

# SECOND NATURE NATUROPATHIC CARE, LLC.

*Naturopathic Medicine for Individuals and Families  
Relearning and Rebalancing the Body's Innate Wisdom*

8 Rockland Place  
Nyack, NY 10960

Work: (845) 358-8385  
Fax: (845) 358-2963  
www.SecondNatureCare.com

## New Patient Intake

**Please Print Clearly.**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ SS# \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Blood Type \_\_\_\_\_ (+ or -)

Address: \_\_\_\_\_  
(Street & Apt.) City State Zip

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_ Retired \_\_\_\_\_

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_  
(Street) City State Zip

Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Domestic Partner \_\_\_\_\_

Live with: Spouse \_\_\_\_\_ Partner \_\_\_\_\_ Parents \_\_\_\_\_ Children \_\_\_\_\_ Friends \_\_\_\_\_ Alone \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Name and Relationship)

How did you hear about Second Nature? \_\_\_\_\_

Are you currently receiving healthcare? If yes, where and from whom? \_\_\_\_\_

### Current Health Concerns

*State your main reason for your visit today. Describe in detail any specific health condition. Include when it started and where, any associated symptoms, and any treatments used for the condition. Is there anything that makes this problem better or worse?*

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

### Allergies

Are you allergic to medicines, herbs, foods, animals, or other substances not mentioned?

Substance	Reaction
_____	_____
_____	_____
_____	_____

**Current Medications** (Prescription and over the counter)

Name of Drug	Reason for Drug	Dose (mg/etc)	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Vitamins, Minerals and Supplements you are taking and dosages**

Name of Supplement	Reason	Dose	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<b>Family History:</b>	<b>Father</b>	<b>Mother</b>	<b>Brothers</b>	<b>Sisters</b>	<b>Spouse</b>	<b>Children</b>
Age (if living)	_____	_____	_____	_____	_____	_____
Health (good, avg.)	_____	_____	_____	_____	_____	_____
Deceased Age	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____
<b>Check ( ✓ ) those applicable</b>						
Allergies	_____	_____	_____	_____	_____	_____
Alcohol/Drug Abuse	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Arthritis (OA or RA)	_____	_____	_____	_____	_____	_____
Autoimmune	_____	_____	_____	_____	_____	_____
Alzheimer's	_____	_____	_____	_____	_____	_____
Cancer (specify kind)	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Thyroid Condition	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

**Past Medical History:** Childhood Illnesses (check ( ✓ ) if you had it)

Chickenpox _____	Coxsackie _____	Diphtheria _____	Fifth's _____	Measles _____
German _____	Mono _____	Mumps _____	Polio _____	Rheumatic Fever _____
Rotovirus _____	Smallpox _____	Typhoid _____	Tuberculosis _____	Whooping Cough _____

**Medical Conditions:** Check ( ✓ ) if you have had any of the following: Indicate if it is a **Current (C)** or **Past Condition (P)**

<b>C or P</b>	<b>C or P</b>	<b>C or P</b>	<b>C or P</b>
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> HIV/AIDS or ARC	<input type="checkbox"/> Stroke
<input type="checkbox"/> Autoimmune	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fracture	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Canker Sores	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Joint Problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chronic Infections	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Weight Changes
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pneumonia	

**Hospitalizations and Surgeries:**

\_\_\_\_\_ Year: \_\_\_\_\_  
 \_\_\_\_\_ Year: \_\_\_\_\_  
 \_\_\_\_\_ Year: \_\_\_\_\_

**X-Rays, CAT Scans, or Other Diagnostic Studies:**

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

Electrocardiogram Y N Result \_\_\_\_\_ Electrocephalogram Y N Result \_\_\_\_\_  
 Intravenous Pyelogram IUP Result \_\_\_\_\_

**Accidents/Injuries/Transfusions (Type, Date and Important Details)**

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

**Have you ever been hospitalized for a Psychiatric condition? Please describe including the diagnosis, date of hospitalization and treatment prescribed.**

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

Immunizations	Date	Screening Tests	Date
DPT		Cholesterol	
Hep A or B		Breast Exam & Self Care	
HIB		Mammogram/U.S.	
Influenza		Pelvic/Pap	
MMR		Prostate	
Pneumococcal		Colorectal Exam	
Polio		Urinalysis	
Tuberculin		Hearing	
Tetanus		Vision	
		Other	

**Current Medical History:**

The general state of your health is: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

What time of day is your energy best: \_\_\_\_\_ worst: \_\_\_\_\_

List 5 important events in your life from the most recent to the most distant.

- 1. \_\_\_\_\_ Date: \_\_\_\_\_
- 2. \_\_\_\_\_ Date: \_\_\_\_\_
- 3. \_\_\_\_\_ Date: \_\_\_\_\_
- 4. \_\_\_\_\_ Date: \_\_\_\_\_
- 5. \_\_\_\_\_ Date: \_\_\_\_\_

Which event has affected you the most and why? \_\_\_\_\_

Numerically rate your stress level with each category (1 is the least and 10 is the most stress)

Family \_\_\_\_\_ Work \_\_\_\_\_ Love Relationship \_\_\_\_\_ School \_\_\_\_\_ Other Relationships \_\_\_\_\_

Personal Growth \_\_\_\_\_ Spiritual Growth \_\_\_\_\_ Physical Growth \_\_\_\_\_ Mental Health \_\_\_\_\_

Do you currently work with a professional counselor, social worker, psychologist, religious counselor, or other kind of therapist? Yes \_\_\_\_\_ No \_\_\_\_\_

**Typical Food Intake:**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

**Regular Exercise:**

Type	Time per Session	Frequency (times per week)	Practiced How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Bowel Movement Habits: Please Check ( ✓ )**

Frequency: How often: Every day \_\_\_\_\_ Every other \_\_\_\_\_ Every week \_\_\_\_\_

Color: Dark \_\_\_\_\_ Brown \_\_\_\_\_ Green \_\_\_\_\_ Yellow \_\_\_\_\_ White \_\_\_\_\_ Gray \_\_\_\_\_

Consistency: Soft \_\_\_\_\_ Hard \_\_\_\_\_ Watery \_\_\_\_\_

Mucus \_\_\_\_\_ or Blood \_\_\_\_\_ Bright \_\_\_\_\_ Dark \_\_\_\_\_ Strong Odor \_\_\_\_\_

**Urine Habits: Please Check ( ✓ )**

Frequency: How often per 24 hour period: \_\_\_\_\_

Color: Dark \_\_\_\_\_ Light Yellow \_\_\_\_\_ Green \_\_\_\_\_ Colorless \_\_\_\_\_

Character: Cloudy \_\_\_\_\_ Clear \_\_\_\_\_ Concentrated \_\_\_\_\_ Dilute \_\_\_\_\_ Any Odor \_\_\_\_\_

Any, Sediment \_\_\_\_\_ Blood \_\_\_\_\_ Bright \_\_\_\_\_ Dark \_\_\_\_\_

Any, Pain \_\_\_\_\_ Incontinence \_\_\_\_\_ Difficulty with Stream \_\_\_\_\_



## PERSONAL SAFETY

1. Do you feel safe at home? Yes \_\_\_\_ No \_\_\_\_
2. Do you have a history of physical or sexual abuse? Yes \_\_\_\_ No \_\_\_\_
3. Are you ever afraid of your partner? Yes \_\_\_\_ No \_\_\_\_

Single \_\_\_\_ Married \_\_\_\_ Co-habiting \_\_\_\_ Widowed \_\_\_\_ Divorced \_\_\_\_

Name of husband/ wife/ partner: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

Other members of the household (names and ages):  
\_\_\_\_\_

Sexually active with: Men \_\_\_\_ Women \_\_\_\_ Both \_\_\_\_ # of Male/Female sexual partners in lifetime: \_\_\_\_

Are you sexually active now? Yes \_\_\_\_ No \_\_\_\_ If No, when were you last sexually active? \_\_\_\_\_

How long with current partner? \_\_\_\_ Monogamous \_\_\_\_ Non Monogamous \_\_\_\_

Has your partner had an HIV test? Yes \_\_\_\_ No \_\_\_\_ Date: \_\_\_\_ Safe sex practices Yes \_\_\_\_ No \_\_\_\_

Any former partners with history of Bisexuality or Intravenous drug use? Yes \_\_\_\_ No \_\_\_\_

Do you have any pets? Yes \_\_\_\_ No \_\_\_\_ Please list:  
\_\_\_\_\_

## REVIEW OF SYSTEMS

**N = NOW**

**P = PAST**

### RESPIRATORY

Cough?	N	P	Sputum?	N	P
Spitting up blood?	N	P	Wheezing?	N	P
Asthma?	N	P	Bronchitis?	N	P
Pneumonia?	N	P	Pleurisy?	N	P
Emphysema?	N	P	Difficulty breathing?	N	P
Pain on breathing?	N	P	Shortness of breath (SOB)?	N	P
Tuberculosis?	N	P	SOB lying down?	N	P
			SOB at night?	N	P

### CARDIOVASCULAR

Heart disease?	N	P	Angina?	N	P
High/Low Blood Pressure?	N	P	Murmurs?	N	P
Blood clots?	N	P	Fainting?	N	P
Phlebitis?	N	P	Palpitations/Fluttering?	N	P
Rheumatic Fever?	N	P	Chest pain?	N	P
Swelling in ankles?	N	P			

**GASTROINTESTINAL**

Trouble swallowing?	N	P	Heartburn?	N	P
Change in thirst?	N	P	Change in appetite?	N	P
Nausea?	N	P	Vomiting?	N	P
Vomiting blood?	N	P	Bowel movements: How Often?		
Blood in stool?	N	P	Is this a change?	N	P
Pain or cramps?	N	P	Constipation?	N	P
Belching or passing gas?	N	P	Diarrhea?	N	P
Black stools?	N	P	Gall Bladder disease?	N	P
Jaundice (yellow skin)?	N	P	Ulcer?	N	P
Liver Disease?	N	P	Hemorrhoids?	N	P

**URINARY**

Pain on urination?	N	P	Increased frequency?	N	P
Frequency at night?	N	P	Inability to hold urine?	N	P
Frequent infections?	N	P	Kidney stones?	N	P

**MUSCULOSKELETAL**

Joint pain or stiffness?	N	P	Arthritis?	N	P
Broken bones?	N	P	Weakness?	N	P
Muscle spasms or cramps?	N	P	Sciatica?	N	P

**BLOOD/ PERIPHERAL VASCULAR**

Easy bleeding or bruising?	N	P	Anemia?	N	P
Deep leg pain?	N	P	Cold hands/ feet?	N	P
Varicose veins?	N	P	Thrombophlebitis?	N	P

**MENTAL/ EMOTIONAL**

Treated for emotional problems?	N	P	Depression?	N	P
Mood swings?	N	P	Tension?	N	P
Anxiety or nervousness?	N	P	Memory problems?	N	P
Considered/Attempted suicide?	N	P	Poor concentration?	N	P

**ENDOCRINE**

Hypothyroid?	N	P	Heat or cold intolerance?	N	P
Hypoglycemia?	N	P	Diabetes?	N	P
Excessive thirst?	N	P	Excessive hunger?	N	P
Fatigue?	N	P	Seasonal depression?	N	P

**IMMUNE**

Vaccinations?	N	P	Reactions to vaccinations?	N	P
Chronic Fatigue Syndrome?	N	P	Chronic infections?	N	P
Chronically swollen glands?	N	P	Slow wound healing?	N	P

## FEMALE REPRODUCTION / BREASTS

Age of first menses? \_\_\_\_\_  
 Are cycles regular? Y N  
 Length of cycle? \_\_\_\_\_ days  
 Duration of menses? \_\_\_\_\_ days  
 Painful menses? Y N  
 Heavy or excessive flow? Y N  
 PMS? Y N  
 PMS symptoms? \_\_\_\_\_  
 Number of pregnancies \_\_\_\_\_  
 Number of live births \_\_\_\_\_  
 Endometriosis? Y N  
 Ovarian cysts? Y N  
 Difficulty conceiving? Y N  
 Cervical Dysplasia? Y N  
 Sexual difficulties? Y N  
 Gonorrhea? Y N  
 Herpes? Y N  
 Are you sexually active? Y N  
 Do breast self exams? Y N  
 Breast pain/ tenderness? Y N

Age of last mense? \_\_\_\_\_  
 Bleeding between cycles? Y N  
 Pain during intercourse? Y N  
 Clotting? Y N  
 Discharge? Y N  
 Birth control? Y N  
 Birth control type? \_\_\_\_\_

Number of miscarriages \_\_\_\_\_  
 Number of abortions \_\_\_\_\_  
 Menopausal symptoms? Y N  
 Abnormal PAP? Y N  
 Chlamydia? Y N  
 Condyloma? Y N  
 Syphilis? Y N  
 Breast lumps? Y N  
 Nipple discharge? Y N

## MALE REPRODUCTION

Hernias? Y N  
 Testicular pain? Y N  
 Venereal disease? Y N  
 Are you sexually active? Y N  
 Gonorrhea Y N  
 Impotence? Y N  
 Premature ejaculation? Y N  
 Birth control? \_\_\_\_\_ Type \_\_\_\_\_

Testicular masses? Y N  
 Prostate disease? Y N  
 Discharge or sores? Y N  
 Chlamydia? Y N  
 Condyloma? Y N  
 Herpes? Y N  
 Syphilis? Y N

## REVIEW OF SYSTEMS

Please check (x) if any of the following apply to you now, in the past or often

CONSTITUTIONAL	Current	Past	Additional notes
Weight loss	_____	_____	
Weight gain	_____	_____	
Fever	_____	_____	
Fatigue	_____	_____	
<b>SKIN</b>			
Rashes	_____	_____	
Color changes	_____	_____	
Dryness/itching	_____	_____	
Sores	_____	_____	

<b>HEAD</b>	<b>Current</b>	<b>Past</b>	<b>Additional notes</b>
Headache	_____	_____	
Dizziness	_____	_____	
<b>EYES</b>			
Double Vision	_____	_____	
Spots before eyes	_____	_____	
Vision changes	_____	_____	
Pain or redness	_____	_____	
<b>EARS</b>			
Hearing changes	_____	_____	
Pain/ infection	_____	_____	
Ringing in the ears	_____	_____	
Vertigo	_____	_____	
<b>NOSE</b>			
Colds	_____	_____	
Nosebleeds	_____	_____	
Discharge	_____	_____	
Allergies/ Sinus	_____	_____	
<b>MOUTH</b>			
Sore throat	_____	_____	
Mouth sores	_____	_____	
Dental problems	_____	_____	
<b>CARDIOVASCULAR</b>			
Painful breathing	_____	_____	
Chest pain	_____	_____	
Difficulty breathing on exertion	_____	_____	
Swelling of legs	_____	_____	
Palpitations of heart	_____	_____	
<b>RESPIRATORY</b>			
Wheezing	_____	_____	
Spitting up blood	_____	_____	
Shortness of breath	_____	_____	
Cough, chronic	_____	_____	
<b>GASTROINTESTINAL</b>			
Loose frequent stool	_____	_____	
Bloody stool	_____	_____	
Nausea/ Vomiting	_____	_____	
Constipation	_____	_____	

<b>URINARY</b>	<b>Current</b>	<b>Past</b>	<b>Additional Notes</b>
Blood in urine	_____	_____	
Pain with urination	_____	_____	
Urgency	_____	_____	
Frequency of urination	_____	_____	
Incomplete emptying	_____	_____	
Stress incontinence	_____	_____	
<b>GENITAL/ REPRODUCTIVE</b>			
Pain with sexual activity	_____	_____	
Unusual vaginal or penile secretion/discharge	_____	_____	
Discomfort, irritation or itching of vulva or penis	_____	_____	
Vaginal dryness	_____	_____	
Changes in libido	_____	_____	
<b>BREAST</b>			
Pain in breast	_____	_____	
Swelling	_____	_____	
Mass/ lumps	_____	_____	
Nipple discharge	_____	_____	
<b>PERIPHERAL VASCULAR</b>			
Intermittent claudication	_____	_____	
Leg cramps	_____	_____	
Varicose veins	_____	_____	
Clots in veins	_____	_____	
<b>MUSCULOSKELETAL</b>			
Muscle weakness	_____	_____	
Joint pain	_____	_____	
Muscle pain	_____	_____	
Chronic back pain	_____	_____	
History of disc disease	_____	_____	
<b>NEUROLOGICAL</b>			
Dizziness	_____	_____	
Seizures	_____	_____	
Numbness	_____	_____	
Trouble walking	_____	_____	
<b>ENDOCRINE</b>			
Dry skin	_____	_____	
Abnormal thirst/ hunger	_____	_____	
Hot or cold intolerance	_____	_____	
Hot flashes/ power surges	_____	_____	
Night sweats	_____	_____	

**PSYCHIATRIC**

**Current**

**Past**

**Additional Notes**

Anxiety

\_\_\_\_\_

\_\_\_\_\_

Depression

\_\_\_\_\_

\_\_\_\_\_

Crying frequently

\_\_\_\_\_

\_\_\_\_\_

Memory problems

\_\_\_\_\_

\_\_\_\_\_

How does your condition affect you? \_\_\_\_\_

What do you think is happening? \_\_\_\_\_

Why?

What do you feel needs to happen for you to get better? \_\_\_\_\_

What do you enjoy most in your life? \_\_\_\_\_

How much change are you willing to make at this time for improving your health?

MINIMAL

SOME

COMPLETE

Is there any information about your health you would like to add? \_\_\_\_\_