Dr. Kim Harris, ND

New Patient Intake Form

PATIENT INFORMATION:

Name:_____Date of birth:_____Age:_____
Address:_____City/State/Zip _____
Phone: _____E-mail address: _____
Emergency Contact Person:_____Emergency Contact Phone:_____
Relationship:_____

I authorize Dr. Harris to leave a detailed message for me on a voice message device associated with the phone number listed below, regarding my:

1. Laboratory reports: ___ yes (initials_____) ___no (initials_____)
2. Protected health information: ___ yes (initials_____) ___no (initials_____)
3. Email newsletter ___ yes (initials_____) ___no (initials_____)

If you answered NO to either of the above, Dr. Harris will, as necessary, leave a message indicating your need to call the clinic to retrieve any of your health-related information.

Whom may we thank for referring you? _____

List in order of importance what your problems are:

1) _____
2) _____
3) _____

Date of most recent blood work and referring physician: _____

Family History

Check YES or NO and list which **relative(s)** has the diagnosis

Yes	No		Relative(s)	Yes	No		Relative(s)
		Anemia				Heart Disease	
		Auto-immune disease				Hypoglycemia	
		Cancer (type)				High blood pressure	
		Allergies				Mental Illness	
		Alcoholism				Skin disorders	
		Asthma				Seizures	
		Gout				Stroke	
		Glaucoma				Thyroid disorders	
		Diabetes				Osteoporosis	

List All Surgeries & Hospitalizations, including date occurred:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Please note when and why you have had each of the following:

X-rays: _____ MRI/CT scan: _____
Ultrasounds: _____ Accidents: _____
TB test: _____ Hepatitis C: _____
HIV: _____ Last dental visit: _____
Last eye exam: _____

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Smoking: Y N P **Number of Packs per day & number of years**: _____
Coffee: Y N P **Number of Cups per day if Yes/Past**: _____
Soda Pop: Y N P **Ounces per day if Yes/Past**: _____
Alcohol: Y N P **How often & how much if Yes/Past**: _____
Antacids Y N P **Analgesics** Y N P **Steroids** Y N P **Recreational Drugs** Y N P

Do you have any food or drug allergies? If yes, please list below:

_____

Immunizations- did you have the following? Disease (D), Get Immunized (I), Neither (N)

Measles	**D I N**	**Chicken Pox**	**D I N**	**Hemophilus Inf**	**D I N**
Tetanus	**D I N**	**Whooping cough**	**D I N**	**Rubella**	**D I N**
German Meas	**D I N**	**Mumps**	**D I N**	**Hepatitis B**	**D I N**

Any immunization reactions? _____

List all Supplements and Medications

Name and Dosage	Name and Dosage
1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

Review of Systems:

Present Weight: _____ **Weight one year ago**: _____ **Height**: _____
Maximum weight & when: _____ **Minimum weight as adult & when**: _____
Ideal Weight: _____

Fatigue: Yes No Past **If you have fatigue, when is it the worst**? Morning Afternoon Evening
Is your daily life effected by fatigue? Yes No

What is your greatest health concern: _____
How does it limit you the most: _____

Are you pregnant or nursing? **Yes** **No**

REGARDING THE NEXT LONG SECTION:

Please check any of the symptoms you are CURRENTLY EXPERIENCING or have experienced in the PAST AND EXPLAIN next to the words

Skin
□ Rash
□ Hives
□ Psoriasis/Eczema
□ Dry skin
□ Cancer
□ Color change
□ Lump
□ Itchy
□Warts/moles

Head
□ Headache □ Migraines
□ Head Injury
□ Dandruff
□ Hair loss

Nose
□ Frequent colds
□ Congestion
□ Polyps
□ Nosebleeds
□ Post Nasal Drip
□ Seasonal Allergies

Eyes
□ Dry/watery
□ Double Vision
□ Blurry Vision
□ Cataracts
□ Glaucoma
□ Itchy
□ Discharge
□ Last Eye Exam:_____

Mouth and Throat
□ Sore Throat
□ Canker Sores
□ Cold Sores (fever blisters)
□ Gum Disease
□ Last Dental Visit_____

Neck
□ Stiffness
□ Swollen Glands
□ Tension

Respiratory
□ Asthma
□ Bronchitis
□ Cough
□ Pneumonia
□ Painful Breathing
□ TB
□ Shortness of Breath
□ Wheezing

Cardiovascular
□ Arrhythmias
□ Chest Pain
□ Edema
□ High Blood Pressure
□ Low Blood Pressure
□ Palpitations
□ Murmurs

Urinary Tract
□ Discharge/blood
□ Frequent Infections
□ Kidney Stones
□ Incontinence
□ Pain with Urination
□ Urgency

Gastrointestinal
Bowel Movement Frequency: ___ / day
□ Bloating
□ Constipation/Diarrhea
□ Nausea/ Vomiting
□ Change in appetite
□ Recent Bowel Changes
□ Heartburn
□ Hemorrhoids
□ Ulcers
□ Pancreatitis
□ Gall Bladder Disease
□ Liver Disease
□ Other: _____
□ Date of Colonoscopy: _____

Nervous
□ Carpal Tunnel Syndrome
□ Sciatica
□ Tingling/ Numbness
□ Seizures
□ Fainting

Musculoskeletal
□ Weakness
□ Stiffness
□ Arthritis
□ Leg Cramps
□ Tremors
□ Pain

Mental/ Emotional
□ Anxiety
□ Anger/ Irritability
□ Depression
□ Eating Disorder
□ Fear/ Panic
□ High Strung/ Tense
□ Psych hospitalization
□ Suicidal

Endocrine
□ Diabetes
□ Fatigue
□ Thyroid
□ Other: _____

Male Genitalia
Sexual Orientation: Hetero Homo Bi
Sexually Active: Yes No
□ Hernia
□ Discharge
□ Impotency
□ Prostate Disease/ Symptoms: _____
□ Testicular Pain/ Swelling
□ STD: _____

Female Genitalia
Sexual Orientation: Hetero Homo Bi
Sexually Active: Yes No
Period lasts _____ days
How often periods occur: every ____ days
□ Heavy Menstrual Bleeding
□ Menstrual Pain
□ Menstrual Cramping
□ PMS
□ Food Cravings
Number of pregnancies: _____
Number of live births: ____
Number of abortions: ____
Number of miscarriages: ____
Date of last Pap Smear: _____ Normal Abnormal
□ Dry Vagina
□ Pain with intercourse
□ STD: _____
□ Diminished Libido
□ Vaginitis
Age at Menopause: ____
□ Use of Hormones:_____
□ Use of Birth Control: _____