Sarah LoBisco, ND
Doctor of Naturopathic Medicine
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Client Intake Form

Name ______________________ Age ____________

Birth date ______________________

Address ______________________ Email ____________

City ______________________ State/Zip ______________________

Home Phone ______________________ Work Phone ______________________

Cell Phone: ______________________

Occupation ______________________

Employer ______________________

Marital Status ______________________

Name of Spouse/Partner ______________________

How Long Have Both of You Been Together? ______________________

Religion/Spiritual Practice ______________________

If Client is a Minor, Name of Responsible Adult

____

Reason for Visit: ______________________

____

What have you tried to help this problem?:

____

What works? ______________________

What makes it worse?: ______________________

Do You Smoke? ____________ How Much? ____________ Do You Drink? ________

How Much per week? ______________________

Do You Take Drugs? ________ If yes, what kind? ______________________

How often per week? ______________________

Allergies? ____________ Date of Last Medical Examination ____________

Reason ______________________

Are You Now Under a Doctor's Care? ______________________

If yes, Doctor’s name: ______________________

Reason for Doctor’s Care: ______________________

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Are You Taking Any Medication?____

If yes, please list? ____

Reason for Medication(s): ____

Supplements taking: ____

Reason:____

Have You Ever Been Hospitalized for a Physical Illness?

Describe: ____

Surgeries (including tonsil removal) ____

____

Have you ever been hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc? Describe: ____

____

Exercise? Type? ____________________________

How often? ___________________________________

Diet (breakfast, lunch, dinner and snacks)
B____

L
____

D
____

S
____

Fluids
____

Water ____ oz/day

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Please indicate if any of the following conditions below currently affect you (X) or if you have experienced them in the past 3 years (3):

_____ High Blood Pressure _____ Blood Clots _____ Heart Attack/Stroke

_____ Low Blood Pressure _______Anemia _______Heart/circulation problems

_____ Vision Problems _____Contact Lenses ______ Dizziness

_____ Low Back Pain ________Muscle pain _____________Joint Pain

_____ Tendonitis _____ Arthritis _____ Bursitis ________ Sprains/Strains

______ Broken bones _______Osteoporosis ______Scoliosis

______Weakness _____ Headaches _____ Diabetes _____ Hypo or Hyperglycemia

_______Bruise easy

_____ Contagious Conditions _____ Skin Infections/Problems _______Varicose Veins

_____ Pregnant, _______ mo. along

_____ Sinus Problems _______Chronic colds/bronchitis

_____ Cancer/ Tumors

_____ Depression _____ Sleep Difficulties _____ Dizziness

______ Cloudy thinking ________Fatigue/low energy

_____ Seizures/Epilepsy _____ Allergies

_____ Numbness/Stabbing Pains _____ Sensitive to Touch/Pressure _____Radiating Pain

_____ Digestive Disturbances: (Circle: Constipation, diarrhea, diverticulosis, gas, bloating)

How many times do you have a bowel movement per week ________________

________Urinary Tract Infections ___________Bladder Infections

Women: _________PMS _________Irregular or painful periods ________Irregular PAP Smear

________Pelvic Pain ___________Heavy flow ___________Problems conceiving

_________Hysterectomy ___________D&C __________C-Sections

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Men: _________BPH _________High PSA _________Irregular DRE

Medical Diagnoses Given By Your Provider:
____

____

Other Concerns not diagnosed or anything you wish to address not covered by this form:

____

____

Your goal for this visit: ____

Your long-term health goal: ____