



MEDERI
Centre for Natural Healing
Botanical Medicine & Clinical Nutrition

PLEASE NOTE: The Patient Intake form is a fillable PDF document. **Please save the document to your computer before filling in the blank form.** If you open the document directly from your email box, and fill in the form boxes, your information will not be saved. Also, please open the document in Adobe Reader or Acrobat, not in Previewer (MAC users). Your information will not be saved when completing data in Previewer.

PATIENT INTAKE FORMS

*For Office Use Only

Date of First Appointment _____ Practitioner _____

Name: _____ Age _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip Code _____

Mailing Address (if different): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Fax: _____ E-mail: _____

Employment Status: Full-time Part-time Student Retired Unemployed Other _____

Occupation: _____
(If retired, state previous occupation)

Employer and address: _____

Support activities/pursuits/groups: _____

Relationship Status: Single Married Divorced Widowed

Living Situation: Alone Friend(s) Partner Spouse Parents Children Pets: _____

Names and ages of those living with you: _____

EMERGENCY CONTACT

Name and Relationship to Patient _____

Phone #1 _____ Phone #2 _____

FINANCIAL AGREEMENT

I claim full financial responsibility for services rendered at MCNH for _____ CLIENT
and understand that payment is required in full at the time of service.

Signed: _____ Relationship to client: _____

How did you hear about MCNH?: _____

Have you ever tried natural medicine or alternative therapies? _____

If so, describe type and frequency:

Therapy	Frequency

Main health concern you wish to address at this time:

CANCER INFORMATION

Have you ever been diagnosed with cancer, a mass or tumor? Yes No

When? _____

Location _____

Type? _____

Current Status (eg; post-surgery, recurrence, etc.) _____

Current Stage _____

Relevant tumor markers _____

CONVENTIONAL TREATMENT HISTORY	
Procedure Date (surgery, chemo, radiation, etc.)	Duration

If you are in a clinical trial or experimental protocol please provide details.

CURRENT/RECENT HEALTH CARE PROVIDERS		
Provider Name	Date(s)	Care Provided (surgery, oncology, PCP, etc.)

HOSPITALIZATION(S) [NON-CANCER]			
Date	Hospital/Facility	Diagnosis/Operation	Provider Name

ACCIDENTS/INJURIES (describe briefly)

MORE than 5 years ago _____

LESS than 5 years ago _____

FAMILY HISTORY					
Please include any of the following: Alcoholism, high blood pressure, cancer, diabetes, heart- disease, osteoporosis, other addiction or illness.					
Member	Living?	Current Age	Important Diseases	Cause of Death	Age at Time of Death
Mother					
Father					
Siblings					
Siblings					
*MGM					
* MGF					
*PGM					
*PGF					

* M = Maternal P = Paternal GM = Grandmother GF = Grandfather

PERSONAL HISTORY

In general, I feel my overall health is: Excellent Good Fair Poor

Mark the following: 1 - IF CURRENT and 2 – IF PAST

	Asthma		Ringing In Ear		Palpitations		Migraines
	Bronchitis		Sciatic Pain		Tightness In Chest		Frequent Headaches
	Pneumonia		Frequent Urination		Rheumatic Fever		Frequent Depression
	Frequent Colds/Flu		Dribbling Urine		Heart Problems		Jaundice
	Epstein-Barr		Painful Urination		Poor Sleep		Hepatitis
	Chronic Fatigue		Scanty Urination		Hypoglycemia		Hemorrhoids
	Mononucleosis		Blood In Urine		Severe Mood Swings		Eye Problems
	HIV Positive		Prostate Problems		Diabetes		Photophobia
	AIDS		No/Low Sex Drive		Overweight		Dizziness
	Allergies		Impotence/Sexual Difficulty		Underweight		Stroke
	Sinus Congestion		Afternoon Persp./Fever		Eating Disorder		Varicose Veins
	Colitis		Night Sweats		Gum/Teeth Problems		Drug Addiction
	Crohn's Disease		Hearing Problems		Lots of Fillings		Alcoholism
	Diverticulitis		Tinnitus		TMJ		Epilepsy
	Parasites		Memory Difficulty		Concussion		Frequent Anger
	Gas		Anxiety/ Stress		Frequent Frustration		Bloating
	Arthritis		PTSD		ADD/ADHD		

Other: _____

Height _____ Weight _____ Blood Pressure _____

Skin: dry oily normal

Please rate the following on a scale of 1 to 10: (10 being the best) and write in any comments

Condition	Rating (1 – 10)	Comments
Sleep		
Appetite		
Energy Level		
Digestion		

Any gas, bloating or other discomfort after eating? Yes No (Describe: _____)

Stools: float sink daily bad odor no odor blood in stool

Please report how often, and what type/brand, you use any of the following for bowel elimination? Enemas

Laxatives _____ Purgatives _____

How do you feel about the following areas of your life? Please check appropriate boxes & make any comments you would like to make.

	Great	Good	Fair	Poor	Comments
Self					
Work					
Partner					
Sex					
Family					
Diet					
Exercise					

Please rate your stress on a scale of 0 to 10: (10 being the most) and write any comments below:

	Yes	No
I worry a great deal		
I feel lonely		
I am bored with my life		
I think a lot about dying		
I have particular concerns relating to my religion		
I feel fearful or afraid		
I feel nervous most of the time		
I often feel depressed		
I feel anxious often		
I am ill frequently		
I sometimes feel weak or light-headed		
I often have pains in my shoulders, neck, and/or back		
I often feel like crying		
I lose my temper more than I used to		

Other personal concerns (please describe):

Please use this space to add any other information about yourself that you think will be of help to us

DIET AND EXERCISE:

Dietary preferences/restrictions: _____

What is your favorite food? _____ Favorite flavor? _____

Sample of day's menu (Please also fill out 3-day food chart if you have been asked to do so)

Breakfast	
Lunch	
Dinner	
Snacks	
Drinks/beverage(s)	

Do you exercise regularly? Yes No

If yes, what type of exercise do you do? _____

How often? _____

Tobacco use: Current Previous How many years? _____

How much? _____

Alcohol use: Yes No How often? _____

How much? _____ How many years? _____

Caffeine use: Yes No

How much? _____ How often? _____

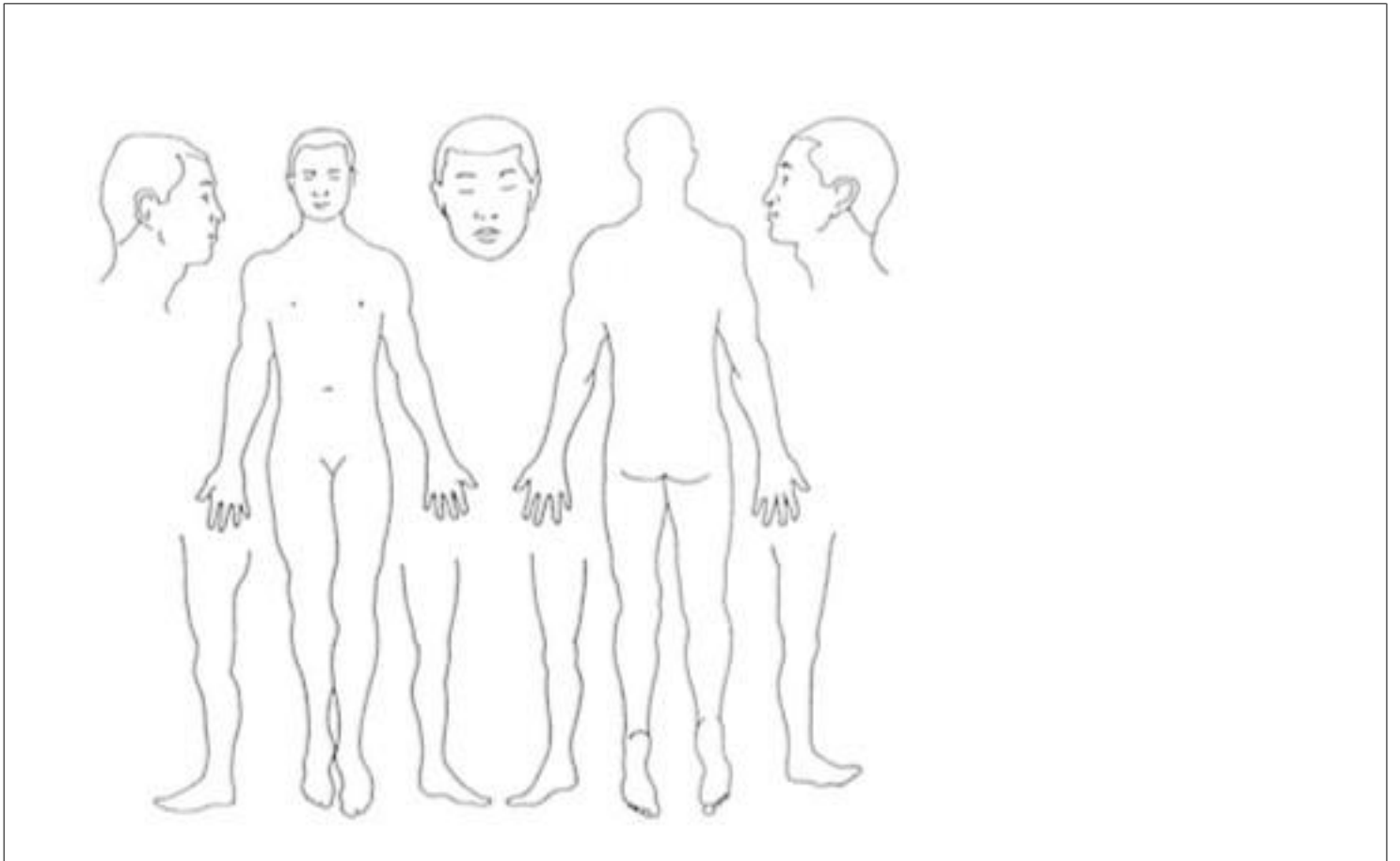
Other mood altering substances:

Which? _____ Past/Present? _____ How much? _____ How often? _____

Which? _____ Past/Present? _____ How much? _____ How often? _____

Which? _____ Past/Present? _____ How much? _____ How often? _____

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life? Please describe:



Area/Description of Symptom(s)/Pain & Frequency	Pain Level 0 to 10 (10 being the highest)

QUESTIONS ON THIS PAGE ARE FOR FEMALE PATIENTS ONLY

MENSTRUAL PERIODS – Please complete this section to the best of your ability, even if you no longer menstruate. It provides valuable information for an accurate assessment.

Menstruating since age: _____

Regular Light Heavy Clots PMS

Color of blood _____ Menstrual cramps? _____ Which days? _____

Flow lasts how many days? _____ Length of Cycle? _____ Date of last menses _____

Mark the following: 1 – IF CURRENT and 2 – IF PAST

	Hysterectomy		Herpes		Mastectomy
	D & C		Yeast Infections		Lumpectomy
	Tubular Ligation		Interstitial Cystitis		Breast Reconstruction
	Ablation		Infertility		Breast Implants
	Irregular PAP Smear		Pain With Intercourse		Fibroids
	Dryness With Intercourse		Osteoporosis		Irregular Bleeding

Vaginal discharge? Yes No

Color _____ Frequency _____ Amount _____

PREGNANCY / BIRTH CONTROL

Are you pregnant now? Yes No

Do you think you might be pregnant? Yes No

Number of pregnancies? _____ Number of children? _____

Tubular pregnancies? _____ Number of miscarriages? _____

Difficulty conceiving? Yes No

MENOPAUSE

No menses since _____

Experiences/symptoms you are currently feeling/having?

Experiences/symptoms you had in the past during menopause?