Vitae Health Center
16521 13th Ave West, Ste. 105, Lynnwood, WA 98037 (425) 742-3800 vitality, naturally

Acute Intake Form

Name: _____ Date of Birth: _____ Date: _____

Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone (home): (_____) _____ (Work/Cell): (_____) _____

Email Address: _____

Education: _____ Occupation: _____ Hours/week: _____

Employer: _____ Works Address: _____

Status (circle): Single Married Separated Divorced Widowed Partnership

Live with (circle): Spouse Partner Parents Children Friends Alone

Spouse:

Name of spouse/partner: _____ Date of Birth: _____

Social Security #: _____

Telephone (home): (_____) _____ (Work/Cell): (_____) _____

Employer: _____ Work Address: _____

Name of parent(s) or guardian(s): _____ Relationship to you: _____

Emergency Contact: _____ Relationship to you: _____

Phone (Home): (_____) _____ Phone (Cell): (_____) _____

Address: _____

How did you hear about this clinic? _____

Any family members currently a patient at this clinic? _____

Have you ever seen a Naturopathic Doctor (ND) before? Yes / No

Would you like to receive health newsletters and education articles from the clinic as they become available? Yes / No

Current Problem List

What are your most important health problems? List as many as you can in order of importance and include time of onset

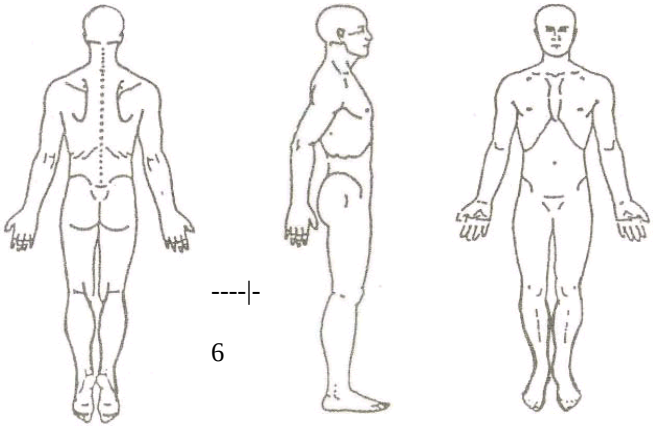
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Please indicate your **CURRENT** pain level on the chart below:

|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Worst



Please mark your areas of pain

Please list any current diagnoses:

1. _____ 3. _____
2. _____ 4. _____
3.

Do you have any known contagious diseases at this time? Y / N If yes what?_____

General Information

Height: _____ Weight:_____Gender (circle): Male / Female

Are you currently receiving healthcare? Y / N If yes where and from whom? _____

If no, are you planning to establish primary care with us? Y / N

When and where did you last receive medical or health care? _____ What was the reason?_____

_____

Allergies

To drugs/medications (including over the counter) _____

Medication

Please list **all medications**, including over the counter you are currently taking and why? (Please indicate dose and frequency)

_____ Starting date _____ _____Starting date _____

_____ Starting date _____ _____ Starting date _____

_____ Starting date _____ _____ Starting date _____

_____ Starting date _____ _____ Starting date _____

Have you taken Aspirin, Ibuprofen, Naproxen or any steroids for a long period of time (3 weeks or longer)? Y / N

If yes for how long and for what? _____

Vitamins and Supplementation
Please list all vitamins and supplements you are taking and why (Please indicate dose and frequency)

_____ Starting date _____ _____ Starting date ___

_____ Starting date _____ _____ Starting date ___

_____ Starting date _____ _____ Starting date ___

_____ Starting date _____ _____ Starting date ___

Family History
Do you or anyone in your family have a history of any of the following? (Please circle and indicate who & what type if appropriate)

Heart disease _____ High cholesterol _____ High Blood Pressure _____
Diabetes _____ Stroke _____ Cancer _____
Kidney disease _____ Arthritis _____ Anemia _____
Asthma _____ Glaucoma _____ Mental Illness _____
Eczema _____ Epilepsy _____ Hay fever/Hives _____

Other relevant family history? _____

Vaccine History: (check all that apply)

- DPT (Diphtheria, Pertussis, Tetanus)
- Tetanus Booster (Usually DT) When was the last booster?_____
- Polio injection / Polio oral
- MMR (Measles, Mumps, Rubella)
- HBV (Hepatitis B Vaccine)
- Hepatitis A Vaccine
- Other (Flu shots, etc.) What?_____

When? _____

Susan Mueller, ND
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