740 N. Lake Avenue • Pasadena, CA 91104
tel: (626) 794-4668 • *fax:* (626) 345-9753
email: info@pasadenanaturealhealth.com
web: pasadenanaturalhealth.com

Paracelsus
Natural Family Health Center, Inc.

112 E. Olive Avenue, Suite E • Redlands, CA 92373
tel: (909) 793-4477 • *fax:* (909) 793-9350
email: info@redlandsnaturalhealth.com
web: redlandsnaturalhealth.com

Daniel Brousseau, D.O. • Simon Barker, N.D. • Nadia Mistry, N.D.

ADULT INTAKE

PERSONAL INFORMATION - *PLEASE PRINT CLEARLY*

NAME: _____ Pronoun(s): _____

TODAY'S DATE: _____

LEGAL/INSURANCE NAME (*if different*):_____

DOB: M_____D_____Y_____ AGE: _____ EMAIL:_____

ADDRESS _____
STREET *CITY* *STATE* *ZIP*

BEST PHONE # _____ hm❑ off❑ cell ❑ Can we leave messages at this number? Y❑ N ❑

ALT PHONE # _____ hm❑ off❑ cell ❑ Can we leave messages at this number? Y❑ N❑

OCCUPATION (previous if retired) _____ EMPLOYER_____

EMERGENCY CONTACT _____ _____ _____
NAME *PHONE* *RELATION*

HOW DID YOU HEAR ABOUT US? ❑ Patient/Friend/Family ❑ Healthcare practitioner ❑ Internet ❑ Other Please specify: _____

PLEASE LIST YOUR HEALTH CONCERNS:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

PERSONAL MEDICAL HISTORY - *Check all that apply, please note when they started*

❑_____ AIDS/HIV Infection	❑_____ Fibromyalgia	❑_____ Lyme Disease
❑_____ Allergies	❑_____ Frequent Steroid Use	❑_____ Migrane Headaches
❑_____ Anemia	❑_____ Gallbladder Disease	❑_____ Mononucleosis
❑_____ Arthritis	❑_____ Glaucoma	❑_____ Neurological Disorder
❑_____ Asthma	❑_____ Gout	❑_____ Occupational Exposure to Toxic Substances
❑_____ Attempted Suicide	❑_____ Hayfever	
❑_____ Cancer	❑_____ Heart Disease	❑_____ Polio
❑_____ Chickenpox	❑_____ Hepatitis B or C	❑_____ Seizure Disorder
❑_____ Chronic Fatigue Syndrome	❑_____ High Blood Pressure	❑_____ Sleep Apnea
❑_____ Depression	❑_____ Hives	❑_____ Stroke/TIA
❑_____ Eating Disorder	❑_____ Kidney Infections	❑_____ Substance Abuse/Addiction
❑_____ Eczema	❑_____ Kidney Stones	❑_____ Thyroid Disease
❑_____ Edema (Fluid Retention)	❑_____ Liver Disease	❑_____ Tuberculosis or Positive TB Test

Next Page →

PERSONAL MEDICAL HISTORY *(cont'd)*

Do you have a specific spiritual practice? Y❑ N❑

If so, please describe it: _____

Is there anything the doctor should know in relation to this? _____

Please list the names of your healthcare providers:

1._____ 4. _____

2._____ 5. _____

3._____ 6._____

Please list all prescription and over the counter medications that you are currently taking:

Medication	*Dose*	*Date Started*	*Prescribed By*

Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking:

Supplement	*Dose*	*Date Started*

Please list any severe or life-threatening allergies:

1._____ 3. _____

2._____ 4. _____

Please Explain: _____

Personal Habits

Please indicate which substances, if any, pertain to you **N** = use **NOW** **P** = used in the **PAST**

Substance	*N / P*	*How Much?*	*How Long?*	*Substance*	*N / P*	*How Much?*	*How Long?*
Tobacco				Soda			
Coffee				Alcohol			
Black Tea				Recreational Drugs			

Do you have any dietary restrictions or follow a particular dietary regimen? If yes, please describe:

_____

_____

Do you exercise regularly? Yes❑ No❑ What type?_____

Next Page →

PERSONAL MEDICAL HISTORY *(cont'd)*
Review of Systems

Please indicate the following:
N = a condition you have **NOW** **P** = a condition you have had in the **PAST**

Head

Migraines_____ Headaches_____
Location of pain_____
Worse: Light __ Noise__ Odors__
Head Injury _____
Describe_____
TMJ _____
Dizziness _____
Fainting _____
Seizures _____

Digestion

Bowel Movement _____
X per day: 1-2___ 2-3___ 3-4___ or
X per week: 1-2___ 2-3___ 3-4___
Size: Sm❑ Med❑ Lg❑
Color: Brown❑ Tan❑ Rust❑
Texture: Dry❑ Hard❑
Wet/Loose❑ Pellets❑
Stools with Mucous❑ Blood❑
Hemorrhoids _____
Bleeding❑ Painful❑ Itching❑
Fissures/Fistulas _____
Stool Incontinence _____
Bowel Disease _____
Liver/Gallbladder Disease _____
Ulcer _____
Heartburn _____
Bloating _____
Belching _____
Gas / Flatus _____
Nausea / Vomiting _____
Pains / Cramps _____

Sleep

Good ❑ Bad❑
How many hours? ____
Wake Easily? Yes❑ No❑
Why?_____When?_____
Difficulty Falling Asleep? Yes❑ No❑
Wake Refreshed? Yes❑ No❑
Grumpy? Yes❑ No❑
Snore? Yes❑ No❑
Talk? Yes❑ No❑
Grind Teeth? Yes❑ No❑
Sleepwalk? Yes❑ No❑
Nightmares? Yes❑ No❑
Dream a lot? Yes❑ No❑
Preferred Sleeping Position_____

Sex/Reproductive

Change in Sex Drive _____
Sexually Transmitted Diseases _____
Painful Intercourse _____
Ever Have an Abnormal Pap Smear? _____
History of Sexual Abuse _____
DES Exposure _____
Frequent Yeast Infections _____
Vaginal Discharge _____
Age Period Began _____
Regular Periods Yes ❑ No ❑ _____
Flow: Heavy ❑ Medium ❑ Light ❑ _____
Length of Cycle ____ Days of Flow ____
Spotting _____
Cramps _____
PMS____ Endometriosis___ PID___
Fibroids_____ Ovarian Cysts_____
Ever Used Birth Control Pills? _____
How Long For?_____ How Long Ago?_____
Present Birth Control _____
Pregnancies (number) _____
Childbirth (number) _____
Complications _____
Miscarriages (number) _____
Abortions (number) _____
Have You Had A Hysterectomy? _____
Age at Menopause _____
Vaginal Dryness _____
Hot Flashes _____
Mammograms (number) _____
Date of Last Mammogram _____
Prostate Enlargement _____
Change in Force of Urine Stream _____
Difficulty Starting Urine _____
History of Undescended Testes _____
Pain / Lump in Scrotum _____
Discharge From Penis _____
Difficulty with Erections _____

Next Page →

PAST MEDICAL HISTORY *Please provide the following information*

Hospitalization(s): _____
_____
_____

Serious Illnesses and Injuries: _____
_____
_____

Date of Last Physical_____ Date of Last Colonoscopy_____
Date of Last Blood Tests_____ Date of Last DEXA (bone density test)_____

FAMILY MEDICAL HISTORY	*Please indicate the following:* **YES** = Checkmark applies to you or one of your family members **RELATION** = Self, or indicate family member (mother, aunt, father, etc. **PAST** (**P**) = A condition you've had in the past **Now** (**N**) = A condition you have now		
CONDITION	**YES**	**RELATION**	**NOW (N)/ PAST (P)**
Alcoholism/Drug Addiction			
Alzheimer's Disease			
Anemia			
Cancer			
- Type:			
- Type:			
- Type:			
Diabetes			
Heart Disease			
Osteoporosis			
Thyroid Disease			
Other:			

•END•

Thank you.
Please return your completed forms to our front desk.
Your new Doctor will be with you shortly!