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natural medicine & aesthetics

New Patient Intake Form

Confidential Contact Information:

Full Legal Name: ____________________/ ______________________ Preferred Name:_____________

Last name *First name*

Address: ______________________________/ _________________/ _____________/ _____________

Street #/ PO Box *City* *State* *Zip code*

Telephone: (H)____________________ (W)_________________(C)_____________________________

Email Address: ____

Would you like to be added to our list to receive occasional newsletters? Sure No thanks

What is the best way to communicate with you? (circle one) Email / Home ph / Work ph / Cell ph

Is there any place you do NOT want us to leave a message? ___________________________________

Emergency Contact: ____________________________________/______________________________

Name *Relationship*

Emergency Contact Phone Number: ____

How did you hear about Dr. Schulz? ____

Demographics & Social History:

Age: _______ Date of Birth:_________________________ Sex: M / F

Relationship: ____Single ____Married ____Partnership ____Seperated ____Divoriced ____Widowed

Occupation: ____ Hours per week: ___________

Employer: ____ SSN: ____-____-___________

Do you have a primary care provider (PCP)? Y N

Name: ___________________________________Location:___________________________________

Social History:

Do you currently or have you ever smoked cigarettes or used any tobacco products ? Yes No

Current or Past: ________________ When did you quit? ________________________________

If currently using tobacco products how often and how much? ______________________________

Do you currently drink alcohol? Yes No If so, how many drinks per week? ____________________

Have you ever felt you needed to cut down on your drinking? Yes No

Activity level (circle 1):

Low: mostly walking Moderate: cardio +resistance >150 min/ week High: cardio + resistance > 250 min/ week

Health Concerns:

List in order of importance, your health concerns and how long you have had these concerns or condition(s).

1. ________________________ ____ 3. ________________________ _____

2. ________________________ ____ 4. ________________________ _____

Have you ever been treated for the above conditions? How and what were the results?

____

____

Date of last physical exam: __________ Any abnormal findings: Yes No If yes, please explain:

____

____

General:

Height: _______ Weight: ______lbs. Weight one year ago: ______lbs.

When during the day is your energy the best? ___________________Worst?__________________

Medications:

List all prescription & over the counter medications you are currently taking: (not supplements)

Med: ______________________________ Dose: ______________ How long?_____________

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Med: ______________________________ Dose: ______________ How long?_____________

Pharmacy you prefer: ______________________ Location: _____________________________

Avalon Natural Medicine & Aesthetics
819 SE Morrison St. Suite 240
Portland, OR 97214
(971) 270-0402

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Supplements:

List all the herbs, vitamins, and minerals you are currently taking:

Supplement: ___________________________________ Dose: _________________ How long?__________

Supplement: ___________________________________ Dose: _________________ How long?__________

Supplement: ___________________________________ Dose: _________________ How long?__________

Supplement: ___________________________________ Dose: _________________ How long?__________

Allergies:

Are you allergic to any medications? Yes No

If yes, please list: ____

What is your reaction to this medication(s)? ____

Do you have any known allergies to foods or environmental exposures (e.g. cats, mold, dust)? Y N

Please list: ____

What is your reaction? ____

Personal Medical History:

What hospitalizations or surgeries have you had? Please give year if possible.

____

____

Family History:

In order to create a preventative wellness plan, it is important to know what diseases run in your family (i.e heart disease, cancer, diabetes, dementia)

Mother: ____

Father: ____

Siblings: ____

Grandparents: ____

Review of systems:

Please circle any symptoms you are currently having, or have recently experienced.

Skin

Psoriasis	Eczema	Acne	Rosacea

Respiratory

Asthma	Shortness of breath	Cough	

Cardiovascular

Chest pain	Murmur	Blood clots	Hypertension

Gastrointestinal

Diarrhea	Constipation	Change in frequency	Ulcers
Heartburn	Bloating	Pain	

Urinary

Incontinence	Freq. infections	Painful urination	Kidney stones

Musculoskeletal

Joint pain	Muscle spasms	Back pain	Sciatica
Arthritis	History of whiplash		

Neurological

Numbness /tingling	Loss of memory	Seizures	History of TBI

Mental/ Emotional

Mood swings	Anxiety	Depression	

Male Reproductive

Testicular mass	Erectile dysfunction	Prostate issues	Low libido
Poor energy	Decreased muscle	Brain fog	

Check here if youl have completed your family ___

Female Reproductive

Age of last menses (if post-menopause) _______ yo. Hysterectomy? Y N

How many days between periods? _______ How many days do you bleed?_________

Date of last PAP smear? ____________ Was is it normal? ________________________

Do you do regular mammograms? Y N Year of last screening: __________________________

Current use of birth control? Y N If yes, what type?_______________________________

Painful menses	Endometriosis	Ovarian cysts	Heavy flow
Fertility issues	Menopause symptoms	Breast lumps	Low libido
Pain with intercourse	Breast tenderness	PMS/ PMDD	

Number of pregnancies: ______ Live births:______ Miscarriages:______ Abortions:________

Ages of children? ___________ Complications of pregnancy?_______________________________

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