

PATIENT INFORMATION

Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Address: _____
(Street) (City) (Postal Code)

Home Ph. #: _____ Cell: _____ Email: _____

Marital status: _____ # of Children: _____ Occupation: _____

Do you wish to receive Dr. Elliott's health E-Newsletter? Y/ N

Can Dr. Elliott use your email address to contact you concerning your care? Y/N

How did you hear about this clinic: Walk by Dr. Elliott's Website Canopy's Website Flyer

Referral: _____ Newspaper Other: _____

Name of Medical Doctor: _____ Permission to contact for labs, etc. Y/N

MAIN HEALTH CONCERNS

My usual health is: Excellent Good Fair Poor

Please list, in order of importance, your chief concerns:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions:

Cancer:	Autoimmune disease:
Eczema:	Arthritis:
Diabetes:	Allergies:
Heart disease:	Asthma:
High blood pressure:	Addictions:
Stroke:	Liver disease:
Thyroid disease:	Mental illness:

List major childhood illnesses: (ear infections, strep throat, tonsillitis, chicken pox, measles, etc.)

Vaccinations: I have been fully vaccinated I get the flu shot regularly I have had some vaccines
 I haven't been vaccinated I have had travel vaccines (ie. Hepatitis) I don't know/don't remember

Successful health care and preventive medicine are only possible when I have a complete understanding of you – including your expectations and obstacles to cure. The nature of your responses to the following questions will go a long way in assisting how I can best help you. Your time, thoughtfulness and honesty in completing this overview are appreciated.

1. What do you know about the naturopathic approach?
2. What expectations do you have from **this** visit to our clinic?
3. What **long term** expectations do you have from working with our clinic?
4. What expectations do you have **of me personally** as your health care provider?
5. What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? Circle level of commitment:
0% 1 2 3 4 5 6 7 8 9 10 (100%)
6. What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?
7. What behaviors or lifestyle habits do you currently engage in regularly that you believe are **self-destructive**?
8. What potential **obstacles** do you foresee in adhering to the therapeutic protocols that I will be sharing with you?
9. Do you feel you are fulfilling your purpose in life? If no, what is standing in your way?

Initial Intake Form

Please list hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc.

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Major mental/emotional traumas: (loss of loved one, divorce, career change, miscarriage, major disease, etc.)

List any real or suspected allergies/sensitivities to drugs, food, alcohol, caffeine, chemicals, perfumes, smoke, environment, or other: _____

Please list supplements you are currently taking:

- | | |
|--|--|
| 1. _____ | 6. _____ |
| (Brand) (Supplement Name) (Daily Dose) | (Brand) (Supplement Name) (Daily Dose) |
| 2. _____ | 7. _____ |
| (Brand) (Supplement Name) (Daily Dose) | (Brand) (Supplement Name) (Daily Dose) |
| 3. _____ | 8. _____ |
| (Brand) (Supplement Name) (Daily Dose) | (Brand) (Supplement Name) (Daily Dose) |
| 4. _____ | 9. _____ |
| (Brand) (Supplement Name) (Daily Dose) | (Brand) (Supplement Name) (Daily Dose) |
| 5. _____ | 10. _____ |
| (Brand) (Supplement Name) (Daily Dose) | (Brand) (Supplement Name) (Daily Dose) |

Read the following questions and fill in the number that applies:

- 0 (leave blank) = Never consume or use
- 1 = Consume or use several times per month
- 2 = Consume or use weekly
- 3 = Consume or use daily

DIET

- | | | |
|-----------------------------|------------------------------------|-------------------------------------|
| _____ Alcohol | 8. _____ Coffee | 15. _____ Refined flour/baked goods |
| _____ Artificial sweeteners | 9. _____ Fast food | 16. _____ Refined sugar |
| _____ Candy or other sweets | 10. _____ Fried foods | 17. _____ Vitamins and minerals |
| _____ Pop/soda | 11. _____ Luncheon meats/hot dogs | 18. _____ Water, distilled |
| _____ Chewing tobacco | 12. _____ Margarine | 19. _____ Water, tap |
| _____ Cigarettes | 13. _____ Milk/cheese/yogurt, etc. | 20. _____ Water, well |
| _____ Cigars/pipes | 14. _____ Non-herbal tea | 21. _____ Diet often (Y or N) |

LIFESTYLE

- _____ Exercise (3 = 5+ times per week, 2 = 2-4 times per week, 1 = once per week, 0 = none)
- _____ Stress (3 = heavy/chronic, 2 = moderate/often stressed, 1 = light/occasionally stressed, 0 = none)
- _____ Changed jobs (3 = within last 2 months, 2 = within last 6 months, 1 = within last 12 months)
- _____ Divorced (3 = within last 6 months, 2 = within last year, 1 = within last 2 years, 0 = never)
- _____ Work over 40 hours/week (3 = always, 2 = usually, 1 = occasionally, 0 = never)

MEDICATIONS

Indicate with a check mark any medications you're currently taking or have taken in the past month:

- | | | |
|-------------------------|----------------------------|--------------------------------|
| _____ Antacids | _____ Birth control | _____ Laxatives |
| _____ Antibiotics | _____ Chemotherapy | _____ Insulin |
| _____ Anticonvulsants | _____ Cortisone | _____ Recreational drugs |
| _____ Antidepressants | _____ Diabetic medications | _____ Relaxants/Sleeping pills |
| _____ Antifungals | _____ Diuretics | _____ Thyroid medication |
| _____ Aspirin/Ibuprofen | _____ Heart medications | _____ Tylenol/acetaminophen |
| _____ Asthma inhalers | _____ High blood pressure | _____ Ulcer medications |
| _____ Beta blockers | _____ Hormone Therapy | Other: _____ |

Read the following questions and circle the number that applies:

- 0 (leave blank) = Do not experience
- 1 = Minor or mild symptom, or it rarely occurs (once a month or less)
- 2 = Moderate symptom or it occasionally occurs (weekly)
- 3 = Severe symptom or it frequently occurs (daily or almost daily)

UPPER GASTROINTESTINAL SYSTEM

- | | | | |
|--|---------|--|---------|
| Belching or gas within 1 hr. of a meal | 0 1 2 3 | Do you feel better if you don't eat? | 0 1 2 3 |
| Heartburn or acid reflux | 0 1 2 3 | Sleepy after meals | 0 1 2 3 |
| Bloating shortly after eating | 0 1 2 3 | Fingernails chip, peel or break easily | 0 1 2 3 |
| Are you a vegan | No Yes | Anemia unresponsive to iron | 0 1 2 3 |
| Bad breath | 0 1 2 3 | Stomach pains or cramps | 0 1 2 3 |
| Loss of taste for meat | 0 1 2 3 | Diarrhea, chronic | 0 1 2 3 |
| Sweat has a strong odor | 0 1 2 3 | Diarrhea shortly after meals | 0 1 2 3 |
| Nausea from taking vitamins | 0 1 2 3 | Black or tarry stools | 0 1 2 3 |
| Sense of excess fullness after meals | 0 1 2 3 | Undigested food in stool | 0 1 2 3 |
| Do you feel like skipping breakfast? | 0 1 2 3 | | |

LIVER/GALLBLADDER

- | | | | |
|--|---------|---|---------|
| Pain between shoulder blades | 0 1 2 3 | Bitter taste in mouth, esp. after meals | 0 1 2 3 |
| Stomach upset by greasy foods | 0 1 2 3 | Become sick if drinking wine | 0 1 2 3 |
| Greasy or shiny stools | 0 1 2 3 | If drinking alcohol, easily intoxicated | 0 1 2 3 |
| Nausea | 0 1 2 3 | Alcoholic beverages per week | 0 1 2 3 |
| Motion sickness (air, car, boat) | 0 1 2 3 | Recovering alcoholic | No Yes |
| History of morning sickness (pregnancy) | No Yes | Hangovers after drinking alcohol | 0 1 2 3 |
| Light or clay colored stools | 0 1 2 3 | History of drug or alcohol abuse | No Yes |
| Dry skin, itchy feet or skin peels on feet | 0 1 2 3 | History of hepatitis | No Yes |
| Headache over the eye | 0 1 2 3 | Long term use of Rx medications | No Yes |
| Gallbladder attacks (past or present) | 0 1 2 3 | Sensitive to chemicals (perfume, etc.) | 0 1 2 3 |
| Gallbladder removed | No Yes | | |

Sensitive to tobacco smoke 0 1 2 3
 Exposure to diesel fumes 0 1 2 3
 Pain under right side of rib cage 0 1 2 3
 Hemorrhoids or varicose veins 0 1 2 3

SMALL INTESTINE

Food allergies 0 1 2 3
 Abdominal bloating 1-2 hrs after eating 0 1 2 3
 Specific foods cause fatigue or bloating 0 1 2 3
 Pulse speeds after eating 0 1 2 3
 Airborne allergies 0 1 2 3
 Experience hives 0 1 2 3
 Sinus congestion, "stuffy head" 0 1 2 3
 Crave bread or pasta 0 1 2 3
 Alternating constipation and diarrhea 0 1 2 3

LARGE INTESTINE

Anus itches 0 1 2 3
 Coated tongue 0 1 2 3
 Feel worse in moldy or musty places 0 1 2 3
 Taken an antibiotic for a length of time
 of 1 = < 1 mo, 2 = < 3 mos., 3 = > 3 mos. 0 1 2 3
 Fungus or yeast infections 0 1 2 3
 Ring worm, "jock itch", athlete's foot,
 or nail fungus 0 1 2 3
 Eating sugar, starch or drinking alcohol
 increases yeast symptoms 0 1 2 3
 Stools hard or difficult to pass 0 1 2 3
 History of parasites No Yes

MINERAL NEEDS

History of carpal tunnel syndrome No Yes
 History of lower right abdominal pain No Yes
 History of stress fractures No Yes
 Bone loss (reduced density on bone scan) 0 1 2 3
 Are you shorter than you used to be? No Yes
 Calf, foot or toe cramps at rest 0 1 2 3
 Cold sores, blisters or herpes lesions 0 1 2 3
 Frequent fevers 0 1 2 3
 Frequent skin rashes and/or hives 0 1 2 3
 Have you ever had a herniated disc? No Yes
 Excessively flexible joints/double jointed 0 1 2 3
 Joints pop or click 0 1 2 3
 Pain or swelling in joints 0 1 2 3
 Bursitis or tendonitis 0 1 2 3
 History of bone spurs No Yes

Nutrasweet (aspartame) consumption 0 1 2 3
 Bothered by aspartame 0 1 2 3
 Chronic fatigue syndrome or fibromyalgia 0 1 2 3

Crohn's disease No Yes
 Wheat or grain sensitivity 0 1 2 3
 Dairy sensitivity 0 1 2 3
 Are there foods you could not give up? No Yes
 Asthma, sinus infections, stuffy nose 0 1 2 3
 Bizarre, vivid or nightmarish dreams 0 1 2 3
 Use over-the-counter pain medications 0 1 2 3
 Feel spacey or unreal 0 1 2 3

Less than one bowel movement
 every day No Yes
 Stools have corners, or edges are flat
 and/or ribbon shaped 0 1 2 3
 Stools are not well formed (loose) 0 1 2 3
 Irritable bowel syndrome 0 1 2 3
 Blood in stool 0 1 2 3
 Mucus in stool 0 1 2 3
 Excessive foul smelling gas 0 1 2 3
 Bad breath or strong body odor 0 1 2 3
 Painful to press outer sides of thighs 0 1 2 3
 Cramping in lower abdomen 0 1 2 3

Morning stiffness 0 1 2 3
 Vomiting or nausea 0 1 2 3
 Crave chocolate 0 1 2 3
 Feet have a strong odor 0 1 2 3
 Tendency to anemia (low red blood cells) 0 1 2 3
 Whites of eyes (sclera) are tinted blue 0 1 2 3
 Hoarseness of voice 0 1 2 3
 Difficulty swallowing 0 1 2 3
 Lump in throat 0 1 2 3
 Dry mouth, eyes and/or nose 0 1 2 3
 Gag easily 0 1 2 3
 White spots on fingernails 0 1 2 3
 Cuts heal slowly and/or scar easily 0 1 2 3
 Decreased sense of taste or smell 0 1 2 3

ESSENTIAL FATTY ACIDS

Aspirin is an effective pain reliever	No	Yes	Headaches when out in the hot sun	0	1	2	3		
Crave fatty or greasy foods	0	1	2	3	Sunburn easily or suffer sun stroke	0	1	2	3
Low or reduced-fat diet (past or present)	0	1	2	3	Muscles become easily fatigued	0	1	2	3
Tension headaches at base of skull	0	1	2	3	Dry, flaky skin and/or dandruff	0	1	2	3

SUGAR HANDLING

Awaken a few hours after falling asleep, and difficulty getting back to sleep	0	1	2	3	Fatigue that is relieved by eating	0	1	2	3
Crave sweets	0	1	2	3	Headache if meals are skipped or delayed	0	1	2	3
Eat desserts or sugary snacks	0	1	2	3	Irritable when skipping meals	0	1	2	3
Binge or uncontrolled eating	0	1	2	3	Shaky if meals are delayed	0	1	2	3
Excessive appetite	0	1	2	3	Family members with diabetes 0 = 0				
Crave coffee or sugar in the afternoon	0	1	2	3	1 = 2 or less, 2 = 2 – 4, 3 = More than 4	0	1	2	3
Sleepy in afternoon	0	1	2	3	Frequent thirst	0	1	2	3
					Frequent urination	0	1	2	3

VITAMIN NEEDS

Muscles become easily fatigued	0	1	2	3	Can hear heart beat on pillow at night	0	1	2	3
Feel worse or sore after exercise	0	1	2	3	Body or limb jerks when falling asleep	0	1	2	3
Vulnerable to insect bites	0	1	2	3	Night sweats	0	1	2	3
Heaviness in arms/legs	0	1	2	3	Restless leg syndrome	0	1	2	3
Enlarged heart, or heart failure	0	1	2	3	Cracks or cuts at corner of mouth	0	1	2	3
Pulse slow (< 65 beats per minute)	No	Yes			Fragile skin, easily chaffed (ie. shaving)	0	1	2	3
ringing in ears	0	1	2	3	Polyps or warts	0	1	2	3
Numbness, tingling or itching in extremities	0	1	2	3	MSG sensitivity	0	1	2	3
Depressed	0	1	2	3	Can't remember dreams on waking	0	1	2	3
Fear of impending doom	0	1	2	3	Taking the birth control pill	0	1	2	3
Worrier, apprehensive, anxious	0	1	2	3	Small bumps on back of upper arms	0	1	2	3
Nervous or agitated	0	1	2	3	Strong light at night irritates eyes	0	1	2	3
Feelings of insecurity	0	1	2	3	Nose bleeds and/or easy bruising	0	1	2	3
Heart races	0	1	2	3	Bleeding gums (ie. when brushing teeth)	0	1	2	3

ADRENAL GLAND

Tend to be a "night person"	0	1	2	3	Crave salty foods	0	1	2	3
Difficulty falling asleep	0	1	2	3	Salt foods before tasting	0	1	2	3
Slow starter in the morning	0	1	2	3	Perspire easily	0	1	2	3
Keyed up, trouble calming down	0	1	2	3	Chronic fatigue, or get drowsy often	0	1	2	3
High blood pressure (normal = 110/70)	0	1	2	3	Afternoon yawning	0	1	2	3
Headache after exercising	0	1	2	3	Afternoon headache	0	1	2	3
Feeling wired or jittery with coffee	0	1	2	3	Asthma, wheezing or difficulty breathing	0	1	2	3
Clench or grind teeth	0	1	2	3	Pain on the inner side of the knee	0	1	2	3
Calm on the outside, troubled inside	0	1	2	3	Tendency to sprain ankles or develop "shin splints"	0	1	2	3
Chronic low back pain, worse tired	0	1	2	3	Tendency to require sunglasses	0	1	2	3
Become dizzy/faint upon standing	0	1	2	3	Allergies and/or hives	0	1	2	3
Difficult maintaining a chiropractic adjustment	0	1	2	3	Weakness, dizziness	0	1	2	3
Pain after manipulative correction	0	1	2	3	Easily stressed out	0	1	2	3
Arthritic tendencies	0	1	2	3					

PITUITARY GLAND

Over 6'6" tall	0	1	2	3	Decreased libido	0	1	2	3
Early sexual development (< age 10)	No		Yes		Abnormal thirst	0	1	2	3
Increased libido	0	1	2	3	Weight gain around hips or waist	0	1	2	3
Splitting type headache	0	1	2	3	Menstrual disorders	0	1	2	3
Memory failing	0	1	2	3	Delayed sexual development (> age 13)	No		Yes	
Ability to tolerate sugar; fine with eating	0	1	2	3	Tendency to have ulcers or colitis	0	1	2	3
Under 4'10" (mature height)	0	1	2	3					

THYROID

Allergic to iodine	0	1	2	3	Mentally sluggish, lacking motivation	0	1	2	3
Difficulty gaining weight	0	1	2	3	Easily fatigued, sleepy during the day	0	1	2	3
Nervous, emotional, or can't work under pressure	0	1	2	3	Cold hands and feet, poor circulation	0	1	2	3
Inward trembling	0	1	2	3	Chronic constipation or sluggish digestion	0	1	2	3
Flush easily	0	1	2	3	Excessive hair loss and/or coarse hair	0	1	2	3
Fast pulse at rest	0	1	2	3	Morning headaches, fade with time	0	1	2	3
Intolerance to high temperatures	0	1	2	3	Loss of outside 1/3 of eyebrow	0	1	2	3
Difficulty losing weight	0	1	2	3	Seasonal sadness	0	1	2	3

MEN ONLY

Prostate problems	0	1	2	3	Interruption of stream during urination	0	1	2	3
Urination difficult or dribbling	0	1	2	3	Pain on inside of legs or heels	0	1	2	3
Difficult to start and stop urine stream	0	1	2	3	Feeling of incomplete bowel evacuation	0	1	2	3
Pain or burning with urination	0	1	2	3	Decreased sexual function	0	1	2	3
Waking to urinate at night	0	1	2	3	History of sexually transmitted infections	No		Yes	

WOMEN ONLY

Depression during periods	0	1	2	3	Vaginal discharge	0	1	2	3
Premenstrual syndrome (PMS)	0	1	2	3	Vaginal dryness	0	1	2	3
Crave chocolate around periods	0	1	2	3	Vaginal itching	0	1	2	3
Breast tenderness associated with cycle	0	1	2	3	Weight gain around hips, thighs and buttocks	0	1	2	3
Excessive menstrual flow	0	1	2	3	Excess facial or body hair	0	1	2	3
Scanty blood flow during periods	0	1	2	3	Thinning skin	0	1	2	3
Occasional skipped periods	0	1	2	3	Hot flashes	0	1	2	3
Variations in menstrual cycles	0	1	2	3	Night sweats (in menopausal females)	0	1	2	3
Endometriosis	0	1	2	3	Pregnant	No		Yes	
Uterine fibroids	0	1	2	3	History of sexually transmitted infections	No		Yes	
Breast fibroids, benign masses	0	1	2	3	Difficulty conceiving/infertility	No		Yes	
Painful intercourse (dyspareunia)	0	1	2	3					

CARDIOVASCULAR

Aware of heavy and/or irregular breathing	0	1	2	3	Ankles swell, especially at end of day	0	1	2	3
Discomfort at high altitudes	0	1	2	3	Cough at night	0	1	2	3
"Air hunger" and/or yawn frequently	0	1	2	3	Blush or face turns red for no reason	0	1	2	3
Compelled to open windows in a closed room	0	1	2	3	Dull pain or tightness in chest, possibly radiates into arm, worse w/exertion	0	1	2	3
Shortness of breath with exertion	0	1	2	3	Muscle cramps with exertion	0	1	2	3

Initial Intake Form

KIDNEY & BLADDER

Pain in mid back region	0 1 2 3	Cloudy, bloody or darkened urine	0 1 2 3
Dark circles under eyes and/or puffy eyes	0 1 2 3	Urine has a strong odor	0 1 2 3
History of kidney stones	No Yes		

IMMUNE SYSTEM

Runny or drippy nose	0 1 2 3	Never get sick (3 = not in last 7 yrs, 2 = not in last 4 yrs, 1 = not in last 2 yrs)	0 1 2 3
Catch colds at the beginning of winter	0 1 2 3	Acne (adult)	0 1 2 3
Mucus-producing cough	0 1 2 3	Itchy skin/dermatitis	0 1 2 3
Frequent infections (ear, sinus, lung, skin, bladder, kidney, etc.)	0 1 2 3	Cysts, boils, rashes	0 1 2 3
Frequent colds or flu	0 1 2 3	History of viruses: Epstein Bar, mono, herpes, shingles, chronic fatigue, hepatitis	0 1 2 3

PSYCHOLOGICAL

Treated for emotional issues	0 1 2 3	Mood swings	0 1 2 3
Depression	0 1 2 3	Ever considered suicide	0 1 2 3
Anxiety/nervousness	0 1 2 3	Ever attempted suicide	0 1 2 3
Poor concentration	0 1 2 3		

Height: _____ Weight: _____ Do you have a religious/spiritual practice? Y/N _____

Blood Type (if known): _____ Do you crave certain foods? Y/N _____

Do you have energy crashes? Y/N Time/s: _____

Informed Consent and Request for Naturopathic Medical Care and Acupuncture

As a patient, I have the right to be informed about my health condition(s) and recommended treatments. Dr. Elliott will discuss the potential benefits, risks and hazards involved. After signing this consent form, I understand I can withdraw consent at any time.

I recognize that even the gentlest therapies may potentially have complications in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs.

I give my written consent for naturopathic evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

Printed Name

Signature

Date