NW Olive Clinic LLC
Natural Medicine and Primary Care

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Intake Form

Date of visit:

Name: _____ Date of Birth: Age: Gender:
Marital status: Single_____ Married_____ Other_____
Address: _____City: _____ State: __ Zip Code: ____
Telephone #(Cell): _____ (Home): _____(Work): _____
Email address: _____Occupation: _____
Is it ok to leave a message? _____
Emergency Contact: _____Relationship: _____ Phone: _____
Address: _____
Preferred Pharmacy**:** _____
Are you currently receiving healthcare? Y N
What are your most important health problems? List as many as you can in order of importance.
1) _____2) _____
3) _____4) _____
5) _____6) _____

Patient history

Y=Yes **N=No** **P=Past**

Hypothyroid	Y	N	Hyperthyroid	Y	N	Hypoglycemia	Y	N
Diabetes	Y	N	Weight loss	Y	N	Weight gain	Y	N
Seizures	Y	N P	Paralysis or stroke	Y	N P	Memory problem	Y	N P
Headaches	Y	N	Migraines	Y	N	Head Injury	Y	N P
Rashes/itching	Y	N	Acne, Boils	Y	N	Lumps/moles	Y	N P
Double vision	Y	N	Cataracts/ Glaucoma	Y	N	Blurriness	Y	N
Color blindness	Y	N	Eye pain/strain	Y	N			
Impaired hearing	Y	N	Ringing/Vertigo	Y	N	Earaches	Y	N
Hay fever	Y	N P	Nose bleeds	Y	N P	Sinus problems	Y	N P
Frequent sore throat	Y	N P	Gum problems	Y	N	Hoarseness	Y	N P
Lumps	Y	N P	Swollen glands	Y	N P	Goiter	Y	N P
Cough (dry or productive)	Y	N	Difficulty breathing	Y	N	Spitting up blood	Y	N P
Tuberculosis or Pneumonia	Y	N P	Asthma	Y	N P	COPD	Y	N
Chest pain	Y	N P	Angina	Y	N P	Heart murmurs	Y	N
High blood pressure	Y	N	Blood clots	Y	N P	Fainting	Y	N
Palpitations/fluttering	Y	N P	Swelling in ankles	Y	N P	Rheumatic fever	Y	N P

Low appetite	Y N	Nausea	Y N	Blood in stool	Y N
Vomiting of blood	Y N	Constipation	Y N	Diarrhea	Y N
Gall bladder/Liver disease	Y N P	Trouble swallowing	Y N P	Abdominal Pain	Y N
Heartburn/GERD	Y N	Vomiting	Y N	Hemorrhoids	Y N
Pain on urination	Y N	STD (STI)	Y N P	Incontinence	Y N
Frequency of urination	Y N	Frequent UTI	Y N P	Kidney stones	Y N P
Joint pain	Y N P	Muscle pain/spasm	Y N	Joint swelling	Y N P
Are you sexually active?	Y N P	Sexual orientation			
Female					
Age of first menses		Are cycles regular?	Y N	Heavy or light	
Age of last menses		PMS symptoms?		Ovarian cysts	Y N
Are you sexually active?	Y N	Sexual orientation?			
Male					
Testicular masses/pain	Y N P	Hernia	Y N P	Prostate disease	Y N
Depression		Suicide history	Y N P	Anxiety	Y N P
Immunizations					
Polio	Y N	Pertussis	Y N	Flu	Y N
Measles/Mumps/Rubella	Y N	Hep B	Y N	H. Influnzae (HIB)	Y N

Family history

	Mother	Father	Brothers	Sisters	MGM	MGF	PGM	PGF
Cancer								
Diabetes								
Heart Disease or High Blood Pressure								
Thyroid disease								
Stroke								
Mental Illness								
Asthma								
Allergy								
Eczema								
Kidney Disease								
Other								

Allergies: Drugs_____
Any foods_____
Any environmentals_____
Please list any prescription medications, over the counter medications, vitamins, or supplements you are currently taking:
1)_____ 2)_____ 3)_____
4)_____ 5)_____ 6)_____
Hospitalization and Surgery: _____ Major Trauma/Injury: _____

_____ _____
Patient (18 years or older) Date

_____ _____
Parent, Guardian, Responsible Party Date