

Sarah LoBisco, ND
Doctor of Naturopathic Medicine
www.dr-lobisco.com

Client Intake Form

Name _____ Age _____

Birth date _____

Address _____ Email _____

City _____ State/Zip _____

Home Phone _____ Work Phone _____

Cell Phone: _____

Occupation _____

Employer _____

Marital Status _____

Name of Spouse/Partner _____

How Long Have Both of You Been Together? _____

Religion/Spiritual Practice _____

If Client is a Minor, Name of Responsible Adult

Reason for Visit: _____

What have you tried to help this problem:

What works _____

What makes it worse: _____

Do You Smoke? _____ How Much? _____ Do You Drink? _____

How Much per week? _____

Do You Take Drugs? _____ If yes, what kind? _____

How often per week? _____

Allergies? _____ Date of Last Medical Examination _____

Reason _____

Are You Now Under a Doctor's Care? _____

If yes, Doctor's name: _____

Reason for Doctor's Care: _____

Sarah LoBisco, ND
Doctor of Naturopathic Medicine
www.dr-lobisco.com

Are You Taking Any Medication? _____

If yes, please list? _____

Reason for Medication(s): _____

Supplements taking: _____

Reason: _____

Have You Ever Been Hospitalized for a Physical Illness?

Describe: _____

Surgeries (including tonsil removal) _____

Have you ever been hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc? Describe: _____

Exercise? _____

How often? _____

Diet (breakfast, lunch, dinner and snacks)

B _____

L _____

D _____

S _____

Fluids

Water _____ oz/day

Sarah LoBisco, ND
Doctor of Naturopathic Medicine
www.dr-lobisco.com

Please indicate if any of the following conditions below currently affect you (X) or if you have experienced them in the past 3 years (3):

- High Blood Pressure Blood Clots Heart Attack/Stroke
- Low Blood Pressure Anemia Heart/circulation problems
- Vision Problems Contact Lenses Dizziness
- Low Back Pain Muscle pain Joint Pain
- Tendonitis Arthritis Bursitis Sprains/Strains
- Broken bones Osteoporosis Scoliosis
- Weakness Headaches Diabetes Hypo or Hyperglycemia
- Bruise easy
- Contagious Conditions Skin Infections/Problems Varicose Veins
- Pregnant, _____ mo. along
- Sinus Problems Chronic colds/bronchitis
- Cancer/ Tumors
- Depression Sleep Difficulties Dizziness
- Cloudy thinking Fatigue/low energy
- Seizures/Epilepsy Allergies
- Numbness/Stabbing Pains Sensitive to Touch/Pressure Radiating Pain
- Digestive Disturbances: (Circle: Constipation, diarrhea, diverticulosis, gas, bloating)
- How many times do you have a bowel movement per week _____
- Urinary Tract Infections Bladder Infections
- Women: PMS Irregular or painful periods Irregular PAP Smear
- Pelvic Pain Heavy flow Problems conceiving
- Hysterectomy D&C C-Sections

Sarah LoBisco, ND
Doctor of Naturopathic Medicine
www.dr-lobisco.com

Men: _____ BPH _____ High PSA _____ Irregular DRE

Medical Diagnoses Given By Your Provider:

Other Concerns not diagnosed or anything you wish to address not covered by this form:

Your goal for this visit: _____

Your long-term health goal: _____