

## Naturopathic Intake Questionnaire – Page 0/-

Patient Name (& Nickname):	Doctor: Jeff Metzger
Date of Birth:	Date of Service:

### Naturopathic Intake Questionnaire

A naturopathic perspective on health takes into account your whole health and history.

The questions on these pages are used to develop an overall picture of your current health issues and general health.

The answers to these questions will help in determining what may have caused, lead to, or aggravated your current illness. The answers will be helpful in determining a treatment plan which may include dietary changes, exercises, help in relaxing and sleeping, physical medicine, botanical medicine, and homeopathy as examples. Other treatment modalities may also be required.

Please fill out Name and Dates on all pages.

Please answer all of the questions as completely as possible.

The last page of the questionnaire is space for any overflow of answers from the other pages.

You can make a copy of the last page for more room if needed.

#### Parents

Please note that this questionnaire is appropriate to adults. If filling out with your child, disregard adult questions.

## Naturopathic Intake Questionnaire – Page 1/

Patient Name:

Doctor: Jeff Metzger

Date of Birth:

Date of Service:

### Past Medical History:

Hospitalizations, major illnesses, traumas (broken bones, concussions, etc), major emotional traumas/stresses, etc  
Birth → school:

Childhood (school years):

Adult years:

**Current issues** - (in brief, just by Name; will get details during the appointment):

Age:      Adopted: Yes     No     Brothers and Sisters (including ½ brothers and sisters):

Married or Marriage history (if adult):

Children:

Immunizations:

Standard childhood vaccinations: Yes     No  If no, please explain:

Other vaccinations (travel, etc.):

Environment (Toxins history): note any history of major toxins on a job, hobby, living situation, etc.

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Patient Name:

Doctor: Jeff Metzger

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### **Psych/Social History:**

Job: Note current job, how long. - & Any significant past jobs.  
(Hours of work per day/week)

Stress:

How high is your average daily stress (1 to 10, 10 is highest)?

What are the main stresses in your life currently?

Have you had any other major stresses in your life previously, particularly just prior to or at the onset of your present health problems?

Do you feel that you have enough emotional support from friends and family? Yes  No  If no, please explain:

Life Satisfaction:

Are you currently satisfied with your situation in life? Yes  No

Yes or no, please elaborate a little.

Emotional Outlook:

Are you generally happy, sad, depressed, alternating moods? Please explain.

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Patient Name:	Doctor: Jeff Metzger
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**Lifestyle Profile** (include history where appropriate):

Exercise:

(Example: yoga 1 hr 4x/wk) – list all

Sleep:

How many hours/night?

What time do you go to bed?

Do you fall sleep easily?

What time do you get up?

Do you wake up and go back to sleep, how often, why?

Do you feel rested in the morning?

Please explain any other sleep issues:

Relaxation: What do you do to relax?

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Patient Name:	Doctor: Jeff Metzger
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### Basic Diet Profile:

General Diet Outline:

Do you eat everything; vegetarian, vegan, etc.? Any particulars?

Breakfast:

(What does an average breakfast look like?)

Lunch:

(What does an average lunch look like?)

Dinner:

(What does an average dinner look like?)

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Patient Name:	Doctor: Jeff Metzger
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### Constitutional Profile:

What is your general energy level (1 to 10, 10 being most energetic)?

Does your energy vary during the day? Yes  No  If yes, please explain:

Would you say that you have a good appetite? Yes  No  If no, please explain:

Do you feel that you perspire more than average, average, or less than average?

Do you normally feel cold, hot, or find temperature to be of not too much concern?

Do you have any problems with breathing whether diagnosed or not?

### Bowels:

How many bowel movements/day on average:

Consistency:

Color:

Ever see any blood in your stool?

Explain any other issues (pain, discomfort, etc.):

### Urine:

About how often each day do you go?

Do you have any times of urgency?

Do you have any incontinence (can't hold it back):

Do you get up at night to go, how often on average?

Color?

Ever see any blood in your urine?

Explain any other issues (pain, discomfort, etc.):

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Patient Name:	Doctor: Jeff Metzger
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### Personal and Family History:

Please check the “yes” box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a “**P**” for past or “**C**” for current. Indicate the “relationship” (**father, sister, etc.**) or the word “**self**” in the “Relationship” column.

	YES	RELATION	DATES RESOLVED Past(P)/Current(C)		YES	RELATION	DATES RESOLVED Past(P)/Current(C)
Alcoholism/Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other:			
Epilepsy				Other:			

### History of Medicines:

antibiotics history –

Other medicines

(History of any significant medications not currently taking) –

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**Additional Descriptions:** - use additional paper if necessary