Dr. Cobi Slater, PhD, DNM, CHT, RNCP, ROHP

Essential Health Natural Wellness Clinic

New Patient Intake Form Date: _____

Note: this is a confidential record of your medical history and will be kept in this office. Information contained here or recorded during the consultation will not be released to any person except when you have authorized in writing to do so. Please complete the questionnaire as thoroughly as possible.

Name: _____ Gender: _____

Date of Birth: _____ Occupation: _____

Address: _____ Employer: _____

City: _____ Home Phone: _____

Postal Code: _____ Cell Phone: _____

Marital Status: _____ Email Address: _____

How did you hear about our clinic? _____

Health Priorities/Chief Concerns:

List your main health concerns in order of importance

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

Medical History:

How would you describe your general state of health? (circle one)

Excellent Good Fair Poor

Please indicate any serious illnesses, surgeries or past hospitalizations:

Surgery/Hospitalization	Date of Diagnosis	Is the condition still present?	Symptoms

Please list any car accidents or other accidents:

Type of Accident	Date of Accident	Injury Sustained	Chronic Issues

Please list all current medications:

Medications	Dose	Prescribing Physician	Length of Use

Please list all current supplements:

Supplements	Dose	Brand	Length of Use

Please indicate any allergies:

Allergy	Symptoms

How many times have you taken antibiotics within the last 5 years? _____

Were you frequently given antibiotics as a child? _____

Have you had any adverse reactions from any vaccinations? _____

Do you get a yearly flu vaccination? _____

Do you use any of the following?

Type	Circle One	How much/How often/Form
Alcohol	Yes No	
Tobacco	Yes No	
Caffeine	Yes No	
Recreational Drugs	Yes No	
Laxatives	Yes No	
Antacids	Yes No	

Please indicate any other medical providers:

Type of Medical Provider	Name

Family History:

Indicate if any family member has had any of the following:

Illness	Circle One	Family Member/Type
Allergies	Yes No	
Asthma	Yes No	
Diabetes	Yes No	
Heart Disease	Yes No	
High Blood Pressure	Yes No	
Kidney Disease	Yes No	
Cancer	Yes No	
Depression	Yes No	
Other mental illness	Yes No	
Thyroid Conditions	Yes No	
Obesity	Yes No	
Other	Yes No	

Lifestyle:

Do you exercise? _____ How often? _____

What type of exercise do you do? _____

Have you recently gained or lost weight? (circle one) YES/ NO_____lbs.

Current Weight _____Ideal Weight _____

Do you eat 3 meals per day? _____ Do you skip meals? _____

How many meals do you eat out per week? _____

Which of the following foods do you consume regularly?

□ Pop

□ Diet pop

□ Refined sugar

□ Fast food

□ Gluten (wheat, rye, barley)

□ Dairy (milk, cheese, yogurt)

Typical Food Intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

What are your biggest challenges with nutrition?

_____

_____

Sleep Patterns:

Are you satisfied with your sleep? _____Do you nap? _____

Average hours of sleep per night? _____Do you wake up in the night? _____

Do you fall asleep within 30 minutes? _____Do you feel well rested? _____

Mental Health:

How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

_____
_____
_____

On a scale of 1-10, one being the worst and ten being the best, describe your usual level of energy. _____

Do you experience energy crashes in the day? _____

On a scale of 1-10, one being the worst and ten being the best, describe your current level of stress_____

What are the main sources of stress in your life?

_____
_____
_____

Digestion:

Do you have regular daily bowel movements? _____

Bowel Movement Consistency

□ soft & well formed
□ often float
□ difficult to pass
□ diarrhea
□ thin, long or narrow
□ small and hard
□ loose but not watery
□ alternating between hard and loose

Do you experience intestinal gas and/or bloating? _____

Check any of the conditions that you are currently experiencing.

General
Numbness/tingling
Fainting
Dizziness
Fatigue
Chronic pain
Difficulty losing weight
Other

Head/Neck
Headaches
Migraines
Vision problems
Earaches
Decreased hearing
Sinus problems
Difficulty swallowing
Other _____

Dermatological
Eczema/Psoriasis
Itching
Bruise easily
Dryness
Boils
Hives
Acne
Cold sores
Hair loss
Weak finger nails
Other

Respiratory
Frequent colds/flus
Chronic cough
Shortness of breath
Smoking
Breathing problems
Asthma/Bronchitis
Pneumonia
Seasonal Allergies
Other

Cardiovascular
Blood pressure issues
Chest pain
Stroke
Varicose veins
Swelling of the ankles
Poor circulation
Heart disease
Palpitations
High Cholesterol
Diabetes
Other _____

Gastrointestinal
Poor digestion
Indigestion
Stomach ulcer
Belching
Gas/Bloating
Nausea/vomiting
Abdominal pain
Constipation
Diarrhea
Hemorrhoids
Liver concerns
Gall bladder issues or stones
Other

Musculoskeletal
Osteoarthritis
Rheumatoid Arthritis
Osteoporosis
Painful joints
Back pain
Neck pain
Injury
Other

Genitourinary
Difficulty urinating
Bladder infections
Kidney stones
Prostate issues
Other

Mental/Emotional
Depression
Anxiety
Insomnia
Mood swings
Panic attacks
Irritability
Chronic stress
Easily overwhelmed
Memory issues
Brain fog
Other _____

Women's Health
Painful menstruation
Excessive flow
Clots
Irregular cycles
PMS
Cramps or backache
Vaginal discharge
Painful breasts
Lumps in the breast
Fertility issues
Chronic yeast infections
# of pregnancies
# of children
Other

Menopause
Hot flashes
Night sweats
Vaginal dryness
Loss of libido
Fatigue
Weight gain
Depression
Anxiety
Insomnia
Other

What are your desired health goals?

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

Please use this space to add any other information about yourself that you think will be of help to us.

_____

_____

_____

_____

_____

_____