

The Luna Center for Natural Health
Dr. Emily Miller, ND
10 Strawberry Dr, Unit 9
Dover, NH 03820

Adult Intake Form

Last Name: _____ First Name: _____ Birthdate: _____

What is your purpose for coming in today?

What do you know of Naturopathic Medicine?

What long-term expectations do you have for your health overall?

What expectations do you have of me as your healthcare provider?

What behaviors do you engage in that are currently supporting your health?

What potential obstacles or challenges do you foresee in addressing the lifestyle factors that may be contributing to your current health condition?

What is your level of commitment? Scale 1-10

Present Health Concerns

What is your main health concern today?

What are your current health problems? List as many as you can.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Are you seeing any other healthcare providers for these problems or have you in the past? Please specify the condition, practitioner seen, and when.

Family History

Do you or anyone else in your family have any of the following? Please circle and indicate below.

- | | | |
|---------------------|------------------|----------------|
| Cancer | Arthritis | Mental Illness |
| Kidney Disease | Thyroid Disorder | Hearing Loss |
| Diabetes | Glaucoma | Asthma |
| Heart Disease | Tuberculosis | Hay Fever |
| High Blood Pressure | Stroke | Hives |
| Epilepsy | Anemia | Eczema |

Other relevant family history? _____

Family Heritage? _____

Personal Past History

Please list any major illness you have had in the past, going back to childhood.

Please list any Surgeries, Hospitalizations, and/or Medical Imaging that you have experienced indicating the year and outcome.

Allergies

Please list any allergies that you are aware of including drug allergies, foods, and environmental or chemical allergies.

Medications

Are you taking any of the following? Please circle and list dosages below.

- | | | |
|---------------------|---------------------|-----------|
| Laxatives | Sleeping Pills | Cortisone |
| Birth Control Pills | Hormone Replacement | |
| Pain Relievers | Thyroid Medication | |
| Antacids | | |

Please list any other prescription medications or supplements (vitamins and herbs) that you are taking and include dosages.

1. _____
2. _____
3. _____
4. _____

General Information:

Do you exercise regularly? Y / N If so, describe.

What are your main interests and hobbies?

Do you have a spiritual practice? Y / N If yes, describe.

For Women Only:

Have you ever been pregnant? If so, please list pregnancies by year, complications if any, and outcome.

Have you had a mammogram? Y / N If so, when?

Conditions: (Please circle any conditions you have currently or have had in the past.)

- | | | |
|---------------------|------------------|--------------------|
| AIDS/HIV | Glaucoma | Polio |
| Alcoholism | Gonorrhea | Prostate Problems |
| Anemia | Gout | Psychiatric Care |
| Anorexia | Heart Disease | Rheumatic Fever |
| Asthma | Hepatitis | Scarlet Fever |
| Bleeding Disorder | Herpes | Stroke |
| Bulimia | High Cholesterol | Thyroid Problems |
| Cancer | Pacemaker | Tuberculosis |
| Epilepsy | Liver Disease | Ulcers |
| Chemical Dependency | Migraines | Vaginal Infections |
| Chicken Pox | Miscarriages | |
| Diabetes | Mumps | |

Symptoms: (Circle symptoms that you currently have or have had in the past year.)

General:

Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of Sleep
Nervousness
Numbness
Sweats

Gastrointestinal:

Bloating
Constipation
Bowel Changes
Diarrhea
Excessive thirst
Rectal Bleeding
Indigestion
Nausea
Stomach pain
Vomiting

Eyes, Ears, Nose:

Bleeding Gums
Vision Changes
Hay Fever
Earache
Ear Discharge
Difficulty Swallowing
Hearing Loss
Nose Bleeds
Persistent Cough
Ringing in Ears
Sinus Problems

Genito-Urinary:

Blood in Urine
Incontinence
Painful Urination
Frequent Urination

Men Only:

Lump in Testicles
Sore on Penis
Erection Difficulty
Penis Discharge

Muscle/Joint:

Pain or weakness in...
Arms
Legs
Hips
Back
Neck
Shoulders
Hands

Cardiovascular:

Chest Pain
High Blood Pressure
Irregular Heart Beat
Poor Circulation
Rapid Heart Beat
Swelling of ankles
Varicose Veins

Skin:

Bruise easily
Discoloration
Hives
Itching
Change in moles
Rash
Sores that won't heal

Women only:

Abnormal Pap
Irregular periods
Breast Lump
Vaginal pain/discharge
Nipple Discharge

Is there anything else you would like Dr. Miller to know about you and/or your health history?