

# Dayspring Naturopathic Clinic

Dr. Taraneh Ballew, ND · Virtual Practice, California · DrTaraneh@msn.com · (925) 461-9335

## ADULT NEW PATIENT INTAKE FORM

Please complete this form and email it to DrTaraneh@msn.com before your first visit. All information is confidential.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address (Street): \_\_\_\_\_  
City: \_\_\_\_\_ State / Zip: \_\_\_\_\_  
Telephone (Home): \_\_\_\_\_ Telephone (Work): \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Email: \_\_\_\_\_  
Emergency Contact (Name & Relationship): \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Family Physician: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

### REASON FOR VISIT

List reason(s) in order of importance (include date of onset):

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

Currently receiving any treatment? Has it been effective?

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

### MEDICATIONS

Current medications (prescription, OTC, vitamins, herbs, homeopathics):

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

Past prescription medications:

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

### MEDICAL HISTORY

Surgeries, hospitalizations, accidents, or serious injuries:

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

Known allergies or intolerances:

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

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### IMMUNIZATIONS

- |  |                                    |   |
|--|------------------------------------|---|
| <input type="checkbox"/> Measles, mumps, rubella | <input type="checkbox"/> Influenza | <input type="checkbox"/> Diphtheria, pertussis, tetanus |
| <input type="checkbox"/> Small pox               | <input type="checkbox"/> Polio     | <input type="checkbox"/> Hepatitis                      |
| <input type="checkbox"/> Other                   |                                    |   |

Adverse reactions to immunizations?

### PERSONAL HEALTH HISTORY

	Poor	Fair	Good	Excellent
General health as adult:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
General health as teenager:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
General health as child:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Any condition (physical, mental, or emotional) from which you have not fully recovered?				

### FAMILY HISTORY

Have any family members had any of the following?

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Depression     | <input type="checkbox"/> Hypertension   |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Anemia     | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Stroke         |
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Other          |

### PAST MEDICAL HISTORY

Have you ever had any of the following?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abscesses          | <input type="checkbox"/> Alcoholism                  | <input type="checkbox"/> Allergies               |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Chicken pox                 | <input type="checkbox"/> Cold sores              |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Emphysema               |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Frequent colds              | <input type="checkbox"/> Gallstones              |
| <input type="checkbox"/> Gonorrhea          | <input type="checkbox"/> Gout                        | <input type="checkbox"/> Hayfever                |
| <input type="checkbox"/> Heart disease      | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> HIV                     |
| <input type="checkbox"/> Kidney disease     | <input type="checkbox"/> Leukemia                    | <input type="checkbox"/> Low/high blood pressure |
| <input type="checkbox"/> Lyme disease       | <input type="checkbox"/> Measles                     | <input type="checkbox"/> Mononucleosis           |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Mumps                       | <input type="checkbox"/> Parasites               |
| <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Strep throat            |
| <input type="checkbox"/> Syphilis           | <input type="checkbox"/> Tonsillitis                 | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Typhoid            | <input type="checkbox"/> Whooping cough              | <input type="checkbox"/> Worms                   |
| <input type="checkbox"/> Other              |  |  |

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### WOMEN'S HEALTH HISTORY

Age at first menstrual period: \_\_\_\_\_ Cycle length (days): \_\_\_\_\_

Duration of period (days): \_\_\_\_\_ Flow:  Light  Moderate  Heavy \_\_\_\_\_

Menstrual concerns (cramps, irregularity, PMS, spotting): \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_ Number of terminations: \_\_\_\_\_

Currently pregnant or trying to conceive?  Yes  No Notes: \_\_\_\_\_

Menopausal status:  Pre-menopausal  Peri-menopausal  Post-menopausal

Hormonal contraceptive or HRT use? Describe: \_\_\_\_\_

Date of last Pap smear: \_\_\_\_\_ Results: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_ Results: \_\_\_\_\_

### LIFESTYLE & ENVIRONMENTAL FACTORS

Do you consume any of the following at least once a week?

- |  |                                     |   |
|--|-------------------------------------|---|
| <input type="checkbox"/> Alcohol               | <input type="checkbox"/> Coffee     | <input type="checkbox"/> Recreational drugs |
| <input type="checkbox"/> Antacids              | <input type="checkbox"/> Fast foods | <input type="checkbox"/> Tea                |
| <input type="checkbox"/> Artificial sweeteners | <input type="checkbox"/> Laxatives  | <input type="checkbox"/> Tobacco            |

Dietary restrictions: \_\_\_\_\_

Exposure to chemicals or tobacco smoke at work or home? \_\_\_\_\_

Energy level (1=very low, 10=excellent): \_\_\_\_\_ Sleep (hours/night): \_\_\_\_\_ Quality:  Poor  Fair  Good  Excellent

Stress level at work / life — how do you handle it? \_\_\_\_\_

How do you relax (hobbies, leisure)? \_\_\_\_\_

Health goals in working with Dr. Ballew: \_\_\_\_\_

Anything important not covered above? \_\_\_\_\_

### CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

*By signing this form, I authorize Dr. Taraneh Ballew, ND to treat me using naturopathic medicines according to the principles of naturopathic practice. If I desire allopathic medical treatment, I am free to seek it from a physician. I understand Dayspring Naturopathic Clinic will make the best effort to treat me but makes no guarantee to cure me. I certify that the above information is true and agree that I am financially responsible for any charges. I understand this is a virtual telehealth practice.*

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

*Thank you. Please email this form to DrTaraneh@msn.com before your first visit.*