



**INTAKE FORM FOR ADULT**

**NAME:** \_\_\_\_\_

Chief health complaint: (what is your main reason for coming in today? When did you notice your condition?) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What kind of treatment have you received and from whom? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What have **you** done to relieve your condition? (Herbs, vitamins, diet, etc. Has it helped?) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever seen a naturopathic physician, chiropractor, acupuncturist, homeopath or other non-traditional health-care provider for your main complaint?       No       Yes

Or for any other problem?       No       Yes

What was the therapy and what were the results? \_\_\_\_\_

What is the general state of your health?     Excellent     Good     Average     Fair     Poor

On average, describe your energy level 1 – 10 ( 1= lowest & 10 = highest): \_\_\_\_\_

When during the day is your energy best? \_\_\_\_\_ Worst? \_\_\_\_\_

What is your current approximate weight? \_\_\_\_\_ Height? \_\_\_\_\_ Weight 1 year ago? \_\_\_\_\_

As an adult what has been your maximum \_\_\_\_\_ and minimum weight \_\_\_\_\_ (Not Pregnant)

Please list the 4 most significant, stressful events in your life, from the most recent to the most distant.

Are any of these continuing to impact your life?    (circle: yes or no)

- |          |             |           |
|----------|-------------|-----------|
| 1. _____ | Date: _____ | Yes or No |
| 2. _____ | Date: _____ | Yes or No |
| 3. _____ | Date: _____ | Yes or No |
| 4. _____ | Date: _____ | Yes or No |

What childhood disease have you had?     measles     mumps     chickenpox  
 whooping cough     polio     diphtheria     rheumatic fever  
 scarlet fever     smallpox     typhoid fever     tuberculosis  
 mono, how long? \_\_\_\_\_

Please list all surgeries and hospitalizations including approximate dates. (Do not include normal deliveries.)

- |          |             |
|----------|-------------|
| 1. _____ | Date: _____ |
| 2. _____ | Date: _____ |
| 3. _____ | Date: _____ |
| 4. _____ | Date: _____ |
| 5. _____ | Date: _____ |

\_\_\_\_ Check here if you have had more than 5 hospitalizations  
\_\_\_\_ Check here if you have received a blood transfusion, when? \_\_\_\_\_

Which of the following have you had and indicate "now or past" & also when/how often.

- |                       |                         |                               |
|-----------------------|-------------------------|-------------------------------|
| ___ pneumonia _____   | ___ diabetes _____      | ___ chronic infections _____  |
| ___ tonsillitis _____ | ___ asthma _____        | ___ migraines/headaches _____ |
| ___ eczema _____      | ___ ear infection _____ | ___ venereal disease _____    |
| ___ gonorrhea _____   | ___ heart disease _____ | ___ thyroid problems _____    |
| ___ syphilis _____    | ___ herpes _____        | ___ high blood pressure _____ |
| ___ allergies _____   | ___ hepatitis _____     | ___ manic/depression _____    |
| ___ seizures _____    | ___ anemia _____        | ___ weight problems _____     |
| ___ mono _____        | ___ depression _____    | ___ schizophrenia _____       |
| ___ stroke _____      | ___ arthritis _____     | ___ hypoglycemia _____        |
| ___ concussion _____  | ___ other, list _____   |                               |

Do you have any allergies to drugs, herbs, foods, animals or others?    [ ] No                      [ ] Yes, what? \_\_\_\_\_

Date of last menstrual period? \_\_\_\_\_                      [ ] Normal            [ ] Abnormal

How many "silver" fillings do you have? \_\_\_\_\_                      How many root canals? \_\_\_\_\_

Test and Immunizations (check those you have had. Enter the year when last taken/given and results if known)

- \_\_\_ chest x-ray \_\_\_\_\_
- \_\_\_ kidney tests \_\_\_\_\_
- \_\_\_ G.I. series \_\_\_\_\_
- \_\_\_ colon x-ray \_\_\_\_\_
- \_\_\_ gallbladder test \_\_\_\_\_
- \_\_\_ E.K.G./E.C.G. \_\_\_\_\_
- \_\_\_ T.B. test \_\_\_\_\_
- \_\_\_ sigmoidoscopy \_\_\_\_\_
- \_\_\_ mammogram \_\_\_\_\_
- \_\_\_ pap smear \_\_\_\_\_
- \_\_\_ E.E.G. (brain wave test) \_\_\_\_\_
- \_\_\_ C.T. scan (of what?) \_\_\_\_\_
- \_\_\_ Thyroid blood tests \_\_\_\_\_
- \_\_\_ Rectal exam (for men over 40) \_\_\_\_\_      PSA (prostate blood test) \_\_\_\_\_
- \_\_\_ CBC/SMAC \_\_\_\_\_
- \_\_\_ Urinalysis \_\_\_\_\_
- \_\_\_ tetanus shot \_\_\_\_\_
- \_\_\_ polio series \_\_\_\_\_
- \_\_\_ flu shots \_\_\_\_\_
- \_\_\_ hepatitis shot \_\_\_\_\_
- \_\_\_ measles \_\_\_\_\_
- \_\_\_ mumps \_\_\_\_\_

Which of the following do you currently use? (amount, how often and how long)

- |                        |                      |
|------------------------|----------------------|
| ___ alcohol _____      | ___ tobacco _____    |
| ___ hormones _____     | ___ coffee/tea _____ |
| ___ cortisone _____    | ___ laxatives _____  |
| ___ sedatives _____    | ___ antacids _____   |
| ___ pain killers _____ | ___ diet pills _____ |

Other medications (give full name and dosage and how long have you been taking):

- |          |               |
|----------|---------------|
| 1. _____ | Length: _____ |
| 2. _____ | Length: _____ |
| 3. _____ | Length: _____ |
| 4. _____ | Length: _____ |
| 5. _____ | Length: _____ |

Vitamins/herbs:

- |          |               |
|----------|---------------|
| 1. _____ | Length: _____ |
| 2. _____ | Length: _____ |
| 3. _____ | Length: _____ |
| 4. _____ | Length: _____ |
| 5. _____ | Length: _____ |

### Family History

Please list ages, health problems and if deceased, cause of death:

	Living (age?)	Health problems	Died (age?)	Cause
Your mother	_____	_____	_____	_____
Your father	_____	_____	_____	_____
Your brothers	_____	_____	_____	_____
	_____	_____	_____	_____
Your sisters	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Mother's Mom	_____	_____	_____	_____
Mother's Dad	_____	_____	_____	_____
Father's Mom	_____	_____	_____	_____
Father's Dad	_____	_____	_____	_____

What is your nationality? (please list all background and give approximate %) \_\_\_\_\_  
 \_\_\_\_\_

Who do you currently live with?  spouse  partner  parent(s)  friends  children  alone

Are you?  married  divorced  widowed  single  in a supportive relationship

What is your current level of education? \_\_\_\_\_ Are you satisfied with this?  Yes  No

Do you have children?  No  Yes, how many \_\_\_\_\_ alive \_\_\_\_\_ deceased

For women – how many? \_\_\_\_\_ miscarriages \_\_\_\_\_ abortions \_\_\_\_\_ stillbirths

Did you ever have? \_\_\_\_\_ toxemia \_\_\_\_\_ excessive nausea/vomiting

Do you have any blood relative (aunt, uncle, grandparent) who has had the following?

- |   |                                       |   |                                 |                                       |                                    |   |
|---|---------------------------------------|---|---------------------------------|---------------------------------------|------------------------------------|---|
| <input type="checkbox"/> allergies        | <input type="checkbox"/> arthritis    | <input type="checkbox"/> asthma           | <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes     | <input type="checkbox"/> anemia    | <input type="checkbox"/> depression       |
| <input type="checkbox"/> skin disease     | <input type="checkbox"/> heart attack | <input type="checkbox"/> high B. P.       | <input type="checkbox"/> stroke | <input type="checkbox"/> sickle cell  | <input type="checkbox"/> cataracts | <input type="checkbox"/> genetic problems |
| <input type="checkbox"/> seizures         | <input type="checkbox"/> ulcers       | <input type="checkbox"/> venereal disease |                                 | <input type="checkbox"/> hypoglycemia |                                    | <input type="checkbox"/> schizophrenia    |
| <input type="checkbox"/> manic-depression | <input type="checkbox"/> other,       | _____                                     |                                 |                                       |                                    |   |

## Occupation/household

How long have you lived at your present address? \_\_\_\_\_

Where have you lived previously? \_\_\_\_\_

Please describe location, if old or new place, i.e., new construction, damp or moldy. \_\_\_\_\_

Do you have specialized air filtration at home?      No    Yes                    Do you live in a city?      No    Yes

Do you work in a building ?                            No    Yes                    Do the windows open?      No    Yes

Do you have specialized air filtration at work?      No    Yes

Do you work in the presence of toxic fumes or chemical?      No    Yes, what \_\_\_\_\_

Do any of your hobbies involve toxic materials?      No    Yes

If you are a non-smoker, are you exposed to second hand smoke currently?  No    Yes                    In the past?  No    Yes

What do you use for your drinking water?    bottled            filtered            tap water

## Personal Habits

What do you enjoy the most in your life? \_\_\_\_\_

What are your main interests or hobbies? \_\_\_\_\_

What do you worry about most? \_\_\_\_\_

Do you currently exercise?  No    Yes, what kind, how much & how often? \_\_\_\_\_

Do you have a spiritual affiliation or practice?      No    Yes, what? \_\_\_\_\_

How important is your spiritual life to you? (1 = not important   10 = very important) \_\_\_\_\_

Do you have problems falling or staying asleep?  No    Yes     How many hours do you sleep a night? \_\_\_\_\_

How many times a week, on average, do you wake up refreshed? \_\_\_\_\_

Do you nap or rest horizontally during the day?    No    Yes, for how long? \_\_\_\_\_

If you work, do you enjoy your work?  No    Yes            If no, explain \_\_\_\_\_

Do you take vacations?    No    Yes

Do you meditate or do relaxation exercises regularly?  No    Yes, what \_\_\_\_\_

Have you traveled to many countries (for work, pleasure or military) Which? (give approximate dates) \_\_\_\_\_

Diet: Is your diet primarily American food?  No    Yes     If no, list anything unusual about your diet \_\_\_\_\_

Please add anything else you feel is important:

## Symptom Survey Form

**INSTRUCTIONS:** Number the boxes, which apply to you. Use **(1) for MILD** symptoms (occur once or twice a year), **(2) for MODERATE** symptoms (occur several times a year), and **(3) for SEVERE** symptoms (you are aware of it almost constantly).

### Group One

- |                               |  |                               |
|-------------------------------|--|-------------------------------|
| 1 [ ] Acid foods upset        | 8 [ ] Gag easily                       | 15 [ ] Appetite reduced       |
| 2 [ ] Get chilled, often      | 9 [ ] Unable to relax; startles easily | 16 [ ] Cold sweats often      |
| 3 [ ] "Lump" in throat        | 10 [ ] Extremities cold, clammy        | 17 [ ] Fever easily raised    |
| 4 [ ] Dry mouth-eyes-nose     | 11 [ ] Strong light irritates          | 18 [ ] Neuralgia-like pains   |
| 5 [ ] Pulse speeds after meal | 12 [ ] Urine amount reduced            | 19 [ ] Staring, blinks little |
| 6 [ ] Keyed up – fail to calm | 13 [ ] Heart pounds after retiring     | 20 [ ] Sour stomach frequent  |
| 7 [ ] Cuts heal slowly        | 14 [ ] "Nervous" stomach               |                               |

### Group Two

- |  |   |   |
|--|---|---|
| 21 [ ] Joint stiffness after arising                     | 29 [ ] Digestion rapid                    | 37 [ ] "slow starter"                             |
| 22 [ ] Muscle-leg-toe cramps at night                    | 30 [ ] Vomiting frequent                  | 38 [ ] Get "chilled" infrequently                 |
| 23 [ ] "Butterfly" stomach, cramps                       | 31 [ ] Hoarseness frequent                | 39 [ ] Perspire easily                            |
| 24 [ ] Eyes or nose watery                               | 32 [ ] Breathing irregular                | 40 [ ] Circulation poor, sensitive<br>to cold     |
| 25 [ ] Eyes blink often                                  | 33 [ ] Pulse slow; feels "irregular"      | 41 [ ] Subject to colds, asthma and<br>bronchitis |
| 26 [ ] Eyelids swollen, puffy                            | 34 [ ] Gagging reflex slow                |   |
| 27 [ ] Indigestion soon after meals                      | 35 [ ] Difficulty swallowing              |   |
| 28 [ ] Always seems hungry;<br>feels "lightheaded" often | 36 [ ] Constipation, diarrhea alternating |   |

### Group Three

- |   |   |   |
|---|---|---|
| 42 [ ] Eat when nervous                   | 49 [ ] Heart palpitates if meals are<br>missed or delayed             | 53 [ ] Crave candy or coffee in the<br>afternoons     |
| 43 [ ] Excessive appetite                 | 50 [ ] Afternoon headaches  | 54 [ ] Moods of depression – "blues"<br>or melancholy |
| 44 [ ] Hungry between meals               | 51 [ ] Overeating sweets upsets                                       | 55 [ ] Abnormal craving for sweets<br>or snacks       |
| 45 [ ] Irritable before meals             | 52 [ ] Awaken after few hours of sleep<br>- hard to get back to sleep |   |
| 46 [ ] Get "shaky" if hungry              |   |   |
| 47 [ ] Fatigue, eating relieves           |   |   |
| 48 [ ] "Lightheaded" if meals are delayed |   |   |

### Group Four

- |   |   |   |
|---|---|---|
| 56 [ ] Hands and feet go to sleep<br>easily, numbness | 63 [ ] Get "drowsy" often   | 68 [ ] Bruise easily, "black and<br>blue" spots   |
| 57 [ ] Sigh frequently, "air hunger"                  | 64 [ ] Swollen ankles worse at night  | 69 [ ] Tendency to anemia   |
| 58 [ ] Aware of "breathing heavily"                   | 65 [ ] Muscle cramps, worse during<br>exercise; get "charley horses"          | 70 [ ] "Nose bleeds" frequent   |
| 59 [ ] High altitude discomfort                       | 66 [ ] Shortness of breath on exertion  | 71 [ ] Noises in head or "ringing<br>in ears"   |
| 60 [ ] Opens windows in closed room                   | 67 [ ] Dull pain in chest or radiating<br>into left arm, worse on<br>exertion | 72 [ ] Tension under the breastbone,<br>or feeling of "tightness",<br>worse on exertion |
| 61 [ ] Susceptible to cold and fevers                 |   |   |
| 62 [ ] Afternoon "yawner"                             |   |   |

### Group Five

- |   |  |   |
|---|--|---|
| 73 [ ] Dizziness                                      | 83 [ ] Feeling queasy, headache<br>over eyes         | 91 [ ] Sneezing attacks                         |
| 74 [ ] Dry skin                                       | 84 [ ] Greasy foods upset                            | 92 [ ] Dreaming, nightmare type<br>- bad dreams |
| 75 [ ] Burning feet                                   | 85 [ ] Stools light-colored                          | 93 [ ] Bad breath (halitosis)                   |
| 76 [ ] Blurred vision                                 | 86 [ ] Skin peels on foot soles                      | 94 [ ] Milk products cause distress             |
| 77 [ ] Itching skin and feet                          | 87 [ ] Pain between shoulder blades                  | 95 [ ] Sensitive to hot weather                 |
| 78 [ ] Excessive falling hair                         | 88 [ ] Use laxatives                                 | 96 [ ] Burning or itching anus                  |
| 79 [ ] Frequent skin rashes                           | 89 [ ] Stools alternate from soft<br>to watery       | 97 [ ] Crave sweets                             |
| 80 [ ] Bitter, metallic taste in<br>mouth in mornings | 90 [ ] History of gallbladders attacks of gallstones |   |
| 81 [ ] Bowel movements painful/difficult              |  |   |
| 82 [ ] Worries, feels insecure                        |  |   |

### Group Six

- |  |  |   |
|--|--|---|
| 98 [ ] Loss of taste for meat                          | 101 [ ] Coated tongue  | 104 [ ] Mucous colitis or irritable bowel |
| 99 [ ] Lower bowel gas several<br>hours after eating   | 102 [ ] Pass large amounts of foul-<br>smelling gas                      | 105 [ ] Gas shortly after eating          |
| 100 [ ] Burning stomach sensations,<br>eating relieves | 103 [ ] Indigestion ½ - 1 hour after eating;<br>may be up to 3 – 4 hours | 106 [ ] Stomach “bloating” after eating   |

#### (A)

- 107 [ ] Insomnia
- 108 [ ] Nervousness
- 109 [ ] Can't gain weight
- 110 [ ] Intolerance to heat
- 111 [ ] Highly emotional
- 112 [ ] Flush easily
- 113 [ ] Night sweats
- 114 [ ] Thin, moist skin
- 115 [ ] Inward trembling
- 116 [ ] Heart palpitations
- 117 [ ] Increased appetite without weight gain
- 118 [ ] Pulse fast at rest
- 119 [ ] Eyelids and face twitch
- 120 [ ] Irritable and restless
- 121 [ ] Can't work under pressure

#### (B)

- 122 [ ] Increase in weight
- 123 [ ] Decrease in appetite
- 124 [ ] Fatigue easily
- 125 [ ] Ringing in ears
- 126 [ ] Sleepy during the day
- 127 [ ] Sensitive to cold
- 128 [ ] Dry or scaly skin
- 129 [ ] Constipation
- 130 [ ] Mental sluggishness
- 131 [ ] Hair coarse, falls out
- 132 [ ] Headaches upon arising wear off during the day
- 133 [ ] Slow pulse
- 134 [ ] Frequency in urination
- 135 [ ] Impaired hearing

### Group Five

#### (C)

- 137 [ ] Failing memory
- 138 [ ] Low blood pressure
- 139 [ ] Increased sex drive
- 140 [ ] Headaches, “splitting or  
rending” type
- 141 [ ] Decreased sugar tolerance

#### (D)

- 142 [ ] Abnormal thirst
- 143 [ ] Bloating of abdomen
- 144 [ ] Weight gain around hips or waist
- 145 [ ] Sex drive reduced or lacking
- 146 [ ] Tendency to ulcers, colitis
- 147 [ ] Increased sugar tolerance
- 148 [ ] Women: menstrual disorders
- 149 [ ] Young girls: lack of  
menstrual function

#### (E)

- 150 [ ] Dizziness
- 151 [ ] Headaches
- 152 [ ] Hot flashes
- 153 [ ] Increased blood pressure
- 154 [ ] Hair growth on face or  
on body (female)
- 155 [ ] Sugar in urine (not diabetes)
- 156 [ ] Masculine tendencies (female)

#### (F)

- 157 [ ] Weakness, dizziness
- 158 [ ] Chronic fatigue
- 159 [ ] Low blood pressure
- 160 [ ] Nails weak, ridged
- 161 [ ] Tendency to get hives
- 162 [ ] Arthritic tendencies
- 163 [ ] Perspiration increase
- 164 [ ] Bowel disorders
- 165 [ ] Poor circulation
- 166 [ ] Swollen ankles
- 167 [ ] Crave salt
- 168 [ ] Brown spots or bronzing of skin
- 169 [ ] Allergies – tendency to asthma
- 170 [ ] Weakness after colds, influenza
- 171 [ ] Exhaustion - muscular  
and nervous
- 172 [ ] Respiratory disorders

**Female Only**

- 173 [ ] Very easily fatigued .
- 174 [ ] Premenstrual tension .
- 175 [ ] Painful menses .
- 176 [ ] Depressed feelings before menstruation .
- 177 [ ] Menstruation excessive and prolonged .
- 178 [ ] Painful breasts .
- 179 [ ] Menstruate too frequently .
- 180 [ ] Vaginal discharge .
- 181 [ ] Hysterectomy/ovaries removed .
- 182 [ ] Menopausal hot flashes .
- 183 [ ] Menses scanty or missed .
- 184 [ ] Acne, worse at menses .
- 185 [ ] Depression of long standing .

**Male Only**

- 186 [ ] Prostate trouble
- 187 [ ] Urination difficult or dribbling
- 188 [ ] Night urination frequent
- 189 [ ] Depression
- 190 [ ] Pain on inside of legs or heels
- 191 [ ] Feeling of incomplete bowel evacuation
- 192 [ ] Lack of energy
- 193 [ ] Migrating aches and pains
- 194 [ ] Tire too easily
- 195 [ ] Avoids activity
- 196 [ ] Leg nervousness at night
- 197 [ ] Diminished sex drive

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**Important**

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

I certify the information on this form is correct to the best of my knowledge. I will not hold Dr. Gennaro or any members of her staff responsible for nay errors or omissions that I may have made.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed by

\_\_\_\_\_  
Date