NATURAL HEALTH CONNECTIONS **JAN A. SOLOY, MS, ARNP**

Integrative Health Care Intake Form

NAME APPOINTMENT DATE AND TIME

MAILING ADDRESS

PHONE NUMBER EMAIL ADDRESS

Concerns (in order of priority)	**Onset** days/wks/yrs	**Frequency** rarely/occ/daily	**Severity** mild/mod/severe
1.____________________	________	________	________
2____________________	________	________	________
3.____________________	________	________	________
4.____________________	________	________	________
5.____________________	________	________	________

What are your goals for this visit?______________________ ____________________________

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Illnesses **YOU** have had	Past	Present	**Family** members who have had these illnesses
Heart Disease	___	___	______ ______________________________
Hypertension	___	___	_____________________________________
Cancer	___	___	_____________________________________
Diabetes	___	___	_____________________________________
Asthma/COPD	___	___	_____________________________________
Hepatitis	___	___	_____________________________________
Digestive problems	___	___	_____________________________________
Seizures	___	___	_____________________________________
Thyroid disease	___	___	_____________________________________
Other _________________	___	___	_____________________________________

Do you have any **ALLERGIES** to medications?

Medication Name	Type of Reaction/Intolerance
____________________	____________________
____________________	____________________

Surgeries/Procedures What	When	**Injuries** What	When

Practitioner Notes:

What is your Occupation?__________________________________ For how long? ______________

What are your hobbies/special interests? ____

With whom do you live? (include all humans and pets in your household)

What physical activities do you do (and how often?)____________________________________

What are the major stressors in your life? ____

Patient Name ____ MR# _______________

What do you do to relax/cope with stress?

____

____

____

What are your spiritual/religious/cultural affiliation(s) ? ____________________________

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____

What prior experiences have you had with alternative/integrative health care?

____

____

____

Please note your use of the following substances:

Tobacco:
__ Never used Smoked/Chewed from age ____ to ____. ___ packs per day

Alcohol:
__ Never used Estimate the number of drinks per day ________.

Other Drugs:

__ Never used

__ Opiates last used ______________________________
__ Cocaine last used ______________________________
__ Meth last used ______________________________
__ Benzo last used ______________________________
__ Marijuana last used ______________________________
Other (Name) _______________ last used ______________________________

What Medications are you taking now? (include prescription and over-the-counter drugs)

Medication Name	Dosage	Reason	When Started

Patient Name ________________________________ **MR#** ____________

What Vitamins/mineral/supplements are you taking now?

Name and Brand	Dosage	Reason	When started

Are you currently on a special diet? If yes, please describe

How would you describe your relationship with food?

On the following page, please list everything you ate yesterday; it doesn't need to be in mealtime order.

Then explain whether this was a typical day diet-wise and if not, what is usually different.

Patient Name ______________________________ MR# ____________

NATURAL HEALTH CONNECTIONS
Nutrition Evaluation

Recall of dietary intake for the past 24 hours:

Please list ALL foods and beverages you have consumed in the past 24 hours. Include meals, snacks, drinks and condiments.

Food Item	Preparation? (baked, fried, etc.)	Amount (cups, Tbsp, ounces, etc.)

Patient Name ________________________________ **MR#** ______________