BOYER B. COLE, N.M.D.

PATIENT INTAKE FORM

NAME:_____PHONE: (_____)_____ CELL(____)_____

BIRTH DATE: ____/_____/____ E-MAIL_____ AGE _____ DATE_____

MAILING ADDRESS:_____ZIP_____

OCCUPATION:(PRES./PAST) _____EMPLOYER: _____WORK PHONE:(_____)_____

SPOUSE'S NAME? _____CHILDREN? _____EMERGENCY PHONE: (_____)_____

LAST PHYSICIAN CONSULTED:_____REASON_____ DATE: _____

HOW WERE YOU REFERRED HERE?_____

CURRENT CONDITIONS OR HEALTH CONCERNS YOU HAVE:_____

_____

ANY ALLERGIES OR REACTION TO DRUGS OR VACCINATIONS? _____

CURRENT MEDICATIONS OR SUPPLEMENTS YOU ARE TAKING: _____

_____

DO YOU: SMOKE? **Y N** IN PAST **Y N** WHEN QUIT____HOW LONG? _____ HOW MANY PACKS? _____

DO YOU: EXERCISE? **Y N** WHAT FORM?_____

DRINK COFFEE **Y N** NUMBER OF CUPS_____ BLACK TEA**? Y N** NUMBER OF CUPS_____

DO YOU: DRINK ALCOHOLIC BEVERAGES? **Y N** AMOUNT _____ USE RECREATIONAL DRUGS? **Y N**

WERE YOU PREMATURE? **Y N** HOW IS YOUR CURRENT STATE OF HEALTH?
_____

DO YOU ENJOY YOUR JOB/WORK? _____ HOW IS YOUR FAMILY/HOME LIFE?
_____

RELATIVE	**HEALTH STATUS**	**AGE**	**IF DECEASED, CAUSE & AGE OF DEATH (if cancer, state type of cancer)**
FATHER			
MOTHER			
SIBLINGS			

FAMILY HISTORY: *Grandparents, Parents, Siblings.* PAST OR PRESENT **FAMILY** CONDITIONS:

____ASTHMA ____BLOOD DISORDERS ____ HEART DISEASE ____STOMACH/INTESTINE

____ARTHRITIS ____CANCER (**type**) ____ HYPERTENSION ____STROKE

____ALLERGIES ____DEPRESSION ____ MENTAL DISORDER ____THYROID CONDITION

____ALCOHOLISM ____DIABETES ____MIGRAINES ____ SKIN DISEASE

(over)

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PERSONAL HISTORY: CURRENTLY, OR IN THE PAST HAVE YOU EXPERIENCED ANY OF THE FOLLOWING. *PLEASE STATE* **YEAR** IN SPACE PROVIDED.

YEAR	YEAR	YEAR
____ ABUSE	____ EATING DISORDER	____ PROSTATE PROBLEMS
____ ALLERGIES	____ FRACTURES/TRAUMA	____ PESTICIDE OR CHEMICAL EXPOSURE
____ ARTHRITIS	____ HEADACHES	____ SHORT OF BREATH
____ ASTHMA	____ HEART DISEASE	____ SINUS PROBLEMS
____ BACK INJURY	____ HEPATITIS	____ SKIN DISEASE
____ CANCER (type)	____ HEMORRHOIDS	____ STOMACH-INTESTINAL DISORDERS
____ CHR, DIARRHEA	____ HERPES	____ TESTED FOR HIV (AIDS) **positive/negative**
____ CONSTIPATION	____ HYPERTENSION	____ THYROID DISEASE
____ DEPRESSION	____ MENTAL ILLNESS	____ T.M.J
____ DIABETES	____ MIGRAINES	____ VENEREAL DISEASE
____ DRUG ABUSE	____ALCOHOLISM	

HAVE YOU HAD ANY **HEAD INJURIES**?_____

NOTE ANY **SERIOUS ILLNESS** OR **SURGERY** YOU HAVE HAD AND THE **DATE** :_____

_____

LIST ANY PLASTIC OR COSMETIC SURGERY _____

DO YOU KNOW YOUR BLOOD TYPE ? _____ DO YOU TEND TO BE: **WARM? COLD?**

DO YOU HAVE AMALGAM (SILVER) FILLINGS **Y N** ANY ROOT CANALS? **Y N** CROWNS? **Y N**

WERE YOU BREAST FED? **Y N** ANY TEETH REMOVED? #_____ DENTURES? **Y N**

YOU HAVE PETS? DOGS CATS HORSES OTHER_____

WOMEN: # OF PREGNANCIES _____ BIRTHS _____ MISCARRIAGES _____ INDUCED ABORTIONS _____

ANY COMPLICATIONS FROM THE ABOVE? _____

FIRST DAY OF LAST PERIOD _____ LENGTH OF *FLOW*_____ LENGTH OF *CYCLE*_____

PAST OR PRESENT: PMS, MENSTRUAL DIFFICULTIES OR **BREAST/OVARY** CYSTS?_____

COULD YOU BE PREGNANT? **Y N** MENOPAUSE? **Y N** WHEN?_____

TYPES OF BIRTH CONTROL PREVIOUSLY USED _____

TYPES CURRENTLY USING _____

HAVE YOU EVER TAKEN ESTROGEN (THE PILL) ? **Y N** ARE YOU CURRENTLY? **Y N** HOW LONG?_____

PLEASE READ AND SIGN THE FOLLOWING: I AM CHOOSING TO SEE A NATUROPATHIC DOCTOR. I UNDERSTAND THAT PAYMENT FOR SERVICES, LAB TESTS AND PHARMACY ITEMS ARE DUE AT THE TIME I RECEIVE THEM.

DATE _____ SIGNATURE _____