Stone Ridge Natural Medicine
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Risë Finkle, ND, LAc
Naturopathic Physician
Licensed Acupuncturist

Adult Naturopathic Intake Form

Name: _____ Age: ___ Birth Date: _____

Mailing Address: _____

Preferred Phone # _____ Alternate Phone #_____

Email: _____ Emergency contact & phone #_____

Primary Care Physician: _____

Occupation: _____ Employer: _____

Please Circle: single married/significant other separated/divorced widowed

Number of Children: _____ Grandchildren: _____

How did you hear about Dr. Finkle ? _____
Have you seen a naturopathic physician/acupuncturist before? _____

Please answer the following questions as honestly and accurately as possible. This form serves only as a guideline for Dr. Finkle. During your office visit, topics will be discussed in more detail.
All information is confidential.

Current Health Concerns:

In order of importance, what health concerns brought you here today:

1. _____ 4._____ 7._____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9._____

Other therapies you are currently using:
Chiropractic Massage Acupuncture Homeopathy Counseling Other: _____

Known or suspected allergies (medications, food, environmental allergies, chemical, etc) :

Medication/ Supplements	Dosage	Since	Reason

Have you researched the side effects of the above?

Antibiotic Use:
When and How Long?

For What Conditions?

Lyme Disease Exposure
___ History of Lyme Disease/co infection
___ Diagnosed by Lab ___
___ History of Tick Bites When? _____
___ Live in area of Lyme Disease
___ Lyme Symptoms: Headaches, Fatigue, Joint pain, Muscle aches, Flu Symptoms, Rash,
___Other:

Thyroid Symptoms

___ Fatigue ___ Headaches ___ Cold/Heat ___ Family History ___Insomnia
___ Weight Loss/Gain ___ Hair Loss ___ Rashes ___Depression ___Other

Hospitalizations - Surgeries - Injuries

Event	When/Age	Complications

Please circle conditions you have had:

Fibroids	Fibrocystic Breasts	Irritable Bowel	Heartburn	Sinusitis
Rashes	Urinary Problems	Parasites	Nausea	Hepatitis.
Prostatitis	Frequent colds	Abdominal Pain	Autoimmune	Chest Pain/tightness
Allergies	Kidney Disease	Insomnia	Suicidal thoughts.	Problems breathing
Arthritis	Gallbladder disease	Seizures	HIV	Excessive Anger
Asthma	Gout	Memory Loss	Thyroid Condition	Depression/Sadness
Cancer	Headaches	Fuzzy thinking	Miscarriage	Anxiety
Heart Disease	Hypertension	Mono		PTSD
Sore throat.	Chronic cough	Autoimmune	Alcoholism	Sexual abuse
Cold Sores	HPV	Tonsillitis	Drug abuse	Emotional abuse
Colitis	Stroke	Pneumonia	Eczema/Psoriasis	
Cysts	Hot flashes/Night Sweats			

Other Conditions Not Listed:
_____

Vaccinations:

___ Influenza ___ Hep B ___ Polio ___MMR ___Varicella ____Others:_____

Reactions/Side Effects:
_____

Do you have any of the following?
___ Amalgams (silver) fillings. How many? ___
___ Root Canals How many? ___ ___ Dental Implants ___ PeriodontalDisease/Infections
___ TMJ ___Orthodontics Other Dental Issues: _____

Have you had breast implants/ pacemaker/ joint replacements/other ?

Environmental Toxin Exposure
___ mold ___ pesticides/herbicides ___ chemical solvents/cleaning solutions/paints ___ mercury
___ cigarette smoke ___toxic fumes ___old/new construction ___wood stove ___heavy metals
___ toxic fumes(work, hobbies) ___ old/new construction ___ wood stove ____ heavy metals

Women Only:

Age of First Period: ___ Number of Pregnancies: ___ Live Births: ___
Any possibility of pregnancy now? _____
Complications of Pregnancies/Deliveries:
_____
Fertility Issues/Difficulties Conceiving:
_____
Age of Menopause: _____ Menopausal Symptoms:
_____
Last PAP: _____ Last Breast Exam: _____ Last Bone Density Exam: _____ Any Abnormal?_____
History of Birth Control, IUDs, Hormone Therapy:
_____
Any History of:
Yeast Infections Urinary Tract Infections Abdominal/Uterine Pain Vaginal Itching/Discharge/Odour

Any symptoms connected to your cycle?
PMS, moodiness, fatigue, bloating, breast tenderness, pelvic pain/cramping, irregular cycles,
Excess Bleeding, Food Cravings , other: _____

Any other Reproductive/Sexual Concerns: _____

Men only:
Last Prostate Exam/PSA: _____ Any abnormals? _____
_____Difficulty with Urination _____Difficulty achieving/maintaining an erection
Any other Reproductive/Sexual Concerns: _____

Digestion & Elimination

How often do you have a bowel movement? _____ Please circle if you experience:

Constipation Diarrhea Gas Bloating Flatulence Belching Heartburn Nausea Heartburn/Reflux Abdominal Pain Rectal Itching Hemorrhoids Blood or Mucous or Undigested Food in Stool

Stool is: ___Hard ___Small ___Thin, long ___Easily Passed ___Hard to Pass ___Discolored

If you have ever fasted, for how long? _____ Parasite Cleanse? ____ Did you feel better/worse?

Any exposure to parasites? (camping/foreign travel/drinking from stream)_____

Other Digestive Concerns: _____

Energy Level & Sleep

What is your current energy level on a scale of 1-10 (10 being most energetic)? _____

When did you last feel energetic ? _____

Trouble falling asleep? _____ Staying asleep? _____ Wake rested? _____

Diet & Lifestyle

How many glasses of water do you drink daily? _____

Food Cravings: _____

Please circle if you use any of the following:

Alcohol Tobacco Coffee Caffeinated Tea Lunch meats Fast Food
Non-sugar sweeteners Marijuana Laxatives Soda Candies Antacids

Any Dietary Restrictions? (Religious, philosophical, vegan, allergies, etc):

_____

Please list your typical Breakfast, Lunch, Supper, Drinks, and Snacks in one day:

How often do you Exercise? ___ What Activities?_____

Family History: Please list any significant health conditions of parents, grandparents, siblings, children (diabetes, stroke, thyroid conditions, autoimmune, cancer, heart disease, alcoholism, anxiety, depression)

Family Member	Age	Age Died	Health Conditions

What is causing the most stress in your life right now?

Past psychological, emotional, physical traumas which have significantly affected your life?

What give you the most joy or contentment in your life, past or present ? (person, activity, hobby, etc)

Any additional concerns?