# Rogue Natural Medicine Intake Form

**Personal Information**

Date of Birth:_____ Age:_____ Today's Date:_____
First Name:_____Middle:_____Last Name:_____
Preferred Name:_____ Gender: F / M / TG
Address _____City:_____State:_____Zip:_____

Live with: Alone_____ Spouse_____ Partner _____ Family_____ Housemate _____ Other _____
Spouse's Name:_____ Number of children:_____
Your occupation: _____ Work hours per week:_____

**Please only list the numbers where you would like us to reach you.** May we leave a message? Y / N
Home Phone:_____ Cell Phone:_____
Work Phone:_____ Email:_____
Which of the numbers listed above is the best number to reach you at?:_____
Emergency Contact:_____ Relationship to you?_____
Day Phone:_____ Night Phone:_____

**Your other current health care providers:**

Name:_____ Name:_____ Name:_____
Type:_____ Type:_____ Type:_____
For:_____ For:_____ For:_____
Date of last visit:_____ Date of last visit:_____ Date of last visit:_____
Phone:_____ Phone:_____ Phone:_____

Have you ever been to a naturopathic doctor before? Y / N
If so, when? _____ and who? _____
How did you hear about us?_____

**Context of Care Review**

What are the top three expectations you have for your first visit (in order of importance)?

1)
2)
3)

What are your top three long-term health goals in working with Dr. Kunkel (in order of importance)?

1)
2)
3)

Circle your present level of motivation for addressing the underlying causes of your health challenges/conditions on a scale of 1-10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe contribute to and support your health? _____

What behaviors or lifestyle habits do you currently engage in regularly that you believe detract from or hinder your health? _____

Do you have or foresee any obstacles that may hinder your ability to make lifestyle changes or embark on an intensive therapeutic program? _____

**Medical History**

What are your main health challenges/conditions? List them in order of importance.

(1

(2

(3

(4

(5

Have you seen other practitioners for these challenges/conditions? If so, when, who and for which conditions? Also, what treatments were tried and were the treatments effective?

| Condition | Doctor | Treatment | Effective? (Y/N) | Date of Treatment(s) |
|---|---|---|---|---|
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Please list any **serious conditions, illnesses, injuries, or hospitalizations**.

| Date or Year | Surgery, Illness, Injury, etc. | Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Do you have any **allergies** (medicines, environmental, etc)? What is your **reaction**?

| Allergy | Describe your Reaction |
|---|---|
| | |
| | |
| | |

Please list all **current prescription medications**, dose, and what it is being used for:

| Medication | Dose | For what condition? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please list all **past prescription medications**, dose, and what it was used for:

| Medication | Dose | For what condition? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please list all **over-the-counter medications, vitamins, herbs, homeopathics, etc.** and why they are being used:

| Product | Dose | For what purpose? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please mark the **childhood illnesses** you have had and your age at the time:

| Illness | Age | Illness | Age | Illness | Age |
|---|---|---|---|---|---|
| Rheumatic fever | | Scarlet fever | | Diptheria | |
| Measles | | Mumps | | Chicken pox | |

Did you receive vaccines as a child? Y / N Which ones?:_____
Any reactions to the vaccine(s)? Y / N Explain:_____

Please indicate the year you had the following **screening tests** performed:

| Screen/Test | Year | Screen/Test | Year |
|---|---|---|---|
| PAP (females) | | Digital Rectal Exam (males) | |
| Breast Exam (both) | | PSA test (males) | |
| Mammogram | | DEXA scan | |
| Routine blood work (CBC, CMP, Lipids) | | Other:_____ | |

Date of your last physical exam?_____ Anything abnormal/remarkable?_____
Have you taken antibiotics in the last 5 years? Y / N If yes, how many times?_____
Were you given antibiotics as a child? Y / N How often?_____

Do you have root canals? Y / N How many?_____ When were they placed?_____
Do you know your blood type? A / B / AB / O / Don't know

**Female (if applicable)**
Are you currently (circle): pre-menopausal perimenopausal post-menopausal Age at menopause?_____
Could you be pregnant? Y / N Date of the beginning of your last menses_____
Age at first period:_____ Are your periods regular? Y / N How long is/was your cycle?_____
PMS symptoms? Y / N If yes, what?_____
Symptoms during your period? Y / N If yes, what?_____
Do you use birth control? Y / N Method:_____ Since:_____
Number of pregnancies:____ Number of miscarriages:____ Number of abortions:___ Number of live births:___

Which of the following do you currently use? (Y = current, P = past, N = never)

| Substance | Y | P | N | Per Day | Type(s) | Duration |
|---|---|---|---|---|---|---|
| Coffee | | | | | | |
| Black tea | | | | | | |
| Soft drinks | | | | | | |
| Artificial sweeteners | | | | | | |
| Alcohol | | | | | | |
| Tobacco | | | | | | |
| Recreational drugs | | | | | | |
| Laxatives | | | | | | |
| Antacids | | | | | | |
| Painkillers | | | | | | |

**Lifestyle:**
Current height: ____feet ____in Current weight:_____lbs Desired weight if different:_____lbs
Weight 1 year ago:_____lbs Maximum weight:_____lbs When?:_____
How would you rate your general state of health? (circle one): Poor Fair Average Good Excellent
Please rate your energy level: low 1 2 3 4 5 6 7 8 9 10 high
What time of the day is your energy highest?_____ What time is your energy lowest?_____
Please rate your stress level: low 1 2 3 4 5 6 7 8 9 10 high
List your major stressors: _____
How does your stress manifest?_____
How do you cope with stress?_____
Do you have a strong emotional support network? Y / N Who?_____
Any major traumas (mental/emotional)? Y / N What and when?_____
Hobbies? Y / N Please list:_____
Exercise? Y / N Doing what?_____
For how many minutes/hours at a time?_____ How many times per week?_____
How many hours of sleep do you get each night?_____ Do you wake feeling rested? Y / N
Do you wake in the night? Y / N For any particular reason? Y / N At any particular time?_____
Do you enjoy your work? Y / N Spend time outside? Y / N History of abuse? Y / N
Religious/spiritual practices? Y / N Do you take vacations? Y / N
Are you aware of any current or past significant environmental exposure to pollutants/toxins? Y / N
If yes, what were you exposed to? _____ and when?_____

**Diet** (Please be as honest as possible):
Describe an average breakfast:_____
Describe an average lunch:_____

Describe an average dinner:_____
Do you generally prepare your meals? Y / N If not, who does?_____
Do you snack? Y / N When?_____ What?_____
How much water do you drink per day? (8 oz = 1 cup) _____ Do you use a water filter? Y / N
What is your current diet? (gluten-free, vegetarian, dairy-free, Paleo, none, etc.)_____
How often do you eat out?_____per day or _____per week. Fast food? Y / N
Do you eat on the run or while working? Y / N Do you skip meals? Y / N
What percentage of your fruits/vegetables are organic? 0% 10 20 30 40 50 60 70 80 90 100%
Do you have any food sensitivities or difficulty digesting specific foods? Y / N List:_____
What foods do you crave/are your favorite?_____
What foods repulse you/are your least favorite?_____
Do you feel like you have any unresolved emotional/psychological issues around food/eating? Y / N
How often do you have a bowel movement?_____per day / week (circle which one)

**Family History:**
Please indicate if any family members (child, sibling, parent, grandparent) has had any of the following:

| Condition | Who? | Condition | Who? | Condition | Who? |
|---|---|---|---|---|---|
| Alcoholism/Drug use | | Diabetes | | Liver/gallbladder problems | |
| Allergies/hayfever | | Digestive/intestinal disorder | | Overweight/obesity | |
| Arthritis | | Depression | | Reproductive problems | |
| Autoimmune disease | | Other mood disorder | | Respiratory problems | |
| Asthma | | Fibromyalgia | | Skin/eczema issues | |
| Bleeding disorder | | Genetic disorder | | Stroke | |
| Bone/skeletal problem | | Heart disease | | Thyroid problems | |
| Brain/neurological problem | | High blood pressure | | Vision/eye problems | |
| Cancer | | Infectious disease/STD | | Other:_____ | |
| Chronic Fatigue Syndrome | | Kidney/bladder problems | | Other:_____ | |

**Review of Systems:**
Please circle whether you are experiencing these symptoms currently (C) and/or have ever experienced them in the past (P). If the symptom doesn't apply, don't circle anything.

**General:**
C / P Weakness
C / P Fatigue
C / P Fever
C / P Chills
C / P Recent weight changes
C / P Fainting

**Skin:**
C / P Rashes
C / P Eczema/dermatitis
C / P Psoriasis
C / P Nail/hair changes
C / P Acne
C / P Boils
C / P Changes in mole(s)
C / P Color change of skin
C / P Skin cancer
C / P Dry skin
C / P Itching
C / P Hives

**Head:**
C / P Headaches
C / P Injury
C / P Dizziness
C / P Lightheadedness

**Eyes:**
C / P Recent vision changes
C / P Eye pain
C / P Double or blurry vision
C / P Blind spot(s)
C / P Cataract(s)
C / P Glaucoma
C / P Dry eyes
C / P Sensitivity to the sun
C / P Itching
C / P Redness
C / P Discharge
C / P Floaters
C / P Thinning eyebrows

**Ears:**
C / P Hearing loss
C / P Sensitive hearing
C / P Ringing
C / P Pain
C / P Infection
C / P Discharge

**Nose/Sinus:**
C / P Frequent colds
C / P Frequent nose bleeds
C / P Nasal discharge
C / P Nasal/sinus congestion
C / P Stuffiness

C / P Allergies/hayfever
C / P Injury
C / P Loss of smell
C / P Polyps
C / P Difficulty breathing through nose

**Mouth/Throat:**
C / P Frequent sore throat
C / P Hoarseness
C / P Teeth grinding
C / P Loss of teeth
C / P Gum problems/bleeding
C / P Mercury fillings
C / P Root canals
C / P Swollen glands
C / P Thyroid problems
C / P Pain/stiffness in neck
C / P Canker sores
C / P Bad breath
C / P Dry tongue/mouth
C / P Loss of taste
C / P Sores/ulcerations
C / P Difficulty swallowing
C / P Goiter (enlarged thyroid)

**Respiratory:**
C / P Difficulty breathing
C / P Hyperventilation
C / P Pain with breathing
C / P Persistent cough
C / P Persistent infections
C / P Shortness of breath (SOB)
C / P SOB on exertion
C / P SOB while lying down
C / P Spitting up blood
C / P Wheezing/asthma
C / P Chronic sputum production
C / P Tuberculosis

**Cardiovascular:**
C / P Hearth disease
C / P Chest pain at rest
C / P Chest pain with exertion
C / P High blood pressure
C / P Low blood pressure
C / P Palpitations
C / P Heart murmurs
C / P High cholesterol/lipids
C / P Rheumatic fever
C / P Blue lips/nails
C / P Cold hands/feet
C / P Blood clots
C / P Ankle/leg swelling
C / P Fainting
C / P Bruise easily
C / P Bleed easily

**Gastrointestinal:**
C / P Abdominal pain
C / P Bloating
C / P Belching
C / P Excessive gas
C / P Constipation
C / P Diarrhea
C / P Gallstones
C / P Heartburn/reflux
C / P Indigestion
C / P Nausea
C / P Vomiting
C / P Vomiting blood
C / P Worse after fatty foods
C / P Hemorrhoids
C / P Bloody stools
C / P Rectal incontinence
C / P Rectal prolapse
C / P Anal fissures
C / P Ulcers
C / P Mucus in stool
C / P Undigested food in stool
C / P Black, tarry stool
C / P Liver disease
C / P Gallbladder disease
C / P Hiatal hernia

**Urinary:**
C / P Blood in urine
C / P Cloudy urine
C / P Dark urine
C / P Foamy urine
C / P Foul smelling urine
C / P Frequent urination
C / P Difficulty holding urine
C / P Night urination
C / P Painful urination
C / P Reduced urine flow
C / P Urinary hesitancy
C / P Frequent infections
C / P Kidney stones

**Musculoskeletal:**
C / P Backache
C / P Bone pain
C / P Broken/fractured bones
C / P Osteoporosis
C / P Heel spurs
C / P Gout
C / P Arthritis
C / P Joint pain
C / P Joint stiffness
C / P Joint swelling
C / P Muscle cramps/spasms
C / P Muscle wasting
C / P Sprain joints easily
C / P Sciatica

**Neurological:**
C / P Involuntary movements
C / P Loss of balance
C / P Loss of coordination
C / P Seizures
C / P Weakness or paralysis
C / P Numbness/loss of sensation
C / P Tingling
C / P Tremors/twitches
C / P Significant memory loss
C / P Trouble concentrating
C / P Blackouts/loss of consciousness
C / P Speech problems/slurring

**Breasts:**
C / P Lumps
C / P Pain/tenderness
C / P Nipple discharge
C / P Perform self breast exams
C / P Implants/surgery

**Mental/Emotional:**
C / P Depression
C / P Mania
C / P Extreme anger
C / P Excessive irritability
C / P Mood swings
C / P Anxiety/nervousness
C / P Panic attacks
C / P Sexual difficulties
C / P Excessive fears/phobias
C / P Excessive worry
C / P Drug abuse
C / P Psychiatric care
C / P Psychological counseling

**Male Reproductive:**
C / P Sexually active
C / P Decreased sex drive
C / P Increased sex drive
C / P Erectile dysfunction
C / P Infertility
C / P Prostate problems
C / P Testicular pain
C / P Hernia
C / P Infection
C / P Discharge or sores

**Female Reproductive:**
C / P Sexually active
C / P Pelvic pain
C / P Pain with intercourse
C / P Decreased sex drive
C / P Increased sex drive
C / P Infertility
C / P Excessive menstrual flow
C / P Absent menstrual flow
C / P Irregular menses
C / P Spotting before/after periods
C / P Vaginal infections/discharge
C / P Vaginal itching
C / P Vaginal dryness
C / P Ovarian cysts
C / P Abnormal PAPS