Pica & Associates
Psychological Services
and
Holistic Medicine

Naturopathic Intake Form
Sarah Gerencher, ND, LMT

***Important: This is a confidential health intake form.** *Please fill out as honestly and completely as possible. At our initial appointment, we can review your answers, clarify your goals, and determine an appropriate course of action. I look forward to meeting you. Thank you.*

Today's Date: _____

PERSONAL INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____

Are you at least 18 years of age? (circle) Yes No

Gender: (circle)
Male Female Transgender, preferred pronoun: _____

Marital Status: (circle)

Single Married Significant Other Separated Divorced Widowed

Occupation: _____

CONTACT INFORMATION

Address: _____City: _____ State: _____

Zip Code: _____ Email: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Confidential E-mails OK? (circle) Yes No **Confidential Voicemails OK?** Yes No
Confidential Texts OK? Yes No Preference: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

PARENT/GUARDIAN/INFORMATION (if patient is a minor)

Name: _____ Date of Birth: _____

Relationship to Client: _____

Legal Guardian: (circle) Yes No

HEALTH MANAGEMENT

Who are you currently seeing for care, treatment, etc. for your chief health concern(s)? (circle)

Medical Doctor Nurse Practitioner Chiropractor Naturopathic Doctor

Nutritionist Psychologist Counselor Massage Therapist

Other(s): _____

Do you have a primary care doctor? (circle) No Yes, specify:

Name of Doctor: _____

Last time seen by doctor (year): _____

For anything specific? _____

How many times do you visit your primary care doctor per year? _____

When did you last have bloodwork? _____

When did you last have a physical? _____

In general, would you say your health today is: (circle)

Excellent Very Good Good Fair Poor

REFERRED BY: (circle) Self Family Friend Doctor Other: _____

Name of person who referred you: _____

HEALTH HISTORY

Height: _____ Weight: _____ (best estimation)

Diagnosed Health Conditions (please include year of diagnosis):

_____

_____

Please list all medication (prescription, over-the-counter) you are currently taking:

Medication (please indicate brand)	Dose/Quantity per day	Why are you taking this product?

Please list all natural products (vitamins, minerals, botanical, herbal, homeopathic) you are currently taking:

Natural Product (please indicate brand)	Dose/Quantity per day	Why are you taking this product?

Have you ever experienced adverse effects or an allergic reaction(s) to any medications/natural products? (circle) No Yes, specify:

_____

Do you have any sensitives and/or allergic reactions to anything else (i.e., food, scents, chemicals, etc.)? (circle) No Yes, specify:

_____

Were you born via: (circle) Vaginal delivery C-section

Were you: (circle) Breast-fed Formula-fed

Please list all hospitalizations, surgeries and /or accidents you have experienced:

Description	Year	Outcome/complications

FAMILY HEALTH HISTORY

Have any of your family members had any significant illness or health concerns?

Mother: _____

Father: _____

Sister(s): _____

Brother(s): _____

Maternal Grandparents: _____

Paternal Grandparents: _____

PRESENTING CONCERN(S)

What are your chief health concern(s)? (List in order of importance)

1._____ 4._____

2._____ 5._____

3._____ 6._____

What do you believe is causing your most important health concern(s)?

_____

_____

How does the condition(s) impact your quality of life?

_____

_____

What aggravates the condition(s)?

_____

_____

What improves the condition(s)?

_____

_____

MENTAL HEALTH HISTORY

Are you currently being seen by a mental health counselor, psychologist, etc. for a mental health condition(s)? No Yes, specify:

With Whom? _____ When? _____

Mental Health Condition(s):

_____

_____

Have you ever received care in the hospital for a mental health concern?

No Yes: When? _____

In the past 12 months have you contemplated suicide?

No Yes: When? _____

Have you ever intentionally harmed yourself in any way or attempted suicide?

No Yes: When? _____

Do you currently take medication for a mental health related concern?

No Yes, specify: _____

Have you taken medication in the past for a mental health related concern?

No Yes, specify: _____

DIET

Please list what you typically eat in a day:

Breakfast	
Lunch	
Dinner	
Snacks	
Fluid intake (Water, soda, juice, etc. in ounces per day)	

DIGESTION

How many bowel movements do you have daily? _____

Please circle all that apply to your bowel movements:

Difficult to pass	Undigested food	Small and hard	Formed
Loose	Fatty or oily	Contains blood	Easy to pass
Diarrhea	Incomplete	Dark in color	Feels complete

Other: _____

SLEEP

Please rate your average quality of sleep and energy with 10 being the absolute best and 0 being the absolute worst:

Sleep	0	1	2	3	4	5	6	7	8	9	10
Energy	0	1	2	3	4	5	6	7	8	9	10

Please circle any that apply to you:

Hard to fall asleep Nightmares Snoring Sleep well
Hard to wake up Sleeping too much Use C-PAP Feel rested in a.m.
Interrupted sleep Sleeping too little Tired in a.m.
Other:_____

EXERCISE

Do you exercise? No Yes, specify:
Type: _____

Frequency: _____

Restrictions? _____

SUBSTANCE USE HISTORY

Do you consume alcohol?
No Yes, how many drinks per week? _____
Current or past tobacco use:
No Yes, specify:
Amount/packs per day: _____ How long: _____
Quit date _____
Please indicate frequency and quantity of use:
Caffeine: _____
Marijuana: _____
Other(s): _____

MISCELLANEOUS QUESTIONS

Do you have a good support system in your life (friends, family, etc.)? (circle)

Excellent Very Good Good Fair Poor Very Poor

With whom do you live? _____

How would you rate your overall stress level? (circle) Extreme High Medium Low

What are your major stressors in life?

_____

_____

What brings you joy in life? Hobbies?

_____

_____

What else would you like me to know about you?

_____

_____

_____

_____

Thank you for completing the intake!! Again, this document is confidential information and will not be released without your consent.