Dr. Donna Acree | Center for Mind Body Therapies | 5 North Bentz Street, Frederick, Maryland 21701
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Adult Intake Form

Name _____ Age ____ Birthdate _____ Today's Date _____

Height _____ Weight _____ Weight 1 yr. ago _____ Max Weight, when _____ Ideal Weight _____

Address _____
(Street)

_____
(City) (State) (Zip Code)

_____
(Home Phone) (Work Phone) (Cell Phone)

_____
(E-Mail) (Fax) (website)

Occupation_____ ☐ Full time ☐ Part-time ☐ Student ☐ Retired

How long at current job? _____ Level of satisfaction at work 10 9 8 7 6 5 4 3 2 1

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner ☐ Same Sex

Spouses' health: ☐Excellent ☐Good ☐Fair ☐Poor Are you the caretaker of a loved one? ☐ Y ☐ N

Do you have children? ☐ Y ☐ N If yes, how many? _____ Ages? _____

Children's Health? _____

How do you hear about us? _____

Emergency Contact

_____
(Name) (Relationship) (Contact Phone #1) (Alternative Phone #2)

NOTE: Effective Naturopathic care involves getting to know all aspects the individual. Your information is both valued and valuable in assisting the Doctor in helping you better. This form is a "health life map" spanning many years or decades, please keep this in mind when you set aside 1 hour or so to complete it. Your pre-submitted answers are reviewed by Dr. Donna prior to your visit and will make the time in the office more efficient.

What expectations do you have from your **first** visit?

What long-term expectations do you have from working with Dr. Donna?

How committed are you to making changes to improve your health, which include modifications of lifestyle factors that contribute to the underlying cause(s) of your physical and mental symptoms?

(0%) 0 – 1 - 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (100 %)

What specific lifestyle factors or behaviors do you engage in that support your health?

What specific lifestyle factors or behaviors do you engage in that do **not** support your health? Of these, are there any you do NOT want to change and why?

Do you know someone that will support you with the positive lifestyle changes you will be making? ☐ Y ☐ N

Physician / Holistic Care Information

Primary Care Physician _____ Date of last appointment _____
Additional Healthcare Practitioner _____ Date of last appointment _____
Do you currently seek care from: ☐Acupuncturist ☐Chiropractor ☐Massage Therapist ☐Counselor
Other: _____
Have you had Naturopathic Care in the past? ☐Y ☐N What was the primary reason?_____

Health Information

List your health problems, in order of importance.
CIRCLE the conditions that have been diagnosed, note date of diagnosis, and by whom.

1) The primary health issue I want to address today is: _____

2)_____

3)_____

4)_____

5)_____

Briefly state **treatment** of each health problem and dates of treatment
1) _____
2) _____
3) _____
4) _____
5) _____

How does the primary health problem limit you most? _____
How long has it been since you have felt healthy? _____

Medications / Supplements

Yes	No		Yes	No	
☐	☐	Antacids	☐	☐	Antibiotics
☐	☐	Laxatives	☐	☐	Pain Relievers
☐	☐	Sleep Aids	☐	☐	Steroids / Cortisone
☐	☐	Stimulants	☐	☐	Appetite suppressants or weight loss pills

	Medications	**Reason**	**Date started?**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Supplements

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Allergies

☐ Y ☐ N Food (s) _____

☐ Y ☐ N Outdoor _____

☐ Y ☐ N Chemical Sensitivities _____

☐ Y ☐ N Drug (s) _____

Although never tested, I feel bad when I drink/eat these foods: _____

How were the food / environmental allergies tested? _____

What was the treatment? _____ When? _____ Results ? _____

Hospitalizations/Surgeries

List all Major Medical procedures, Surgeries, and Hospitalizations. (use back of page If needed)

Year	**Reason**
_____	_____
_____	_____
_____	_____
_____	_____

Injuries/accidents/broken bones: dates, briefly describe, treatment?

_____

_____

_____

Tests and Diagnostic Imaging

Circle (Y)es or (**N**)o to any of the following tests, exams, or imaging in the **past year** and the results

Test	**Yes / No**	**Results**
Blood Sugar	Y N	_____
Blood Pressure	Y N	_____
X-rays	Y N	_____
MRI/CAT Scans	Y N	_____
Ultrasounds	Y N	_____
Colonoscopy	Y N	_____
Testicular/Prostate	Y N	_____
PAP Test	Y N	_____
DEXA Bone Scan	Y N	_____
Mammogram/Thermogram	Y N	_____

Last Eye Exam: _____ Last Dental Visit : _____
Last Time you had bloodwork (date) _____ Problems? _____
Blood Type O A B AB Don't Know

Medical Conditions

Indicate date when diagnosed, If known (ex. Anemia 5/06)

C = Current Condition I = Intermittently P = Past condition

C	**I**	**P**	
☐	☐	☐	Alcohol/Drug Addiction
☐	☐	☐	Allergies/Hay Fever
☐	☐	☐	Anemia
☐	☐	☐	Anxiety
☐	☐	☐	Arthritis (Osteo/Rheumatoid)
☐	☐	☐	Asthma
☐	☐	☐	Bladder or Kidney Disease
☐	☐	☐	BPH or Prostate Disease
☐	☐	☐	Bronchitis
☐	☐	☐	Cancer (type _____)
☐	☐	☐	Candida (yeast overgrowth)
☐	☐	☐	Celiac Disease
☐	☐	☐	Chrons Disease or Colitis
☐	☐	☐	Clogged Arteries
☐	☐	☐	Diabetes (type 1 or 2)
☐	☐	☐	Depression
☐	☐	☐	Diverticulosis
☐	☐	☐	Other: _____
☐	☐	☐	Other: _____

C	**I**	**P**	
☐	☐	☐	Emphysema
☐	☐	☐	Food Allergies/Sensitivities
☐	☐	☐	Gall stones
☐	☐	☐	GERD
☐	☐	☐	Heart Attack / Heart Disease
☐	☐	☐	Hepatitis A B C
☐	☐	☐	High Blood Pressure
☐	☐	☐	Hypo or Hyperglycemia
☐	☐	☐	Irritable Bowel Syndrome (IBS)
☐	☐	☐	Kidney Stones
☐	☐	☐	Osteoporosis/Osteopenia
☐	☐	☐	Ovarian Cysts or PCOS
☐	☐	☐	Pneumonia
☐	☐	☐	Psychological disorders
☐	☐	☐	Sexually Transmitted Disease
☐	☐	☐	Sleep Disorder / Insomnia
☐	☐	☐	Thyroid
☐	☐	☐	Tuberculosis
☐	☐	☐	Ulcers (where?) _____
☐	☐	☐	Uterine Fibroids

Immunizations

Circle If received (**I**)mmunization, acquired the (**D**)isease, or (**N**)either . If you had the disease, note the **date**

I D N	Hepatitis B	I D N	Hemophilus (Hib)	I D N	Mumps
I D N	Rotavirus	I D N	Polio	I D N	Rubella (German Measles)
I D N	Diphtheria	I D N	Pnemococcus	I D N	Meningococcus
I D N	Pertussis	I D N	Influenza	I D N	Chicken Pox
I D N	Tetanus	I D N	Measles	I D N	Hepatitis A
				I D N	HPV (Cervical Cancer Vaccine)

Other_____

Vaccination reactions? □ Y □ N to which vaccine and when_____

Rheumatic Fever? □ Y □ N

Chronic Health Problems as a child? □ Y □ N If yes, briefly explain

_____

Have you traveled outside the USA? □ Y □ No

If Yes, when and where_____

Illnesses acquired there or in the months following, briefly explain.

_____

Family History

			Siblings				
	Father	Mother	1	2	3	4	Grandparents
Age if living	_____	_____	_____	_____	_____	_____	_____
Age when died	_____	_____	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____	_____

Check (√) who has the disease: F = Father M = Mother S = Sibling GP = Grandparent

F	M	S	GP		F	M	S	GP	
□	□	□	□	ADHD | Autism	□	□	□	□	Epilepsy or Seizure
□	□	□	□	Allergies | Eczema	□	□	□	□	GERD | IBS
□	□	□	□	Alzheimer's	□	□	□	□	Heart Attack | Heart Disease
□	□	□	□	Arthritis (type_____)	□	□	□	□	High Blood Pressure
□	□	□	□	Alcoholism	□	□	□	□	Mental Illness
□	□	□	□	Asthma	□	□	□	□	Obesity
□	□	□	□	Cancer (type _____)	□	□	□	□	Osteoporosis
□	□	□	□	Celiac Disease | Chrons Disease	□	□	□	□	Stroke
□	□	□	□	CFS | Fibromyalgia	□	□	□	□	Thyroid Disease
□	□	□	□	COPD | Chronic Bronchitis	∅	□	□	□	Uterine Fibroids
□	□	□	□	Diabetes	□	□	□	□	Other: _____

Lifestyle Habits

Exercise

Regular Exercise □ Yes □ No What form? _____
How often? □ daily □ 4-5 x week □ 2-3 x week □ 1 x week
Duration? □ less than 15 minutes □ 30 minutes or more □ 1 hour or more

Sun

Daily Sun Exposure? □ none □ less than 15 minutes □ 30 minutes or more □ hours

Water

Source of drinking water? _____ Drink from plastic | Styrofoam? □ Y □ N Glasses per day? ___

Caffeine and Sugar

Do you drink coffee? □ Y □ N □ Caffeinated □ Decaf Cups/day □ 1 □ 2 □ 3 or more
Drink soda or sugared drinks? □ Y □ N what type? _____ how often? _____

Alcohol/ Tobacco/ Drugs

Smoke? □ Y □ N Packs/day? _____ what age did you start? _____
Consume alcohol? □ Y □ N how much? _____ how often? _____
Use recreational drugs? □ Y □ N how often? _____ when started? _____

Sleep

Wake refreshed? □ Yes □ No
How many hours do you sleep at night? _____
How many hours of sleep do you need to feel rested and healthy? _____
Check those which apply: □ Nightmares □ Grind Teeth □ Snore □ Sleep Apnea □ Restless sleep
□ Waking in the night Number of times? ____ What times? _____

Energy

Do you have energy throughout the day? □ Yes □ No
Are you fatigued now? □ Yes □ No
If yes, when is it worse? □ upon waking □ mid morning □ after lunch □ evening
If fatigued, can you do what you need to do during the day? □ Yes □ No
Do you know what contributes to your fatigue? _____
I rely on coffee to get going in the morning? □ Yes □ No
Will napping or resting revitalize you? □ Yes □ No

Mental / Emotional Health

Where do you find joy and happiness? _____
Spiritual practice □ Yes □ No
Daily Quiet Time (ex. Prayer, Meditation) □ Yes □ No
Have you ever considered Suicide or attempted suicide? □ Yes, when? _____ □ No
Do you often feel Anxiety and/or have difficulty relaxing? □ Yes □ No
Do you have Depressive episodes that last for several days? □ Yes □ No
Do you often feel Angry or Irritable? □ Yes □ No
How do you deal with these emotions? _____
Have you experienced the loss of a loved one in the past year? □ Yes □ No
Have you ever been abused physically, emotionally, or sexually? □ Yes □ No
Have you ever had counseling? □ Yes □ No When? _____ Results? _____
Do you have a friend or loved one who you can trust, confine in, and feel emotionally supported by? □ Y □ N

Review of Systems

Check √ all conditions you are currently experiencing or have experienced in the past 6 months

SKIN / HAIR / NAILS
Herpes (simplex 1 or 2)
Color Change (skin) or Mole changes
Lump (skin)
Rosacea
Psoriasis/eczema
Dry / itchy
Rash or Hives
Thinning Hair
Toenail fungus

HEAD
Headache or Migraine
TMJ (jaw clicking and pain)

EYES
Cataracts
Macular Degeneration
Glaucoma
Vision Changes
Dark under Eyelid
Poor Night Vision
Dry eyes

NOSE
Polyps
Chronic Sinusitis
Nosebleeds

MOUTH/ THROAT
Toothache
Bleeding Gums
Gum Disease (i.e. Gingivitis)
Silver Filings # _____
Canker Sores
Hoarse Voice

EARS
Hearing Changes
Ringing in ears
Itching Ears

LUNG/RESPIRATORY
Shortness of breath with exercise
Shortness of breath without exertion
Cough
Wheezing
Exposure to 2nd hand smoke
Exposure to airborne chemicals

CARDIOVASCULAR
Chest Pain with Exercise
Chest Pain without exertion
Pain in legs with walking
Varicose Veins
Rapid Pulse (> 85 beats/min)
Irregular heart beat (Arrhythmias)
Murmurs
Swelling in ankles and/or feet
High Cholesterol

GASTROINTESTINAL
Indigestion (belching)
Heartburn / reflux
Abdominal pain or cramps
Nausea / vomiting
Constipation / Diarrhea
Excess gas
Change in Appetite
Fatigue after eating
Bowel Movement Frequency / per day ____
Recent change in BM's
Hemorrhoids
Light Color stools
Black stool or blood in stool

URINARY
Incontinence
Blood in urine
Bladder Infections
Pain with urination
Frequent urination (___daytime ___ night)

MUSCULOSKELETAL
Joint pain / swelling
Neck / Back Pain
Muscle cramps or spasms where? _____
Weakness

NEUROLOGICAL
Lightheaded / Dizzy
Poor concentration
Loss of memory
Numbness/ Tingling
Muscle weakness
Tremor (resting / with movement)
Sciatica

IMMUNE FUNCTION
Frequent Infections
Slow Wound Healing / Slow Recovery from infections
Swollen or tender Lymph Glands

ENDOCRINE
Cold hands and feet
Excess thirst / Excess hunger
Cold or Heat intolerance

MALE
Prostate Disease/ Urinary problems
Testicular pain/swelling
Decreased Sexual function
Discharge from Penis / Sores / Rash in genital area

WOMEN'S HEALTH HISTORY

NAME: _____ Birthdate: _____ Today's Date _____
Age Period Began _____ How many days between periods_____
Date of your last period _____ How long did it last?_____

Menopausal? □ Y □ N **If yes, Please skip to ♥**

Is your cycle regular?_____ spotting between cycles? □ Y □ N
Pads or tampons? _____ Non-bleached | regular tampons/pads
How many on heaviest day? _____
PMS? □ Y □ N Menstrual Pain/ Cramping □ Y □ N Heavy bleeding □ Y □ N

Premenstrual symptoms before your period
(Grade intensity – 1= mild, 2= moderate, 3= severe)

____ Breast Tenderness _____ Bloating _____ Acne _____ Mood Changes
____ Headache _____ Cramping _____ Diarrhea _____ Appetite Changes
____ Chocolate Craving _____ Low Back Pain _____ Constipation _____ Weight Gain

Do the above premenstrual symptoms get better with your period flow? □ Y □ N
Do you presently have vaginal discharge unrelated to the normal monthly discharge? □ Y □ N

♥ Date of most recent Pap _____
Any abnormal Paps? _____ If yes, date _____ diagnosis?_____
Do you do monthly breast exams? □ Y □ N
Mammography or Thermagraphy □Y □ N If yes, date of last exam _____ results? _____
Breast Problems? _____ Discharge _____ Tenderness _____ Swelling _____ Lumps _____ Rash

◆Sexually active □Y □ N Healthy Sex Drive □Y □ N Vaginal dryness □Y □ N
Pain with Intercourse □Y □ N Vaginitis □Y □ N Recurring vaginal or bladder infections? □ Y □ N
Past history of herpes, genital warts, Chlamydia or other STD? □ Y □ N
Sexually transmitted Disease now? □Y □N If yes, what? _____ treatment? _____

♠ Number of Bowel Movements per day? _____ per/week? _____
Fibrocystic Breast Disease? □Y □N Uterine Fibroids? □Y □N
Family History of endometrial, breast, or ovarian cancer? □Y □ N
If yes, who, what type, and age diagnosed _____
Personal history of Breast Cancer? □Y □N When diagnosed? _____
Treatment? _____
Estrogen + / Progesterone positive +
Spread to Lymph? □ Y □ N If yes, when Diagnosed _____

♣ Have you ever had gynelogical or breast surgery? □ Y □ N If yes, what and when _____

Method of Birth Control is:_____ in the past was:_____

If Birth Control Pill (Name) _____# of years taken _____
Times Pregnant _____ How many births _____ Premature Births _____ Abortions_____
Miscarriages _____ Your age at the birth of 1st child _____
Did you breast feed? □ Y □ N Difficulty conceiving? □ Y □ N Fertility Drugs Used □ Y □ N
Are you trying to become pregnant now? □ Y □ N

Menopausal Women: Use of hormones now? □ Y □ N Used in the past and how long? _____
Vaginal Dryness □ Y □ N Night Sweats □ Y □ N Hot Flashes □ Y □ N Insomnia □ Y □ N
Declining Bone Density □ Y □ N Depression □ Y □ N Irritability □Y □ N Low sex drive □ Y □ N

Pregnancies (use the back of page for more entries)

No	Born Month/Year	Weight at birth	Sex	Length of Pregnancy	Delivery Type	Complications –Describe
1						
2						
3						

Environmental Health Form

Residence

1. What City and State did you grow up in? _____
2. Was it near a refinery, agricultural or polluted area _____ When? _____
3. Do you currently live near the above listed? _____
4. Have you ever lived near a busy street or highway? _____ When? _____ How long? _____
5. Have you ever lived in a house built before 1978? ____ or in a building insulated with asbestos? _____
6. Do you currently live near a chemical factory, landfill, golf course, electrical towers or lines? _____
7. Do you currently or have you ever lived in a home where mold was a problem? _____
8. Have you noticed any change in your health after moving to a new home or apartment? _____
   If yes, explain _____
9. Have you ever felt there were conditions in your home that affected your health such as (painting, chemicals, cleaners, aerosol sprays etc.) _____ When? _____ How long? _____
10. Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____
11. Have you tested your basement for Radon? _____
12. Do you use bleach, disinfectants, furniture polish, etc. in your home? _____
13. Do you use pesticides, herbicides, or other chemicals in or around your home? _____
14. Use a Microwave? How often is it used?

Workplace

1. Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials? _____ How long? _____
2. Have you noticed any negative change in your health since you started your present job? _____
3. Describe any toxic exposures at your work place:

Lifestyle

1. How many X rays have you had in your lifetime? _____ # times per year do you fly?_____
2. Hours spent sitting in front of the computer? _____ How old is the Computer Monitor? _____
3. Number of electrical appliances in your bedroom (including a computer)?
4. Drink out of plastic containers or cook in plastic containers? _____
5. Color your hair? _____ Have Mercury fillings? _____ If yes, how many? ___ how old? _____
6. Use Fluorinated toothpaste? _____
7. Drink, cook with, or bathe with city water? _____
8. Have a water purification system on your tap or shower? _____
9. Get a flu shot every year? (contains mercury) _____
10. Eat Non-Organic Produce? _____ Non-Organic animal products? _____
11. Smoke or are you consistently exposed to 2nd hand smoke? _____
12. How many times have you had general anesthesia? _____
13. How many medications do you currently take? _____
14. Have you ever regularly worked with chemicals in any hobby? (paints, solvents, stains, cleaners, etc)? what specifically?

Symptoms of reduced chemical metabolism

1. Have you ever experienced adverse reactions to medications? _____ Please explain? _____
2. Do you ever have a sudden onset of symptoms (headaches, skin rashes, nausea, fatigue,etc) on exposure to chemicals, mold, dust, pollens, or other environmental allergens? _____

   What symptoms? _____
3. Have you ever had a known chemical injury or major exposure? _____
4. Please list all the chemicals you get adverse reactions to:
5. Are you particular sensitive to perfumes, gasoline or other smells? _____
6. Do you avoid caffeine in the afternoon or all together because it can keep you up at night? _____
7. Have you had to lower the regular dose of a prescription, OTC medication, or vitamin supplements because you were too sensitive to normal doses?