Initial Intake Form

Date of Initial Consult ___________

Client Information

Last Name ______________________________

First Name ______________________________

Street Address ______________________________

City State Zip ______________________________

Home Phone ______________________________

Cell Phone ______________________________

Work Phone ______________________________

Email Address ______________________________

Date of Birth ______________________________

Social Security # ______________________________

Sex ______________________________

Marital Status ______________________________

Occupation ______________________________

Name of Spouse/Partner ______________________________

Name/Ages of Children ______________________________

____

Contact Information

Emergency Contact Name ______________________________ Number ______________________

Preferred Number for Us to Contact You ____

Reason for Visit

Please list present health concerns, problems or symptoms in order of importance and date they began

____

____

____

____

Please list alternative and allopathic practitioners you have seen for these concerns __________________

____

Please list diagnoses you have been given ____

____

Please list your goals and expectations for today's visit ____

____

Have you seen a naturopath before? __________ Who? ______________________________

How did you here about this office? ____

Aurora Therapeutics, Inc.
2206 Jo An Drive suite 4
Sarasota, Florida 34231

ph: 941.951.6820
fax: 941.951.6821

Medical Information

Primary care physician ___________________________________ Phone __________________________

Current Medications (please include dosages) ____

____

____

Current Supplements ____

____

____

Please list any known allergies to drugs, foods, environmental (pollen, animals, chemicals, etc.) ______

____

____

Medical History

	Yes	No
1. Are you currently under medical treatment?	☐	☐
Please describe: ___________________________________		
2. Have you had any serious illnesses or injuries?	☐	☐
Please describe: ___________________________________		
3. Have you ever had a reaction to:		
Local anesthetic (exp. Novocain)	☐	☐
Penicillin or other antibiotic	☐	☐
Sulpha drugs	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Barbiturates (sleeping pills)	☐	☐
Latex	☐	☐
Other	☐	☐
*Please explain*____________________		

FAMILY HISTORY

Please indicate if you or your immediate family members have or have had any of the following conditions

Condition	List self or family member
Asthma	________________________
Diabetes	________________________
Depression	________________________
Heart Disease	________________________
Stroke	________________________
High Blood Pressure	________________________
High Cholesterol	________________________
Breast Cancer	________________________
Colon Cancer	________________________
Lung Cancer	________________________
Other Cancer	________________________
Alcoholism	________________________
Allergies	________________________

4. Hospitalizations/Surgeries: (please indicate reasons/dates) ____

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For Women

Age at onset of menstruation? ____
Any period of time without a menstrual cycle, if so how long? ____________________________________
Any use of oral contraceptives? If so how long? ____
Number of children: __________________________________ Ages of children: ____________________
Number of miscarriages and/or abortions ____
Age at onset of menopause? _______ Symptoms: ____
Any hormone replacement therapy, if so type and how long? _____________________________________
Date of last Pap smear: _____________ Results Were: (circle one) Normal Abnormal Don't know
Date of last mammogram: ___________ Results: ____
Date of last DEXA: ________________ Results: ____

Symptom Checklist

Have you ever experienced (**P**ast) or do you suffer (**C**urrently) from any of the following:

Alcoholism ___	Allergies___	Anemia___	Anxiety___	Arthritis___
Asthma___	Back Pain___	Bad Breath___	Bloating/Gas___	Bloody Stool___
Brain Fog ___	Bruise Easily___	Bursitis___	Cancer___	Chest Pain___
Fatigue___	Depression___	Diabetes___	Diarrhea___	Cramps___
Chronic Fatigue___	Constipation___	Hay Fever___	Headaches___	Dizziness___
Insomnia___	Leg Pain___	Nausea___	PMS___	Stroke___
Tremors___	Sciatica___	Vaginitis___	STD__	Hot Flashes___
Dry Hair___	Dry Skin___	Joint Pain___	Neck Pain___	Nosebleeds ___
Hemorrhoids___	Tuberculosis___	Craving for Salt___	Cravings for Sugar___	
Difficulty Waking__	Disturbing Dreams___	Dry/Brittle Nails___	Ear Ringing___	Eye Pain/Changes___
Fluid Retention___	Cold/Hands/Feet___	Foot Pain___	Forgetfulness___	Frequent Colds___
Frequent Urination___	Heartburn/GERD___	Heart Palpitations___	High Blood Pressure___	
Interrupted Sleep___	Kidney Pain/Infection___		Irregular Menses___	Lump in Breast___
Mood Swings___	Night Sweats___	Numb/Tingling___	Phlegm/Mucus___	Poor Circulation___
Poor Digestion___	Prostate Issues___	Shortness of Breath___	Shaky if Hungry___	Sinus Problems___
Skin Problems___	Thyroid Problems___	Ulcers/Herpes___	Varicose Veins___	Weight Gain___
Weight Loss___	Worry/Feel Insecure___	Decreased Sex Drive___		

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Test History

Please check box if tests received and indicate date of most recent procedure. Circle any tests that were abnormal and explain in space provided below.

Test	Date	Test	Date	Test	Date
❑ Chest X-ray		❑ Cholesterol		❑ PSA (prostate)	
❑ Spine X-ray		❑ Liver Blood Tests		❑ Complete Physical Exam	
❑ EKG		❑ Thyroid Blood Tests		❑ Eye exam	
❑ MRI		❑ Sigmoidoscopy		❑ Others (Please list)	
❑ CAT Scan		❑ Colonoscopy			
❑ Ultrasound		❑ Rectal exam			
❑ Cardiac Stress Test		❑ Blood type			

Abnormal exams:

____

____

____

Personal Habits

Do you:

☐ Use tobacco _______ packs per day/week for how long _______ date quit__________

☐ Drink coffee _______ cups per day/week

☐ Drink black tea _______ cups per day/week

☐ Drink water _______ glasses per day/week tap purified spring

☐ Drink alcohol _______ glasses per day/week

☐ Drink soda _______ cans per day/week

☐ Use artificial sweeteners _______ packets per day/week

☐ Use margarine _______ pats per day/week

☐ Use recreational drugs, please explain ____

☐ Eat out at restaurants _______ times per week/month, where _________________________

Any particular dietary restrictions? ____

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Lifestyle

Rate your energy level from 1 to 10 (10 being worst) _______ Best time of day ___________ Worst _________

How many hours of sleep per night? ___________________ From when ________ to when _____________

Do you wake throughout night? __________ How often? __________ Do you wake rested? _______________

How often do you exercise? ______________ For how long? ______________ Doing what? _______________

Occupation ____ Hours per week? _______________

How do you relax? ____

How many vacations do you take per year? ____

Is your home a sanctuary? please explain ____

Pets? _________________________ Mold? ________________________ Firearms? ____________________

Do you live in: Trailer Apartment House Condo Year built? _______

Rate your current stress level (1 to 10, 10 being worst) ____

What are the most stressful or difficult aspects in your life? Please list in order of importance/degree of stress.

1. ____

2. ____

3. ____

4. ____

Rate your current state of emotional health: Excellent Good Fair Poor Unstable Crisis

Who/What is your support system? ____

Are you sexually active? ___________ Are you satisfied with this? ___________________________________

Method of birth control ____

Any toxic/chemical exposure, please explain ____

Past or present amalgam (silver, mercury) fillings? ________________ How many? ______________________

Congratulations! You have finished this form!

Thank you for taking the time and thought required to complete this intake form. It is an important tool to help you and your practitioner gather important information about yourself and your life experience in order to work together as a team to attain your personal health and lifestyle goals. Naturopathy is a process of education and self-awareness that facilitates your ability to be empowered to take charge of your health. We are happy to share knowledge and help guide you, but never forget that you are your own best expert and advocate!

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