

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 <u>(if cancer, state type of cancer)</u>
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FATHER	_____	_____	_____
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MOTHER	_____	_____	_____
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SIBLINGS	_____	_____	_____
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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** 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 _____