



*Thank you for taking the time to fill out the overview form. This information will greatly assist us in helping you achieve your health and wellness goals. All information is strictly confidential as required by law and center privacy policy.*

**Intake Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

Would you like to be on our email list?    Y    N    *(Never given out to any other person or business.)*

Telephone Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Spouse/Partner Name: \_\_\_\_\_

Children Names & Ages: \_\_\_\_\_

Do you have health insurance with alternative medical coverage?    Y    N

How did you hear about Namaste Health Center? \_\_\_\_\_

Other healthcare providers:

1. Name: \_\_\_\_\_ 2. Name: \_\_\_\_\_

Profession: \_\_\_\_\_ Profession: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Fax: \_\_\_\_\_

3. Name: \_\_\_\_\_ 4. Name: \_\_\_\_\_

Profession: \_\_\_\_\_ Profession: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Fax: \_\_\_\_\_



1800 E. Third Avenue  
Suite 112  
Durango, CO 81301

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**Health Information**

Please list your health concerns (physical, emotional, or psychological) in order of importance to you, and the date of onset:

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

Anything further: \_\_\_\_\_  
\_\_\_\_\_

Please list your most stressful life experiences (physical or psychological):

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

Anything further: \_\_\_\_\_  
\_\_\_\_\_



### Supplements & Drug Medications

Please list all **current** vitamins/minerals, herbs, or homeopathic remedies, along with the daily dose, and how long you have taken it.

Supplement	Dose/day	How long	Reason for Supplement?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all **current** medications (prescription and over-the-counter), the daily dose, how long you have taken it, and the reason for the medication.

Medication	Dose/day	How long	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are the medications well tolerated? Y N If no, please list the adverse reactions or side effects and from what medication:

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

In the last 10 years, approximately how many **courses of antibiotics** have you taken? \_\_\_\_\_

### Medical History

Please indicate if you have had any of the following diagnostic tests performed:

Test	Notable finding	Test	Notable finding
<input type="checkbox"/> Thyroid Panel	_____	<input type="checkbox"/> Cholesterol	_____
<input type="checkbox"/> Liver Panel	_____	<input type="checkbox"/> Hormone level	_____
<input type="checkbox"/> Complete blood count	_____	<input type="checkbox"/> EKG	_____
<input type="checkbox"/> Blood sugar test	_____	<input type="checkbox"/> Chest x-ray	_____
<input type="checkbox"/> Colonoscopy	_____	<input type="checkbox"/> Mammography	_____
<input type="checkbox"/> Food Allergy	_____	<input type="checkbox"/> Thermography	_____
<input type="checkbox"/> Heavy Metals	_____	<input type="checkbox"/> Adrenal Function	_____
<input type="checkbox"/> Digestive Stool Analysis	_____	<input type="checkbox"/> other	_____



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Date of last **physical exam**: \_\_\_\_\_ Findings: \_\_\_\_\_

Please list any past **surgeries or hospitalizations** with approximate dates:

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

Please list all **past injuries** (ie. broken bones, joint sprains, burns, falls, car accidents, etc.) with dates:

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

List all **dental work** and the approximate date of the procedure (root canal, mercury or ceramic filling, implants, caps, dentures):

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

Indicate if you had any of the following:

**Childhood Illness**

- Asthma
- Chickenpox
- Eczema
- Frequent ear infections or colds
- Measles
- Mumps
- Polio
- Rubella
- Rheumatic fever
- Scarlet fever
- Whooping cough

**Vaccination History**

- Measles
- Hepatitis A
- Hepatitis B
- Tetanus
- Small pox
- Diphtheria
- Mumps
- Flu Shot
- Chicken pox
- Pertussis
- Rubella
- Polio
- Shingles

**Other Medical Procedures**

- Joint replacement
- Pacemaker
- Pins or plates

What is your **blood type**?      A+      B+      O+      AB+      A-      B-      O-      AB-

Height: \_\_\_\_\_ Current weight: \_\_\_\_\_ Weight 1 yr. ago: \_\_\_\_\_ Max weight: \_\_\_\_\_ When? \_\_\_\_\_ Desired weight: \_\_\_\_\_

## Review of Systems

**Circle** if the symptom has occurred in the **last year**. Place a **check mark** if the symptom has occurred in the **past**.

<b>General</b>	weight gain weight loss significant wt. loss significant wt. gain history of dieting	chronic fatigue afternoon fatigue weakness excessive thirst anemia	spontaneous swelling night sweats fever/chills sick more than 1 time / yr	intolerance to heat intolerance to cold cold hands/feet other:
<b>Skin</b>	dry skin itchy skin rashes hives moist skin bruising easily	acne eczema psoriasis shingles ringworm	athlete's foot moles bumpy skin on back of arms spider/varicose veins	changes to nails changes to skin color changes to moles nail fungus nail ridges other:
<b>Head</b>	headaches migraines	dizziness vertigo	trauma hair loss	other:
<b>Eyes</b>	dry eyes watery eyes itchy eyes eye pain red eyes discharge from eyes	floaters/hallo/flashes blurred vision impaired vision double vision eyes sensitive to light poor night vision	sties cataracts vision loss other	vision correction: _____ vision: near -or- far contacts glasses laser
<b>Ears</b>	ear pain itchy ears waxy ears	discharge from ears ringing in ears hearing loss	ear infections ear infections as a child	hearing aids other:
<b>Nose &amp; Sinuses</b>	itchy nose discharge from nose congested nose/sinuses	postnasal drip nosebleeds loss of smell	breathes thru mouth snores	other:
<b>Mouth &amp; Throat</b>	Dry mouth itchy mouth/throat sores on mouth/lips hay fever/allergies bad breath root canals	frequent sore throat coughing up blood persistent cough difficulty swallowing loss of taste hoarseness	dentures inflamed/bleeding gums cavities braces teeth sensitivity	jaw clicks TMJ other dental concerns... treatment for strep as a child... other:
<b>Neck</b>	neck pain or stiffness	swollen glands	trauma	other:
<b>Respiratory</b>	shortness of breath wheezing pain with breathing chronic cough coughing up blood	asthma allergies bronchitis/pneumonia positive TB test history of smoking	exposure to chemicals exposure to solvents exposure to particulates	history of 2nd hand smoke other:
<b>Cardiovascular</b>	high blood pressure low blood pressure high cholesterol high glucose chest pain heaviness in legs cold hands/feet	feel heart racing chest tightness difficulty breathing at night palpitations swelling in ankles heart fluttering	purple fingers/lips irregular heartbeat heart murmur dizziness on standing exhaustion with minor exertion	varicose veins hemorrhoids spider veins calf pain at night calf pain walking other:

continues next page

**Circle** if the symptom has occurred in the **last year**. Place a **check mark** if the symptom has occurred in the **past**.

<b>Gastrointestinal</b>	poor appetite excessive appetite changes in appetite excessive thirst trouble swallowing stomach pain nausea / vomiting vomit blood burping / belching abdominal pain abdominal bloating gas / flatulence	indigestion heartburn / antacid use constipation (<1 stool/d) stool hard to pass foul smelling stools loose stools (break up when hit water) diarrhea blood in stools black tar in stools mucous in stools undigested food in stools	stool shape: - one piece - hard little pellets - breaks up in water - other:  Color: - yellow - green - light brown - dark brown - black	intolerance to specific foods:  fatigue after eating food sensitivity anal itching liver disease gallbladder disease treated for parasites ulcers hemorrhoids other:
<b>Endocrine</b>	hypothyroid hyperthyroid hypoglycemia excessive thirst	heat or cold intolerance diabetes fatigue	poor appetite excessive hunger seasonal depression	unexplained wt loss easy wt gain other:
<b>Immune</b>	slow wound healing reactions to vaccinations	chronic fatigue syndrome	chronically swollen glands	chronic infections other:
<b>Neurological</b>	fainting dizziness / vertigo numbness or tingling trembling hands	head trauma poor concentration memory loss lack of alertness	loss of grip strength loss of muscle tone muscle weakness head heavy heavy extremities	other:
<b>Urinary</b>	frequent urination urinate <3 times/day can't hold urine urination with cough or sneeze	light yellow urine yellow urine yellow dark urine red urine cloudy urine strong smelling urine	kidney infections bladder infections urination at night pain/burning urination	dripping after urination bed-wetting other:
<b>Musculoskeletal</b>	pain in: - arms                   - hands - shoulders           - neck - upper back         - lower back - hips                   - legs - feet	painful bones tight shoulder muscles swollen knees/elbows numbness / tingling burning spasms/cramps morning stiffness	chronic pain loss of height unable to sit straight activities limited due to pain	arthritis herniated/slipped disk tendonitis osteoporosis broken bone other:

**Circle** if the symptom has occurred in the **last year**. Place a **check mark** if the symptom has occurred in the **past**.

<b>Women only</b>	age of first menses: _____ length of period: _____ length of cycle: _____ date of last menses: _____ heaviest flow day: _____ # of pads/tampons on heaviest day: _____ abnormal pap	# pregnancies: _____ # live births: _____ sexually active Y N which gender are you sexually active with: - men - women - both type of birth control:  type of STD control: - condoms - monogamy - other:	spotting between periods clots with period menstrual cramps wt gain with period PMS irritability moodiness crave sweets tendency to cry bloating / swelling breast tenderness low back pain fatigue with period missed periods irregular periods difficulty conceiving lack of sexual desire	vaginal itching vaginal discharge vaginal odor yeast infections vagina mucosa dry painful intercourse painful masturbation history of STDs Y N tested for STDs Y N uterine cyst/fibroids hysterectomy Use of birth control pill for greater than 10 yrs?
<b>Women only</b>	monthly breast self-exam Y N fibrous breast breast feed your child breast implants history of mammograms abnormal mammogram nipple discharge	hot flashes vaginal dryness changes in cycle moodiness brain fog menopause age of menopause: _____	use of hormone replacement:	other:
<b>Men only</b>	sense of full bladder difficulty urinating burning/pain with urination wake up to urinate dripping after urination increased straining w urination	discharge from penis sore on penis history of STDs Y N tested for STDs Y N premature ejaculation painful ejaculation erectile dysfunction infertile lack of sexual drive sexual difficulties	testicular lump testicular pain breast lump monthly testicular/breast self-exam? Y N history of prostatitis enlarged prostate prostate exam? Y N PSA test? Y N prostate cancer pain/cold in genital area hernias	currently sexually active? Y N Which gender are you sexually active with: - men - women - both type of birth control:  type of STD control: - condoms - monogamy - other:
<b>Emotional</b>	depression mood swings	treated for emotions tension	suicidal thoughts anxiety / nervousness	other:



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## Family History

Please indicate whether any **family members** have had any of the following:  
(Include parents, siblings, maternal grandparents (MGP), paternal grandparents (PGP), aunts, uncles. Include age and cause of death if applicable.)

**Relation to you**

**Relation to you**

Alcoholism \_\_\_\_\_

Diabetes \_\_\_\_\_

Allergies \_\_\_\_\_

Drug abuse \_\_\_\_\_

Alzheimer's disease \_\_\_\_\_

Heart disease \_\_\_\_\_

Arthritis \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Asthma \_\_\_\_\_

Kidney disease \_\_\_\_\_

Cancer (indicate type) \_\_\_\_\_

Osteoporosis \_\_\_\_\_

Depression \_\_\_\_\_

Stroke \_\_\_\_\_

Epilepsy \_\_\_\_\_

Thyroid condition \_\_\_\_\_

Autoimmune condition \_\_\_\_\_

Anemia \_\_\_\_\_

Skin condition \_\_\_\_\_

Glaucoma \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Other medical illness \_\_\_\_\_

### Activities of Daily Living

Activity	How often per day, week, month, ever, or never	Activity	How often per day, week, month, ever, or never	Activity	How often per day, week, month, ever, or never
Coffee / black tea		# meals /day		# hours sleep	
Soda		# 8oz. water / day		Once up, feel rested	
Tobacco		eat red meat		difficulty going to sleep	
Alcohol		eat chicken		difficulty staying asleep	
Recreational drugs		eat fish		difficulty waking up	
physical activity / exercise		eat fresh vegetables		take time for yourself	
drive w seat belt		eat fruit		watch TV	
brush teeth		eat dairy products		participate in friendships, community, support groups	
dental floss		eat refined wheat		# hours in car or bus	
wear sunscreen		eat products with sugar added		sexually active with self or partner	
chemical exposure		eat whole grains		contraception	
# hrs / wk at work		# bowel movements		# sexual partners	
# vacations / year		# times urinate		does a condition limit your activities?	
cellphone use		sleep with electric blanket		exposed to pets or animals	
exposed to mold		exposed to heavy metals		exposed to radiation: x-ray / CT / PET / mammo / EEG / ECG / MRI / etc.	



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Please list all Allergies (food, medication, environmental): \_\_\_\_\_

\_\_\_\_\_

Please describe the emotional climate of your home: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Rate your stress level (1=low, 10=high)      1   2   3   4   5   6   7   8   9   10

Which factors most contribute to your stress?

- health       work       money       family       marriage

Please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In your everyday life, your present faith/spiritual practices are (1=unimportant, 10=very important):

1   2   3   4   5   6   7   8   9   10

Please rate your level of motivation to affect change in your health (1=unmotivated, 10=highly motivated):

1   2   3   4   5   6   7   8   9   10

What brings you joy? \_\_\_\_\_

\_\_\_\_\_

Any additional information about your health that you would like to share: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## Diet Diary

**Please fill out 3 days worth and bring to your appointment or when you return the whole Intake Form.**

**Guidelines:** Write down EVERYTHING you eat and drink for meals and snacks. List BRAND NAMES of foods you bought. List EXACT INGREDIENTS of home-made food. The purpose is not to judge your eating habits, but to learn more about your nutritional, biochemical, hormonal needs and strengths. Under BM, please list the time you had a bowel movement and if it was D (diarrhea) and/or C (constipation).

**Record type and amount of insulin injected (if pertinent).**

**Name:** \_\_\_\_\_

Breakfast times	Lunch times	Dinner times	Symptoms times	BM times
Day 1				
Day 2				
Day 3				