***Purity Integrative Health & Wellness Center, PLLC***

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| naturopathic INTAKE |
| All questions contained in this questionnaire are strictly confidential and will become part of your medical record.Date & Time of Initial Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name Full Legal Name: |  |
| Date of Birth:  |
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| PERSONAL HEALTH HISTORY |
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| \*\*GYNECOLOGICAL HISTORY--WOMEN ONLY\*\* |
| How old were you when you started your period: |  |  |  |  |
| Are you currently in Menopause? If yes, approximately when was your last menstrual cycle? | 🞎 | Yes | 🞎 | No |
| Any hot flashes or sweating at night? | 🞎 | Yes | 🞎 | No |
| Date of last menstruation (this is the date you began your period): |
| Period every \_\_\_\_\_ days and they last for \_\_\_\_\_ days  |
| Do you have any of the following: Heavy periods, irregularity, spotting, pain, or discharge? (Circle) | 🞎 | Yes | 🞎 | No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? (circle) | 🞎 | Yes | 🞎 | No |
| Gestational History:Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_ Number of Abortions \_\_\_\_\_ Number of Miscarriages \_\_\_\_\_Approximately how far along in the pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any complications during pregnancy such as pre-eclampsia or gestional diabetes? |
| Are you CURRENTLY pregnant or breastfeeding? | 🞎 | Yes | 🞎 | No |
| Did you breastfeed your children? If yes, for how many months? \_\_\_\_\_\_\_\_\_\_\_ | 🞎 | Yes | 🞎 | No |
| Any urinary tract, bladder, or kidney infections **within the last year**? | 🞎 | Yes | 🞎 | No |
| Any blood in your urine currently? | 🞎 | Yes | 🞎 | No |
| Any problems with control of urination? | 🞎 | Yes | 🞎 | No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? (circle) | 🞎 | Yes | 🞎 | No |
| Have you ever had an abnormal pap? If you’ve had an abnormal pap, did you have HPV?Did you receive treatment? If yes, what was done? | 🞎 | Yes | 🞎 | No |
| Date of last pap?Have you ever had a rectal exam? If yes, when? |

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| \*\*UROLOGY—MEN ONLY\*\* |
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| Do you usually get up to urinate during the night? If yes, # of times \_\_\_\_\_ | 🞎 | Yes | 🞎 | No |
| Do you feel pain or burning with urination? | 🞎 | Yes | 🞎 | No |
| Any blood in your urine? | 🞎 | Yes | 🞎 | No |
| Do you feel burning discharge from penis? | 🞎 | Yes | 🞎 | No |
| Has the force of your urination decreased? | 🞎 | Yes | 🞎 | No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | 🞎 | Yes | 🞎 | No |
| Do you have any problems emptying your bladder completely? | 🞎 | Yes | 🞎 | No |
| Any difficulty with erection or ejaculation? | 🞎 | Yes | 🞎 | No |
| Any testicle pain or swelling? | 🞎 | Yes | 🞎 | No |
| Have you had a prostate and rectal exam? If yes, date of most recent: | 🞎 | Yes | 🞎 | No |
| Last PSA test and value? |
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| MENTAL HEALTH |
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| Is stress a major problem for you? If yes, what is your stress level on a scale of 1-10?What are your primary stressors:  | 🞎 | Yes | 🞎 | No |
| Do you currently feel depressed? | 🞎 | Yes | 🞎 | No |
| Do you deal with anxiety on a regular basis? | 🞎 | Yes | 🞎 | No |
| Do you have problems with eating or your appetite? (Either overeating or under eating--circle) | 🞎 | Yes | 🞎 | No |
| Do you cry frequently? | 🞎 | Yes | 🞎 | No |
| Have you ever attempted suicide? | 🞎 | Yes | 🞎 | No |
| Have you ever seriously thought about hurting yourself? If yes, when or how recent? | 🞎 | Yes | 🞎 | No |
| Do you have trouble sleeping? | 🞎 | Yes | 🞎 | No |
| Have you ever been to a counselor, either individually or family/marriage? If yes, when & why? | 🞎 | Yes | 🞎 | No |

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| HEALTH HABITS AND PERSONAL SAFETY |
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| All questions contained in this questionnaire are optional and will be kept strictly confidential. |
| Exercise (Outside of work) | 🞎 Sedentary (No exercise) | 🞎 Mild exercise (golf, take stairs, yoga, etc) | 🞎 **Occasional** vigorous exercise (cardio 4x/wk for 30 minutes, active occupation) |
| 🞎 **Regular** vigorous exercise (i.e., work or recreation 5x/week for 30+ minutes, HR above 70% MaxHR) |
| **HOW MANY DAYS DO YOU EXERCISE PER WEEK:** | **HOW MANY MINUTES:** |
| **WHAT DO YOU DO FOR EXERCISE (run, walk, weights, etc):** |
| Diet | Do you follow a specific diet? Vegan Vegetarian Paleo Keto Whole 30 Other: |
| Typical Breakfast: |
| Typical Lunch: |
| Typical Dinner: |
| Typical Snacks/Treats: |
| How Much PURE water do you drink: \_\_\_\_\_\_\_\_\_\_ ounces or liters | JUICE:  | MILK: |
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| Caffeine | 🞎 None | 🞎 Coffee | 🞎 Tea | 🞎 Cola | 🞎 Energy Drinks |
| # of cups/cans per day? What kind? (Diet, regular, drip, espresso) |
| Alcohol | Do you drink alcohol? | 🞎 | Yes | 🞎 | No |
| If yes, what kind? | 🞎 Beer | 🞎 Wine | 🞎 Liquor/Mixed Drinks |
| How many drinks per day or week? | 🞎 Rarely or occasional/holidays |
| Are you concerned about the amount you drink? | 🞎 | Yes | 🞎 | No |
| Have you considered stopping? | 🞎 | Yes | 🞎 | No |
| Have you ever experienced blackouts? | 🞎 | Yes | 🞎 | No |
| Are you prone to “binge” drinking? | 🞎 | Yes | 🞎 | No |
| Have you ever been in treatment for alcohol or drugs? | 🞎 | Yes | 🞎 | No |
| Tobacco | Do you **currently** use tobacco products: | 🞎 | Yes | 🞎 | No |
| 🞎 Cigarettes – pks./day | 🞎 Chew - #/day | 🞎 Pipe - #/day | 🞎 Cigars - #/day |
| 🞎 # of years used: | Have you **ever** used tobacco? | 🞎 Year quit: |
| Drugs | Do you **currently** use recreational or street drugs? | 🞎 | Yes | 🞎 | No |
| Have you **ever** used or tried recreational/street drugs? If yes, list: | 🞎 | Yes | 🞎 | No |
| Sex | Are you sexually active? | 🞎 | Yes | 🞎 | No |
| If yes, are you trying for a pregnancy? | 🞎 | Yes | 🞎 | No |
| If not trying for a pregnancy list contraceptive or barrier method used: |
| Any discomfort with intercourse? | 🞎 | Yes | 🞎 | No |
| Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? |  |  |  |  |
| 🞎 | Yes | 🞎 | No |
| Personal Safety | Do you live alone? | 🞎 | Yes | 🞎 | No |
| Do you feel safe in your home physically, emotionally, sexually? | 🞎 | Yes | 🞎 | No |
| Do you have vision or hearing loss? | 🞎 | Yes | 🞎 | No |
| Do you have an Advance Directive or Living Will? | 🞎 | Yes | 🞎 | No |
| Do you have frequent falls? | 🞎 | Yes | 🞎 | No |
| Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? |  |  |  |  |
| 🞎 | Yes | 🞎 | No |

Additional Information—Anything else you want the doctor to know? Describe below: