

**Berkeley Naturopathic Medical Group  
Intake Form**

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_

Work \_\_\_\_\_

Email \_\_\_\_\_

(Your email will never be shared.)

Occupation \_\_\_\_\_

Number of hours worked per week \_\_\_\_\_

Emergency Contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

How did you hear about us? Be as specific as possible:

\_\_\_\_\_

1. Why did you choose to come to this clinic?
  
  
  
  
  
  
  
  
  
  
  2. What do you know about our approach?
  
  
  
  
  
  
  
  
  
  
  3. What three expectations do you have from this visit to our clinic?
  
  
  
  
  
  
  
  
  
  
  4. What long term expectations do you have from working with our clinic?
  
  
  
  
  
  
  
  
  
  
  5. What expectations do you have of me personally as your physician?
  
  
  
  
  
  
  
  
  
  
  6. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)
- 1    2    3    4    5    6    7    8    9    10
7. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

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b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits? (please list)

8. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

9. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

10. What do you LOVE to do?

CHIEF COMPLAINT: Please list health concerns in order of importance

1 _____	5 _____
2 _____	6 _____
3 _____	7 _____
4 _____	8 _____

CURRENT SUPPLEMENTS: Please list homeopathics, herbs, vitamins, minerals with dosage and frequency

1 _____	5 _____
2 _____	6 _____
3 _____	7 _____
4 _____	8 _____

CURRENT MEDICATIONS: Please list current medications with dosage and frequency

1 _____	5 _____
2 _____	6 _____
3 _____	7 _____
4 _____	8 _____

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ALLERGIES: Please list any allergies or adverse reactions to medications, inhalants, foods, medicines, perfumes, smoke, chemicals...

\_\_\_\_\_

Describe your allergy attack or reaction

What happens when you have an allergic reaction to medication?

Hospitalizations: List reason, year & duration

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

Date of last physical exam \_\_\_\_\_

**SOCIAL HISTORY**

Are you currently: Married/Domestic Partnered \_\_\_\_\_ Single \_\_\_\_\_  
Separated/Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
Number of children \_\_\_\_\_ Ages \_\_\_\_\_

**DIET & LIFESTYLE**

Coffee, colas or black tea: How much daily?

Alcohol: What kind & how many per day or week?

Water: Tap, spring, well, filtered or distilled; how many per day?

Other fluids not listed above: \_\_\_\_\_

How many glasses per day? \_\_\_\_\_

Do you use tobacco? \_\_\_\_\_

What kind & how much? \_\_\_\_\_

Do you salt your food? Heavily, moderately, lightly, not at all?

How often do you eat salted foods: chips, pickles, fries?

How often do you eat processed or fast food? \_\_\_\_\_

Any diet restrictions or regimen? Describe \_\_\_\_\_

Are you usually relaxed when you eat? \_\_\_\_\_

What is your appetite like at breakfast? \_\_\_\_\_

At lunch? \_\_\_\_\_ At dinner? \_\_\_\_\_

When do you eat your largest meal? \_\_\_\_\_

What foods or beverages do you crave? \_\_\_\_\_

Are you satisfied with your current diet? \_\_\_\_\_

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Do you exercise? \_\_\_\_\_  
What kind & how often? \_\_\_\_\_  
How do you describe your general energy level (without caffeine or stimulants)? \_\_\_\_\_  
\_\_\_\_\_

**REVIEW OF SYSTEMS**

Y=Yes (within the past year)

N=Never

P=Past

**FEMALE REPRODUCTIVE**

Age menses began \_\_\_\_\_  
Average # of days \_\_\_\_\_  
Length of cycle \_\_\_\_\_  
Bleeding bet. periods \_\_\_\_\_  
Are cycles regular \_\_\_\_\_  
Pain during intercourse \_\_\_\_\_  
Painful menses \_\_\_\_\_  
Excessive flow \_\_\_\_\_  
Are you sexually active? \_\_\_\_\_  
Sexual Partners:  
Men \_\_\_\_\_ Women \_\_\_\_\_  
Current birth control method \_\_\_\_\_

\_\_\_\_\_

Past birth control methods used \_\_\_\_\_  
\_\_\_\_\_

Sex transmitted infections \_\_\_\_\_  
Do you do self breast exam? \_\_\_\_\_  
Breast lumps \_\_\_\_\_  
Breast pain or tenderness \_\_\_\_\_  
Nipple discharge \_\_\_\_\_  
Date of last Pap/Gyn exam \_\_\_\_\_

\_\_\_\_\_

**MALE REPRODUCTIVE**

Hernias \_\_\_\_\_  
Testicular masses \_\_\_\_\_  
Testicular pain \_\_\_\_\_  
Are you sexually active? \_\_\_\_\_  
Sexual partners:  
Men \_\_\_\_\_ Women \_\_\_\_\_  
Sexual difficulties \_\_\_\_\_  
Prostate disease \_\_\_\_\_  
Sex transmitted infections \_\_\_\_\_

**MUSCULOSKELETAL**

Joint pain or stiffness \_\_\_\_\_  
Arthritis \_\_\_\_\_  
Broken bones \_\_\_\_\_  
Muscle spasms or cramps \_\_\_\_\_  
Weakness \_\_\_\_\_

**PERIPHERAL VASCULAR**

Deep leg pain \_\_\_\_\_  
Cold hands/feet \_\_\_\_\_  
Varicose veins \_\_\_\_\_  
Thrombophlebitis \_\_\_\_\_

**NEUROLOGICAL**

Fainting \_\_\_\_\_  
Seizures \_\_\_\_\_  
Paralysis \_\_\_\_\_  
Muscle Weakness \_\_\_\_\_  
Numbness or tingling \_\_\_\_\_  
Loss of memory \_\_\_\_\_

**EMOTIONAL**

Depression \_\_\_\_\_  
Mood swings \_\_\_\_\_  
Anxiety or nervousness \_\_\_\_\_  
Tension or stress \_\_\_\_\_

**ENDOCRINE**

Hypothyroid \_\_\_\_\_  
Heat or cold intolerance \_\_\_\_\_  
Excessive hunger \_\_\_\_\_  
Excessive thirst \_\_\_\_\_

**BLOOD**

Anemia \_\_\_\_\_  
Easy bleeding or bruising \_\_\_\_\_

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REVIEW OF SYSTEMS (continued)

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SKIN

Rashes \_\_\_\_\_  
Eczema, hives \_\_\_\_\_  
Acne, boils \_\_\_\_\_  
Itching \_\_\_\_\_  
Color change \_\_\_\_\_  
Night sweats \_\_\_\_\_

HEAD

Headache \_\_\_\_\_  
Head injury \_\_\_\_\_

EYES

Impaired vision \_\_\_\_\_  
Glasses or contacts \_\_\_\_\_  
Eye pain \_\_\_\_\_  
Tearing or Dryness \_\_\_\_\_  
Double vision \_\_\_\_\_  
Glaucoma \_\_\_\_\_  
Cataracts \_\_\_\_\_

EARS

Impaired hearing \_\_\_\_\_  
Ringing \_\_\_\_\_  
Earache \_\_\_\_\_  
Dizziness \_\_\_\_\_

NOSE & SINUSES

Frequent colds \_\_\_\_\_  
Nose bleeds \_\_\_\_\_  
Stuffiness \_\_\_\_\_  
Hay fever \_\_\_\_\_  
Sinus problems \_\_\_\_\_

MOUTH & THROAT

Frequent sore throat \_\_\_\_\_  
Sore tongue \_\_\_\_\_  
Gum problems \_\_\_\_\_  
Hoarseness \_\_\_\_\_  
Cavities \_\_\_\_\_

NECK

Lumps \_\_\_\_\_  
Swollen glands \_\_\_\_\_  
Goiter \_\_\_\_\_  
Pain or stiffness \_\_\_\_\_

RESPIRATORY

Cough \_\_\_\_\_  
Sputum \_\_\_\_\_  
Spitting up blood \_\_\_\_\_  
Wheezing \_\_\_\_\_  
Asthma \_\_\_\_\_  
Bronchitis \_\_\_\_\_  
Pneumonia \_\_\_\_\_  
Pleurisy \_\_\_\_\_  
Emphysema \_\_\_\_\_  
Difficulty breathing \_\_\_\_\_  
Pain on breathing \_\_\_\_\_  
Shortness of breath (SOB) \_\_\_\_\_  
    SOB At Night \_\_\_\_\_  
    SOB Lying down \_\_\_\_\_  
Tuberculosis \_\_\_\_\_

CARDIOVASCULAR

Heart disease \_\_\_\_\_  
Angina \_\_\_\_\_  
High blood pressure \_\_\_\_\_  
Murmurs \_\_\_\_\_  
Rheumatic fever \_\_\_\_\_  
Chest pain \_\_\_\_\_  
Swelling in ankles \_\_\_\_\_  
Palpitations, fluttering \_\_\_\_\_

GASTROINTESTINAL

Trouble swallowing \_\_\_\_\_  
Heartburn \_\_\_\_\_  
Change in thirst \_\_\_\_\_  
Change in appetite \_\_\_\_\_  
Nausea \_\_\_\_\_  
Vomiting \_\_\_\_\_  
Vomiting blood \_\_\_\_\_  
Jaundice \_\_\_\_\_

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REVIEW OF SYSTEMS (continued)

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GASTROINTESTINAL (cont)

Bowel movements:  
How often? \_\_\_\_\_  
Is this a change? \_\_\_\_\_  
Blood in stool \_\_\_\_\_  
Hemorrhoids \_\_\_\_\_  
Belching or passing gas \_\_\_\_\_

URINARY

Pain on urination \_\_\_\_\_  
Increase in frequency \_\_\_\_\_  
Frequency at night \_\_\_\_\_  
Inability to hold urine \_\_\_\_\_  
Frequent infections \_\_\_\_\_  
Kidney stones \_\_\_\_\_

FAMILY HISTORY

Please list any major illnesses or diseases for your first degree relatives: Mother, Father, Brother, Sister or Children.

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I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_