Deneen Natural Health - Dr. Shana Deneen
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Intake Form

Name: _____ Birth Date: _____
If you are under 18, what are your guardian's name(s): _____
What name do your prefer to be called?_____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Alternate phone: _____
Email address: _____
How do you prefer us to contact you? _____
Is it okay to leave a message on your phone? ____ Is it okay to send an email? _____
Can I add you to my email newsletter with health information and recipes? __ Yes __No

Emergency Name / Contact Number: _____

Primary Care Physician (PCP): _____
When is the last time you saw your PCP? _____
Other Health Care Providers: _____
How did you hear about us? _____

Health History

For what concerns are you presenting here?
1. _____
2. _____
3. _____

Other Current Medical Diagnosis

_____
_____

Past Surgeries and Traumatic Injuries

_____
_____

Allergies & Intolerances

_____
_____

Family Medical History

Mother: _____
Maternal Grandparents: _____

Father: _____
Paternal Grandparents: _____
Siblings: _____
What is your family heritage? _____
_____

Review of Systems - ***Indicate past (P) or current (C)***

HEAD
___ Headaches / Migraines
___ Visual Disorder
___ Watery, itchy, or dry eyes
___ Sensitivity to light
___ Sinus problems
___ Dental problems
___ Hearing Loss
___ Ringing in the ears
___ Earache
___ Light-headed / dizzy

RESPIRATORY
___ Asthma, bronchitis
___ Hoarseness
___ Emphysema
___ Pneumonia
___ Tuberculosis
___ Shortness of breath
___ Chronic cough

GASTROINTESTINAL
___ Reflux / Ulcers
___ Sore throat / difficulty swallowing
___ Inflammatory Bowel Disorder
___ Hepatitis
___ Gallbladder disease
___ Constipation
___ Abdominal pain
___ Diarrhea
___ Nausea / Vomiting
___ Gas / Bloating

CARDIOVASCULAR
___ High blood pressure
___ Elevated cholesterol
___ Heart disease
___ Arrhythmia / Murmur / Palpitations
___ Chest pain
___ Heart Attack
___ Stroke

NERVOUS SYSTEM
___ Dementia

MUSCULOSKELETAL
___ Back Pain
___ Carpal Tunnel Syndrome
___ Gout
___ Osteoporosis
___ Joint pain or stiffness
___ Arthritis

SKIN
___ Acne
___ Itching
___ Rashes, cysts, or warts
___ Easy bruising
___ Swelling / edema
___ Eczema / Psoriasis
___ Dry skin
___ Varicose veins
___ Hair loss / changed texture
___ Nail changes

ENDOCRINE
___ Chronic Fatigue
___ Diabetes
___ Thyroid Disorder
___ Weight loss / gain
___ Change in thirst / appetite
___ Overly cold or hot

MENTAL / EMOTIONAL
___ Depression
___ Anxiety
___ Anger management
___ Grief
___ Drug addiction
___ Eating disorder
___ Learning disorder
___ Alcoholism
___ ADD / ADHD

IMMUNE / BLOOD
___ Clotting disorder
___ Chronic infection
___ Slow wound healing
___ HIV / AIDS

MALE REPRODUCTIVE
___ Enlarged Prostate
___ Sexually active
___ Decreased sex drive
___ Infertility
___ STD
Type Date Diagnosed
_____ _____
_____ _____

Date of last prostate exam ____

FEMALE REPRODUCTIVE
___ Menstrual irregularities
___ Endometriosis
___ Fibrocystic breasts
___ Fibroids / ovarian cysts
___ PCOS
___ Premenstrual syndrome
___ Menopausal symptoms
___ Breast Cancer
___ Vaginal infections
___ Decreased sex drive
___ Urinary Tract Infection
___ STD
Type Date Diagnosed
_____ _____
_____ _____

Date of last menstrual cycle ___
Length of cycle _____ Interval of time between cycles _____
Date of last GYN exam _____
PAP +/- Date _____
Sexually active? Y N
Birth control? _____
# of children _____
# of pregnancies _____
Are you pregnant? Y N
Age of first period? _____
List any PMS symptoms (e.g. heavy / scanty flow, clots, cramp, breast tenderness, bloating, mood changes, other)

___ Seizures
___ Poor concentration / memory
___ Neuropathy or Paralysis
___ Multiple Sclerosis
___ Restless Legs

___ Anemia

CANCER

Type	Date
_____	_____
_____	_____

_____
_____

___ Post menopausal
___ Surgical menopause

URINARY

___ Kidney or Bladder Disease
___ Incontinence
___ Frequent or painful urination
___ Kidney stones

OTHER

_____
_____
_____

Medications and Supplements

Current medications, supplements and herbal medicines (write on back, if necessary).
Include any medication you take for pain, as well

Medication / Supplement	**Used for**	**Date Started**	**Dosage / Frequency**

Tobacco: ___ Never used ____ Used, but quit ____ Currently using
Alcohol: ___ Never used Frequency: _____
Recreational Drugs: ____ Never used _____ Used, but quit ____ Currently using
Are you currently having thoughts of harming yourself or others? ___Yes ____No

Lifestyle

Occupational Status: _____
What do you love to do? _____
Please list your spiritual orientation or religion? _____

What is your marital status? ____ Single ____ Married ____ Separated / Divorced
____ Significant partner (not legally married) ____ Widowed ____Other:_____

Do you cook for yourself or your family? ____ Yes ____ No
How many times do you eat each day? _____

How many hours do you sleep? _____
Do you have difficulty: ____ Falling asleep ____ Staying asleep ____ Waking early ____ Waking refreshed

What have you eaten and drank in the past 24 hours (or on a typical day)?
_____
_____

Are there any foods you avoid? _____
What type of regular movement do you engage in? _____

How would you rate the level of stress in your life (0-10, 10 highest)? _____
How do you rate your ability to manage your stress (0-10, 10 best)?_____
How do you rate your energy level (0-10, 10 best)? _____

What healthy habits do you already engage in?
_____
_____

What are your long term goals in regards to your overall health and working with this Clinic?
_____
_____

Have you ever worked with a naturopathic doctor before? _____

What modalities are you open to trying (place a "?" if you don't know)
_____ Nutrition ____ Supplements ____ Botanical / Herbal Medicine
_____ Acupuncture ____ Hydrotherapy ____ Homeopathy
_____ Lab work ____ Lifestyle / Movement

I attest the above information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____