Dr. Anita M. Larrow, ND

"Bringing Naturopathic Medicine to Your Door"

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New Patient Intake Form

The initial, Naturopathic Intake includes a comprehensive consultation, a complete review of systems, and the following physical exams (when necessary and/or possible): respiratory, cardiac, head, ears, nose, eyes, throat, neurological, and abdominal. Other specific exams maybe be needed.

Lab testing is an important part of diagnosis. I ask that you have your recent bloodwork on hand, if not provided by Dr. Larrow, before the appointment. Lab work will help complete your case history. Required and/or necessary lab work will be billed separately through the lab company (and/or in accordance with your insurance company where applicable).

Personal Information

Name:		Date:
Age:	Sex:	Birth Date:
Profession:		Marital Status:

Contact Information

Phone:	Secondary Phone:
Email Address:	

Home Address: _____ _____ _____ _____

2nd Address: _____ _____ _____ _____

Street City State ZIP

Emergency Contact: _____ _____ _____

Name Phone Relationship

Your Health Concerns (In Order of Importance)

1 _____

2 _____

3 _____

4 _____

5 _____

Medical History	
Last Physical Exam:	Physician's Name/Contact:
Date of last bloodwork:	Blood Type (if known):

Current Medical Treatment(s):

Hospitalizations / Surgeries (descriptions, dates, seriousness):

Medical History (cont.)

	Date	Why?
Last X-Ray:		
Last MRI / CAT:		
Last Ultrasound:		
Accident:		
Last TB Test:		
Hepatitis C Test:		
Last HIV Test:		
Last Dental Exam:		
Last Eye Exam:		
Other:		
Other:		

Did You Have Any of The Following (Yes, No, Immunized)

Measles: No
Chicken Pox: No
Mumps: No
Hepatitis A: No
Hepatitis B: No
Hepatitis C: No
Tetanus: No
Whopping Cough: No
Flu: No
Rubella: No
Vaccine Reactions:

Do You Do/Use Any of The Following (Yes, No, Past)

Antacids: No
Steroids: No
Pain Meds: No
Laxatives: No
Coffee: No
Cups/Day:
Soda Pop: No
Ounces/Day:
Alcohol: No
How often:
Alcohol Addiction: No
Alcohol Add. Treatment: No
Recreational Drugs: No
Drug Addictions: No
Drug Add. Treatment: No
Drug Treatment Date:
Smoke: No
Packs/Day:
Years Smoking:

Family History (Yes, No, Don't **K**now**)**

	Father	Mother	Sibling	Sibling	Sibling
Age if living:					
Age at death:					
Cause of death:					
Cancer Type (if any):					
High Blood Pressure:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Heart Attack/Stroke:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Heart Disease:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Asthma/Allergies:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Mental Illness:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
TB:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Auto-Immune Dis.:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Diabetes (1 or 2):	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Osteoporosis:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Arthritis:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Thyroid:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know

	Spouse	Grandma (Mother's)	Grandpa (Mother's)	Grandma (Father's)	Grandpa (Father's)
Age if living:					
Age at death:					
Cause of death:					
Cancer Type (if any):					
High Blood Pressure:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Heart Attack/Stroke:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Heart Disease:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Asthma/Allergies:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Mental Illness:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
TB:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Auto-Immune Dis.:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Diabetes (1 or 2):	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Osteoporosis:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Arthritis:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Thyroid:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know

Family History (cont.) (Yes, No, Don't Know)

	Child	Child	Child	Child	Child
Age if living:					
Age at death:					
Cause of death:					
Cancer Type (if any):					
High Blood Pressure:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Heart Attack/Stroke:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Heart Disease:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Asthma/Allergies:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Mental Illness:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
TB:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Auto-Immune Dis.:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Diabetes (1 or 2):	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Osteoporosis:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Arthritis:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know
Thyroid:	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know

Social Life

Highest level of Edu.: Enjoy Job: N.A. Hours Worked/Week:

Quality of significant relationships:

Active spiritual practice:

What is your greatest health concern?:

How does that concern limit you?:

How committed to valuable change are you?:

Mental and Emotional State (Yes, No, Past)

Depression:	No	Anger/Irritability:	No
Anxiety:	No	Fear/Panic:	No
Eating Disorder:	No	High-Strung:	No
Psych Hospitalization:	No	Suicidal:	No

History of sexual, mental/emotional, and/or physical abuse?: No

If abuse, at what age and by whom?:

Sleep (Yes, No, Past)

How many hours per night do you sleep?:

If you wake up frequently, what is the reason?:

What time do you typically go to bed?:

What time do you typically wake up?:

Nightmares:	No	Sleepwalk:	No
Wake Refreshed:	No	Grind Teeth:	No
Must nap during day:	No	Snore:	No

Exercise

How often do you exercise?:

What type of exercise?:

Exercise for how long?:

Hobbies?:

Typical Daily Diet

Breakfast:

Lunch:

Dinner:

Snacks

Fluids:

Toxin Exposure (Yes, No)

Did you grow up near any refinery, polluted area, or in a home with leaded paint?: No

If so, what sort of pollution were you exposed to?:

Any jobs where you were exposed to solvents, heavy metals, fumes, etc.?: No

Health problems with new carpet, painting, cabinetry, etc.?: No

Are you particularly sensitive to perfumes, gasoline, or other vapors?: No

Do you use pesticides, herbicides, or other chemicals around your home?: No

Please list those chemicals:

Current Pharmaceuticals (All)

Medication	Dosage	For How Long

Prescriber(s) of them:

Botanicals, Homeopathics, and/or Supplements

Name	Dosage	For How Long

Allergic Reactions (Yes, No)

Codeine/Novocain:	No	Sulfa Drugs:	No
Penicillin/Anti-Biotics:	No	Sedatives:	No
Anti-Coagulants/Coumadin:	No	Iodine:	No
Barbiturates:	No	Aspirin:	No

Please name anything else including, but not limited to, foods, plants, vitamins, etc.:

Review of Systems

Weight

Current:	lbs	Ideal Weight:	lbs
One Month Ago:	lbs	One Year Ago:	lbs

Maximum weight and when:

Minimum weight as an adult:

Height:

Energy (Yes, No)

Good Energy:	No	Fatigue:	No

If you have fatigue, when during the day is worst?:

If fatigued, can you do what you need to during the day?:

Skin (Yes, No, Past)

Rash:	No	Color Change:	No
Hives:	No	Lump:	No
Psoriasis/Eczema:	No	Itchy:	No
Dry:	No	Warts/Moles:	No
Cancer of Skin:	No	Perspiration:	No

Head (Yes, No, Past)

Headache:	No	Migraine:	No
Dandruff:	No	Head Injury:	No
Oily/Dry Hair:	No	Hair Loss:	No

Eyes (Yes, No, Past)

Dry/Watery:	No	Blurry Vision:	No
Double Vision:	No	Cataracts:	No
Glaucoma:	No	Styes:	No
Strain:	No	Discharge:	No
Itchy:	No	Dark Under Eyelids:	No

Ears (Yes, No, Past)

Diminishing Hearing:	No	Ringing in Ears:	No
Infections:	No	Pain:	No

Nose (Yes, No, Past)

Frequent Colds:	No	Nosebleeds:	No
Congestion:	No	Post-Nasal Drip:	No
Polyps:	No	Seasonal Allergies:	No

Mouth / Throat (Yes, No, Past)

Canker Sores:	No	Cold Sores:	No
Sore Throat:	No	Gum Disease:	No
Dentures:	No	Cavities:	No
Loss of Taste:	No	Hoarseness:	No

Neck (Yes, No, Past)

Stiffness:	No	Swollen Glands:	No
Tension:	No	Full Movement:	No

Do you see a Chiropractor (and how often)?:

Respiratory (Yes, No, Past)

Cough:	No	TB:	No
Breath shortness with exertion:	No	Bronchitis:	No
Shortness of breath while sitting:	No	Pneumonia:	No
Shortness of breath lying down:	No	Asthma:	No
Wheezing:	No	Painful Breathing:	No

Cardiovascular (Yes, No, Past)

High Blood Pressure:	No	Rheumatic Fever:	No
Low Blood Pressure:	No	Murmurs:	No
Arrhythmias:	No	Palpitations:	No
Edema:	No	Chest Pain:	No

Gastrointestinal (Yes, No, Past)

Heartburn:	No	Bowl Movement Freq.:	(Per Week)
Indigestion:	No	Recent BM Change:	No
Bloating:	No	Diarrhea/Constipation:	No
Nausea:	No	Hemorrhoids:	No
Vomiting:	No	Gall Bladder:	No
Change in Appetite:	No	Liver Disease:	No
Pancreatitis:	No	Ulcer:	No

Urinary Tract (Yes, No, Past)

Incontinence:	No	Pain with Urination:	No
Frequent Infections:	No	Kidney Stones:	No
Urgency:	No	Discharge/Blood:	No

Musculoskeletal (Yes, No, Past)

Weakness:	No	Arthritis:	No
Stiffness:	No	Leg Cramps:	No
Tremors:	No	Pain:	No

Nervous System (Yes, No, Past)

Paralysis:	No	Sciatica:	No
Tingling/Numbness:	No	Carpal Tunnel:	No
Seizures:	No	Fainting:	No

Male Genitalia (Yes, No, Past)

Testicular pain/swelling:	No	Sexually active:	No
Hernia:	No	S.T.D:	No
Discharge:	No	Prostate disease/symptoms:	No
Impotence:	No		

Female Genitalia (Yes, No, Past)

Age Period Began:		Period Frequency:	
How Long Period Lasts:		Date of Last Cycle:	
Heavy Menstrual Cycle:	No	Menstrual Pain/Cramping:	No
PMS:	No	Food Cravings:	No
Times Pregnant:		Last Pap Smear:	
How Many Births:		Pap Smear Diag.:	
Miscarriages:	No	Abnormal Pap Date:	
Abortions:	No	Use of Hormones:	No
Menopausal Since Age:		Types of Hormones:	
Dryness:	No	Healthy Libido:	No
Pain with Intercourse:	No	Sexual Activity:	No
S. T. D.:	No	Vaginitis:	No
Bone Density Scan:	No	Mammography:	No

Bone Density Scan Results:

List any birth control used and ages taken:

Anything else I should know?:

How did you hear about my practice? (Please name a referral, too):