MAINE NATURAL MEDICINE
Empowering Health™

Patient Intake Form

GENERAL INFORMATION

Name *First* *Middle* *Last*

Preferred Name

Date of Birth

Age

Gender ☐ Male ☐ Female

Job Title

Nature of Business

Primary Address *Number, Street*

City *State* *Zip*

Alternate Address *Number, Street*

City *State* *Zip*

Home Phone Work Phone

Cell Phone Fax

E-mail

Emergency Contact *Name* *Phone Number*

Relationship *Cell Phone*

Address *Work Number*

City *State* *Zip*

Primary Care Physician *Name* *Phone Number*

Fax

MARLY SACHSMAN, ND, MA-CCC
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ALLERGIES_____

Medication / Supplement / Food	Reaction

CONCERNS_____

What do you hope to achieve in your visit with us?_____

_____

List your top 3 health concerns

1. _____
2. _____
3. _____

When was the last time you felt well?_____

_____

Did something trigger your change in health?_____

_____

What makes you feel worse?_____

_____

What makes you feel better?_____

_____

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MEDICAL HISTORY_____

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

Past Condition	*Ongoing Condition*	
		GASTROINTESTINAL
☐	☐	Irritable Bowel Syndrome_____
☐	☐	Inflammatory Bowel Disease_____
☐	☐	Crohn's_____
☐	☐	Ulcerative Colitis_____
☐	☐	Gastritis or Peptic Ulcer Disease_____
☐	☐	GERD (reflux)_____
☐	☐	Celiac Disease_____
☐	☐	Other _____
		CARDIOVASCULAR
☐	☐	Heart Attack_____
☐	☐	Other Heart Disease_____
☐	☐	Stroke_____
☐	☐	Elevated Cholesterol_____
☐	☐	Arrhythmia (irregular heart rate)_____
☐	☐	Hypertension (high blood pressure)_____
☐	☐	Rheumatic Fever_____
☐	☐	Mitral Valve Prolapse_____
☐	☐	Other _____
		METABOLIC/ENDOCRINE
☐	☐	Type 1 Diabetes_____
☐	☐	Type 2 Diabetes_____
☐	☐	Hypoglycemia_____
☐	☐	Metabolic Syndrome_____ (Insulin Resistance or Pre-Diabetes)
☐	☐	Hypothyroidism (low thyroid)_____
☐	☐	Hyperthyroidism (overactive thyroid)_____
☐	☐	Endocrine Problems_____
☐	☐	Polycystic Ovarian Syndrome (POCS)_____
☐	☐	Infertility_____
☐	☐	Weight Gain_____
☐	☐	Weight Loss_____
☐	☐	Frequent Weight Fluctuations_____
☐	☐	Bulimia_____
☐	☐	Anorexia_____
☐	☐	Binge Eating Disorder_____
☐	☐	Night Eating Syndrome_____
☐	☐	Eating Disorder (non-specific)_____
☐	☐	Other _____
		CANCER
☐	☐	Lung Cancer_____
☐	☐	Breast Cancer_____
☐	☐	Colon Cancer_____
☐	☐	Ovarian Cancer_____
☐	☐	Prostate Cancer_____
☐	☐	Skin Cancer_____
☐	☐	Other _____

Past Condition	*Ongoing Condition*	
		GENITAL AND URINARY SYSTEM
☐	☐	Kidney Stones_____
☐	☐	Gout_____
☐	☐	Interstitial Cystitis_____
☐	☐	Frequent Urinary Tract Infections_____
☐	☐	Frequent Yeast Infections_____
☐	☐	Erectile Dysfunction_____ Or Sexual Dysfunction
☐	☐	Other _____
		MUSCULOSKELETAL/PAIN
☐	☐	Osteoarthritis_____
☐	☐	Fibromyalgia_____
☐	☐	Chronic Pain_____
☐	☐	Other _____
		INFLAMMATORY/AUTOIMMUNE
☐	☐	Chronic Fatigue Syndrome_____
☐	☐	Autoimmune Disease_____
☐	☐	Rheumatoid Arthritis_____
☐	☐	Lupus SLE_____
☐	☐	Immune Deficiency Disease_____
☐	☐	Herpes-Genital_____
☐	☐	Severe Infectious Disease_____
☐	☐	Poor Immune Function_____ (frequent infections)
☐	☐	Food Allergies_____
☐	☐	Environmental Allergies_____
☐	☐	Multiple Chemical Sensitivities_____
☐	☐	Latex Allergy_____
☐	☐	Other _____
		RESPIRATORY DISEASES
☐	☐	Asthma_____
☐	☐	Chronic Sinusitis_____
☐	☐	Bronchitis_____
☐	☐	Emphysema_____
☐	☐	Pneumonia_____
☐	☐	Tuberculosis_____
☐	☐	Sleep Apnea_____
☐	☐	Other _____
		SKIN DISEASES
☐	☐	Eczema_____
☐	☐	Psoriasis_____
☐	☐	Acne_____
☐	☐	Melanoma_____
☐	☐	Skin Cancer_____
☐	☐	Other _____

MEDICAL HISTORY (continued)

Past Condition	*Ongoing Condition*	**NEUROLOGICAL**
☐	☐	Depression_____
☐	☐	Anxiety_____
☐	☐	Bipolar Disorder_____
☐	☐	Schizophrenia_____
☐	☐	Headaches_____
☐	☐	Migraines_____
☐	☐	ADD/ADHD_____
☐	☐	Autism_____

Past Condition	*Ongoing Condition*	
☐	☐	Mild Cognitive Impairment_____
☐	☐	Memory Problems_____
☐	☐	Parkinson's Disease_____
☐	☐	Multiple Sclerosis_____
☐	☐	ALS_____
☐	☐	Seizures_____
☐	☐	Other Neurological Problems_____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam_____
- ☐ Bone Density_____
- ☐ Colonoscopy_____
- ☐ Cardiac Stress Test_____
- ☐ EBT Heart Scan_____
- ☐ EKG_____
- ☐ Hemoccult Test-stool test for blood_____
- ☐ MRI_____
- ☐ CT Scan_____
- ☐ Upper Endoscopy_____
- ☐ Upper GI Series_____
- ☐ Ultrasound_____

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy_____
- ☐ Hysterectomy +/- Ovaries_____
- ☐ Gall Bladder_____
- ☐ Hernia_____
- ☐ Tonsillectomy_____
- ☐ Dental Surgery_____
- ☐ Joint Replacement – Knee/Hip_____
- ☐ Heart Surgery - Bypass Valve_____
- ☐ Angioplasty or Stent_____
- ☐ Pacemaker_____
- ☐ Other_____
- ☐ None

INJURIES

- ☐ Back Injury
- ☐ Neck Injury
- ☐ Other_____
- ☐ Head Injury
- ☐ Broken Bones

BLOOD TYPE:

- ☐ A
- ☐ AB
- ☐ Rh+
- ☐ B
- ☐ O
- ☐ Unknown

HOSPITALIZATION ☐ **None**

Date	*Reason*

COMMENTS

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GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY *Check box if yes and provide number of*

☐ Pregnancies_____ ☐ Caesarean_____ ☐ Vaginal Deliveries_____

☐ Miscarriage_____ ☐ Abortion_____ ☐ Living Children_____

☐ Post-Partum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby Over 8 Pounds

☐ Breast Feeding for how long?_____

MENSTRUAL HISTORY

Age at First Period:_____Menses Frequency:_____ Length:____ Pain: ☐Yes ☐No Clotting: ☐Yes ☐No

Has you period ever skipped?____For how long?_____

Last Menstrual Period:_____

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long?_____

Do you use contraception? ☐Yes ☐No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility

☐Painful Periods ☐ Heavy Periods ☐ PMS

Last Mammogram:_____ ☐ Breast Biopsy/Date:_____

Last PAP Test:_____ ☐Normal ☐ Abnormal

Last Bone Density:_____ Results: ☐High ☐Low ☐Within Normal Range

Are you in Menopause? ☐Yes ☐No

Age at Menopause:_____

☐Hot Flashes ☐Mood Swings ☐Concentration/Memory Problems ☐Vaginal Dryness ☐Decreased Libido

☐Heavy Bleeding ☐Joint Pains ☐Headaches ☐Weight Gain ☐Loss of Control of Urine ☐Palpitations

☐Use of hormone replacement therapy How long?_____

MEN'S HISTORY (for men only)

Have you had a PSA done? ☐Yes ☐No

PSA Level: ☐0-2 ☐2-4 ☐4-10 ☐> 10

☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

☐ Nocturia (urination at night). How many times at night?_____

☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

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MEDICATIONS

CURRENT MEDICATIONS

Medication	Dos	Frequency	Start Date	Reason For Use

PREVIOUS MEDICATIONS (*Last 10 years)*

Medication	Dos	Frequency	Start Date	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement &	Dos	Frequency	Start Date	Reason For Use

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FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic,												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

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SOCIAL HISTORY

NUTRITION HISTORY

Have you made any changes in your eating habits because of your health? ☐Yes ☐ No Describe:_____

Do you currently follow a special diet or nutritional program? ☐Yes ☐ No

Food sensitivities and/or restrictions: _____

_____

_____

_____

SMOKING

Currently Smoking? ☐Yes ☐ No If yes, how many years?_____

Packs per day:_____

Previous Smoking: How many years?_____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits*

☐ None ☐1-3 ☐4-6 ☐7-10 ☐> 10

OTHER SUBSTANCES

Caffeine Intake: ☐Yes ☐ No | Coffee cups/day: ☐1 ☐2-4 ☐> 4 | Tea cups/day: ☐1 ☐2-4 ☐> 4 Caffeinated

Sodas or Diet Sodas Intake: ☐Yes ☐ No | 16 oz bottle of soda/day: ☐1 ☐2-4 ☐> 4

EXERCISE

How much exercise do you get per day: _____

How much exercise do you get per week: _____

Do you sweat: ☐Yes ☐ No

STRESS/COPING

Do you feel you have an excessive amount of stress in your life? ☐Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐Yes ☐ No

Average Daily Stressors: Rate on scale of 1-10

Work_____ Family_____ Social_____ Finances____ Health____ Other____

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SLEEP/REST

Average number of hours you sleep per night: ☐> 10 ☐8-10 ☐6-8 ☐< 6

Do you have trouble falling asleep? ☐Yes ☐ No

Do you feel rested upon awakening? ☐Yes ☐

No Do you have problems with insomnia? ☐Yes ☐

No Do you snore? ☐Yes ☐ No

Do you use sleeping aids? ☐Yes ☐ No Explain_____

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT_____

Do you have known adverse food reactions or sensitivities? ☐Yes ☐ No If yes, describe symptoms:

_____

Do you have any food allergies or sensitivities? ☐Yes List all:_____ ☐ No

Do you have an adverse reaction to caffeine? ☐Yes ☐ No

When you drink caffeine do you feel: ☐Irritable or Wired ☐Aches and Pains

Do you adversely react to *(Check all that apply)*

☐ Monosodium glutamate (MSG) ☐Aspartame (NutraSweet) ☐Caffeine ☐Bananas ☐Garlic ☐Onion ☐ Cheese

☐Citrus Foods ☐Chocolate ☐Alcohol ☐Red Wine

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐Preservatives (ex. Sodium Benzoate)

☐ Other:_____

Which of these significantly affect you? *(Check all that apply)*

☐ Cigarette Smoke ☐Perfumes/Colognes ☐Auto Exhaust Fumes ☐Other:_____

In your work or home environment, are you exposed to: ☐Chemicals ☐Electromagnetic Radiation ☐Mold

Have you ever turned yellow (jaundiced)? ☐Yes ☐No

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐Insecticides (frequent visits of exterminator) ☐Pesticides ☐Organic Solvents

☐ Heavy Metals ☐Other_____

Chemical Name, Date, Length of Exposure: _____

Do you or have you lived or worked in a damp or moldy environmentor had other mold exposure? ☐Yes ☐No

DENTAL HISTORY_____

☐ Silver Mercury Fillings How many?_____

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Problems with Chewing

Do you floss regularly? ☐Yes ☐ No

SYMPTOM REVIEW_____

Please check all current symptoms occurring or present in the past 6 months

GENERAL

- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

HEAD, EYES & EARS

- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision Problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MUSCULOSKELETAL

- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness
- ☐ Muscle Twitches – around eyes
- ☐ Muscle Twitches – Arms or Legs
- ☐ Muscle Weakness
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES

- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression
- Difficulty
  - ☐ Concentrating
  - ☐ With Balance
  - ☐ With Thinking
  - ☐ With Judgment
  - ☐ With Speech
  - ☐ With Memory
- ☐ Dizziness (Spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

EATING

- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (breads, pasta)
- ☐ Sweet Cravings (candy, cookies, cakes)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION

- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Bloating of Lower Abdomen
- ☐ Bloating of Whole Abdomen
- ☐ Bloating After Meals
- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/ Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Food "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting

Intolerance to:

- ☐ Lactose
- ☐ All Dairy Products
- ☐ Wheat
- ☐ Gluten (Wheat, Rye, Barley)
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast
- ☐ Liver Disease/Jaundice (yellow eyes/ skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools

SKIN PROBLEMS

- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN

- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

SKIN, DRYNESS OF

- ☐ Eyes
- ☐ Feet
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Hair
- ☐ Hair Unmanageable?
- ☐ Hands
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - ☐ Any Dandruff?
- ☐ Skin in General

LYMPH NODES

- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

NAILS

- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft
- ☐ Thickening of fingernails
- ☐ Thickening of toenails
- ☐ White Spots/Lines

RESPIRATORY

- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat

Hay Fever

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Change of Season

- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR

- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

URINARY

- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

MALE REPRODUCTIVE

- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps in Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:

- ☐ Bloating Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual:

- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between