Crystalin Montgomery, Naturopathic Doctor, Licensed Acupuncturist

Adult Intake Form

Name _____Today's Date _____/ _____/ _____ Birth date _____/_____/ _____

Address_____City/State/Zip_____

Email_____ Preferred phone _____

Gender: F__ M__ Non-binary__ Other_____ Preferred Pronoun: she/her___ he/him____ they/them____ other_____

Married: ____Separated:____ Divorced:____ Widowed:____ Single:____ Partnership:____

Live with: Spouse____ Partner____ Parents____ Children____ Friends____ Alone ____

Occupation:_____ Hours per week:_____ Employer:_____

Hobbies/Interests:_____

How did you find Dr. Montgomery? Please check one:

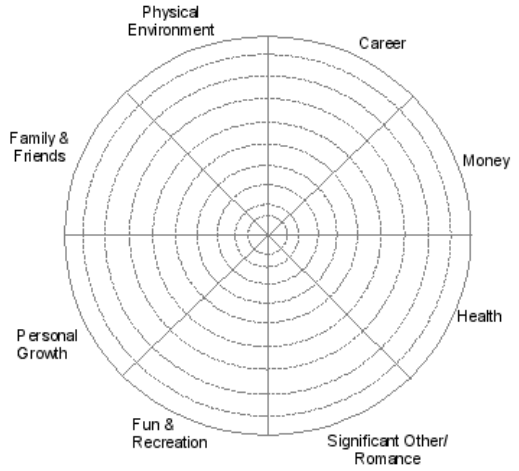
- ☐ Referred by _____
- ☐ Minnesota Association of Naturopathic Physicians website
- ☐ American Association of Naturopathic Physicians website
- ☐ Health Profs website
- ☐ Other _____

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Are you currently receiving healthcare? Y N: If yes, where and from whom:_____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

Do you have any known contagious diseases at this time? Y N: If yes, what?_____

List current and ongoing health concerns:	Rate: Mild/Moderate/Severe	Date of Onset
1)		
2)		
3)		
4)		
5)		

What goal(s) do you have for today's appointment?_____

What is your present level of commitment to making healthy lifestyle choices? (Rate from 0 to 10 with 10 being 100% committed):

1 2 3 4 5 6 7 8 9 10

Family History

Do you have a family history of any of the following (please check)?

_____Cancer _____Diabetes _____Heart Disease _____High Blood Pressure _____ Osteoporosis _____Anemia

_____Kidney Disease _____Epilepsy _____Arthritis _____Glaucoma _____Tuberculosis _____Stroke

_____Mental Illness _____ Alcoholism _____Asthma/Hayfever/Hives _____ Endometriosis

_____Alzheimer's or Dementia _____Ulcers _____Celiac Disease _____Migraines _____ Thyroid Disorder

_____ Autism/Asperger's _____ADD/ADHD Other_____

Childhood Illnesses

Please check whether you had any of these as a child:

_____Scarlet fever _____Diphtheria _____Rheumatic fever _____Measles/Mumps/German measles _____Chicken Pox

_____Frequent colds/flus _____Frequent fevers _____Tonsillitis _____Ear infections _____Allergies/Hives

_____Eczema/Skin Condition _____Asthma _____Exposure to second hand smoke _____Urinary Tract Infections

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, or imaging studies (i.e. x-rays, CT Scans, MRIs, EEGs, EKG's) have you had?

_____year: _____ _____ year: _____

_____year: _____ _____ year: _____

_____year: _____ _____ year: _____

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental substances or chemicals? _____

Current Medications

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

(You may attach a separate list if extra space is needed.)

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

How often have you taken antibiotics?	Less than 5 times	Greater than 5 times
Infancy/Childhood		
Teens		
Adulthood		

General

Height:_____ Weight: lbs. _____ Weight 1 year ago: lbs. _____

Maximum Weight : _____When: _____

When during the day is your energy the best?_____ worst? _____

Food Intake for the last 3 days

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

REVIEW OF SYSTEMS

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Habits

Do you exercise? Y N If yes, what kind? How often? _____

Do you use tobacco?	Y N P	Do you drink cola/other sodas?	Y N P
Smoked previously?	Y N P	Drink coffee?	Y N P
How many years? _____ how many packs per day? ___		Drink black/green tea?	Y N P
Use recreational drugs?	Y N P	Do you add salt?	Y N P
Type and frequency_____		Do you eat refined sugar?	Y N P
Use alcoholic beverages?	Y N P	Do you eat 3 meals a day?	Y N
How many drinks per week?_____		Do you go on diets often?	Y N
Treated for alcoholism or drug dependence?	Y N P	Do you eat out often?	Y N
Do you have a history of abuse?	Y N P	Average 6-8 hours sleep every night?	Y N
Any major traumas?	Y N P	Awaken rested?	Y N
Do you have a religious or spiritual practice?	Y N P		

If yes, what? _____

Mental / Emotional

Treated for emotional concerns?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Restlessness/Irritability?	Y N P

Reduced sex drive?	Y N P	Easily stressed?	Y N P

Immune

Reactions to immunizations/vaccines?	Y N P	Allergies?	Y N P
Chronic Fatigue Syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P
Autoimmune disease?	Y N P	Lyme Disease?	Y N P
Mononucleosis?	Y N P	Were you breast fed as an infant?	Y N

Endocrine

Hypothyroid or hyperthyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P
Headaches or migraines?	Y N P	Learning disabilities?	Y N P
Poor physical coordination?	Y N P	Difficulty making decisions?	Y N P

Skin

Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P
Color Change?	Y N P	Perpetual Hair Loss?	Y N P
Lumps?	Y N P	Night Sweats?	Y N P

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems?	Y N P

Eyes

Spots in eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P
Itchy, swollen, red or sticky lids?	Y N P	Bags or dark circles under eyes?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches or ear infections?	Y N P	Dizziness?	Y N P
Itchy ears?	Y N P	Fluid or discharge from ear?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness?	Y N P	Hayfever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore or swollen tongue/lips?	Y N P
Swollen or bleeding gums?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Gagging/frequent need to clear throat?	Y N P
Canker sores?	Y N P		

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	Shortness of breath lying down?	Y N P
Tuberculosis?	Y N P		

Cardiovascular

Heart disease?	Y N P	Angina or chest pain?	Y N P
High/Low Blood Pressure?	Y N P	Irregular or skipped heartbeats?	Y N P
Rapid or pounding heartbeat?	Y N P	Blood clots?	Y N P
Fainting?	Y N P	Phlebitis?	Y N P
Rheumatic Fever?	Y N P	Swelling in ankles?	Y N P

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching, bloating, or passing gas?	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? _____	
Gall Bladder disease?	Y N P	Is this a change? _____	
Liver Disease?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P

Lactose intolerance?	Y N P	Parasites?	Y N P

Urinary

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Feeling of weakness or tiredness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P
Osteoporosis?	Y N P		

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

Men Only

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Venereal disease?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N	Chlamydia?	Y N P
Sexual orientation: _____		Gonorrhea?	Y N P
Impotence?	Y N P	Condyloma?	Y N P
Premature ejaculation?	Y N P	Herpes?	Y N P
Birth control?	Y N P	Syphilis?	Y N P
Type?_____			

Women Only

Age of first menses? _____		Date of last annual exam/ PAP _____	
Age of last menses? (if menopausal) _____		Are cycles regular?	Y N
Length of cycle? _____ days		Bleeding between cycles?	Y N P
Duration of menses? _____ days		Pain during intercourse?	Y N P
Painful menses?	Y N P	Clotting?	Y N P
Heavy or excessive flow?	Y N P	Discharge?	Y N P
PMS?	Y N P	Birth control?	Y N P
If yes, what are your symptoms? _____		What type? _____	
Number of pregnancies: _____		Number of live births: _____	
Number of miscarriages: _____		Number of abortions: _____	
Ovarian cysts?	Y N P	Endometriosis?	Y N P
Difficulty conceiving?	Y N P	Menopausal symptoms?	Y N P
Cervical Dysplasia?	Y N P	Abnormal PAP?	Y N P

Sexual difficulties?	Y N P	Chlamydia?	Y N P
Gonorrhea?	Y N P	Condyloma?	Y N P
Herpes?	Y N P	Syphilis?	Y N P
Are you sexually active?	Y N	Sexual orientation: _____	
Do you do breast self exams?	Y N P	Breast lumps?	Y N P
Breast pain/tenderness?	Y N P	Nipple discharge?	Y N P