
Hoarseness	Y	N	P	Dentures	Y	N	
Chewing tobacco	Y	N	P				
Eyes							
Eye pain or injuries	Y	N	P	Cataracts	Y	N	P
Double vision	Y	N	P	Dryness	Y	N	P
Tearing	Y	N	P	Glaucoma	Y	N	P
Glasses/Contacts	Y	N	P	Last eye exam _____			
Ears							
Discharge	Y	N	P	Earaches	Y	N	P
Dizziness	Y	N	P	Impaired hearing	Y	N	P
Ringing	Y	N	P	Injuries	Y	N	P
Head							
Hair loss	Y	N	P	Headaches	Y	N	P
Head injury	Y	N	P	Skull fracture	Y	N	P
Nose and Sinuses							
Frequent colds	Y	N	P	Hay fever	Y	N	P
Nose bleeds	Y	N	P	Sinus pain	Y	N	P
Stuffiness	Y	N	P	Persistent runny nose	Y	N	P
Neck							
Goiter	Y	N	P	Pain/Stiffness/Injuries	Y	N	P
Swollen glands	Y	N	P				
Respiratory							
Short of breath	Y	N	P	Asthma/Wheezing	Y	N	P
with exertion	Y	N	P	Emphysema	Y	N	P
while lying down	Y	N	P	Pneumonia	Y	N	P
Tuberculosis	Y	N	P	Bronchitis	Y	N	P
Spitting up blood	Y	N	P	Difficult/Painful breathing	Y	N	P
Cardiovascular							
Angina	Y	N	P	Dizziness after standing	Y	N	P
Chest pain	Y	N	P	High blood pressure	Y	N	P
Heart disease	Y	N	P	Swollen ankles	Y	N	P
Murmurs	Y	N	P	Rheumatic fever	Y	N	P

Palpitations Y N P Fluttering Y N P

Gastrointestinal

Blood in stool Y N P Bowel movements:_____ x/day
Change in thirst/appetite Y N P Consistency & Color _____
Nausea/vomiting Y N P Foul odor? Y N
Heartburn Y N P Belching/Passing gas Y N P
Hemorrhoids Y N P Jaundice/Yellow skin Y N P
Ulcers Y N P Liver disease Y N P
Hernia Y N P Abdominal pain Y N P
Diarrhea Y N P Constipation Y N P

Urinary

Kidney stones Y N P Frequent infections Y N P
Kidney pain Y N P Increased frequency Y N P
Nighttime frequency Y N P Incontinence Y N P
Pain with urination Y N P Urethral discharge Y N P
Hesitancy Y N P Dribbling Y N P

Female Reproductive

Date and results of last pap smear_____ By Whom? _____
History of abnormal pap smears: Y N When? _____
Age menses began _____ Birth Control Y N P
Age menopause began _____ Type _____
Average # of days of flow _____ Days between periods_____
Number of pregnancies _____ Number of live births _____
Number of miscarriages _____ Number of abortions _____
Hysterectomy Y N Month/Year _____ Ovaries removed Y N
Difficulty conceiving Y N P PMS Y N P
Pain during intercourse Y N P Excess flow Y N P
Irregular cycles Y N P Painful menses Y N P
Menopausal symptoms Y N P Sexual difficulties Y N P
Are you sexually active Y N Sexually Transmitted Infection Y N P
Sexual orientation: Heterosexual Homosexual Bisexual

Breasts

Do you do self exams Y N Lumps Y N P
Pain Y N P Nipple discharge Y N P
Last mammogram and findings: _____Where? _____

Male Reproductive

Do you do testicular self exams? Y N Hernias Y N P
Testicular pain Y N P Sexual difficulties Y N P
Testicular masses Y N P Penile discharge Y N P
Sexually Transmitted Infection Y N P Difficult urination Y N P
Prostate pain Y N P Prostate disease Y N P
Sexual Orientation Heterosexual Homosexual Bisexual
Sexually active Y N Birth control type _____
Last digital prostate exam and findings: _____By Whom? _____
Last Prostate Specific Antigen (PSA) measurement and value: _____

Musculoskeletal

Joint pain/stiffness Y N P Broken bones Y N P
Joint swelling Y N P Muscle weakness Y N P
Muscle cramps Y N P Arthritis Y N P

Peripheral vascular

Deep leg pains Y N P Cold/Numb hands & feet Y N P
Leg pain while walking Y N P Varicose veins Y N P

p

Neurological

Dizziness	Y	N	P	Numbness/tingling	Y	N	P
Fainting	Y	N	P	Memory loss	Y	N	P
Seizures	Y	N	P	Paralysis	Y	N	P
Stroke	Y	N	P	Tremors	Y	N	P

Endocrine and Blood

Anemia	Y	N	P	Low libido	Y	N	P
Hypothyroid	Y	N	P	Easy bleeding/bruising	Y	N	P
Excessive hunger/thirst	Y	N	P	Heat/cold intolerance	Y	N	P
Excessive fatigue	Y	N	P	Insomnia	Y	N	P

Mental and Emotional

Excessive fears	Y	N	P	Anxiety/nervousness	Y	N	P
Mood swings	Y	N	P	Depression	Y	N	P
Tension	Y	N	P	Excessive anger	Y	N	P

Habits

Do you wake rested? Y N

Sleep well? Y N

Ave. hours sleep _____

What are you main hobbies/interests?

_____

_____

Enjoy your job? Y N

Watch TV? Y N Hours/day _____

Read? Y N Hours/day _____

Take vacations? Y N

What forms of exercise do you get and how often

_____

_____

Have you ever been treated for alcohol dependency Y N Drug dependency? Y N

If yes, when and where? _____

Do you currently use recreational drugs? Y N Which ones, how often? _____

Do you consume alcohol? Y N How much & how often? _____

Do you currently smoke cigarettes? Y N Have you ever smoked? Y N

Age started? _____ How much per day? _____ When did you quit? _____

Do you currently use chewing (smokeless) tobacco? Y N Have you ever used chewing tobacco? Y N

Age started? _____ How much per day? _____ When did you quit? _____

Thank you for taking the time to fill out this form completely. During your office visit, we will discuss your responses in detail.

Consent to Naturopathic Treatment Provided by Breana McElgunn, ND

I. This is to acknowledge that I have been informed and understand that:

- i) Any treatment or advice provided to me as a patient of Breana McElgunn, ND is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider.
- ii) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider
- iii) I understand that Breana McElgunn, ND is not preventing me from seeking or following the advice of another licensed health care provider.
- iv) The treatment and therapies provided to me by Breana McElgunn, ND may be different from those offered by another licensed health care provider.

II. I agree to pay for any fees for services, costs of supplements and homeopathic remedies, cost of laboratory tests, or other fees that are not covered by my insurance plan, at the time of the visit.

III. I hereby authorize and consent to treatment.

_____ _____

Signature Date