

Lake Meridian Healing Arts, PLLC *Health Care for a Higher Quality of Life*

Alexandria Easter, ND • 15215 SE 272nd ST. Suite 105, Kent WA 98042

P: (425) 395-7542 F: (425) 657-0934

**Confidential Adult Patient Intake Form:**

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M/F \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (email) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Ph \_\_\_\_\_ Relation \_\_\_\_\_

Insurance \_\_\_\_\_ Name of Insured \_\_\_\_\_

Date of Birth of Insured \_\_\_\_\_ Copay Amount \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Relationship Status:     Single     Married     Significant Other

Occupation \_\_\_\_\_ Do you enjoy your work? \_\_\_\_\_

**Current health concerns:**

\_\_\_\_\_  
\_\_\_\_\_

**Allergies to medications, foods, insects, pollens** \_\_\_\_\_

\_\_\_\_\_

**Current Medications and Dosage**

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_

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**Current Supplements**

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_

**Family History:**

	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparent</u>	<u>Child</u>	<u>Aunt/Uncle</u>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease/ Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Kids:**

Name, Age, and Health Issues \_\_\_\_\_  
\_\_\_\_\_

**Personal History:**

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Do you currently have any diagnosed medical conditions? \_\_\_\_\_

Major Illnesses/Accidents (please include dates)? \_\_\_\_\_

**Review of Systems: (Current or Past)**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Nausea             | <input type="checkbox"/> Vomiting              | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Constipation       |
| <input type="checkbox"/> Abdominal Pain     | <input type="checkbox"/> Hemorrhoids           | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Allergies          |
| <input type="checkbox"/> Eczema             | <input type="checkbox"/> Psoriasis             | <input type="checkbox"/> Rash                  | <input type="checkbox"/> Hives              |
| <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Headache              | <input type="checkbox"/> Joint Pain            | <input type="checkbox"/> Dizziness          |
| <input type="checkbox"/> Numbness           | <input type="checkbox"/> Tingling              | <input type="checkbox"/> Muscle Pain           | <input type="checkbox"/> Weakness           |
| <input type="checkbox"/> Hair loss          | <input type="checkbox"/> Brittle nails         | <input type="checkbox"/> Anemia                | <input type="checkbox"/> Thyroid Issue      |
| <input type="checkbox"/> Weight Loss        | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Hypertension       | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Irregular Menses      | <input type="checkbox"/> Cramps             |
| <input type="checkbox"/> PMS                | <input type="checkbox"/> Missed Cycles         | <input type="checkbox"/> Painful Breasts       | <input type="checkbox"/> Painful Urination  |
| <input type="checkbox"/> Hotflashes         | <input type="checkbox"/> Pelvic Pain           | <input type="checkbox"/> Heavy Flow            | <input type="checkbox"/> Varicose Veins     |
| <input type="checkbox"/> Enlarged Prostate  | <input type="checkbox"/> Difficult Urine Flow  | <input type="checkbox"/> Back Pain             | <input type="checkbox"/> Bleeding Gums      |
| <input type="checkbox"/> Kidney Stones      | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> STD                   | <input type="checkbox"/> Chest Pain         |
| <input type="checkbox"/> Leg swelling       | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Ringing Ears          | <input type="checkbox"/> Hearing Loss       |
| <input type="checkbox"/> Change Taste/Smell | <input type="checkbox"/> Change in Vision      | <input type="checkbox"/> Frequent Sore Throat  | <input type="checkbox"/> Frequent Sinusitis |
| <input type="checkbox"/> Weight Gain        | <input type="checkbox"/> Irregular Heart Beat  | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Kidney Disease     |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Anxiety/Panic Attacks | <input type="checkbox"/> Attention Issues      | <input type="checkbox"/> Memory Loss        |

**Current Exercise:** \_\_\_\_\_

Amount and Frequency \_\_\_\_\_

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**Diet/Digestion/Genitourinary:**

Typical Breakfast \_\_\_\_\_

Typical Lunch \_\_\_\_\_

Typical Dinner \_\_\_\_\_

Do you have experience constipation, diarrhea, bloating/gas, or reflux/indigestion? \_\_\_\_\_

Bowel Movements, Frequency \_\_\_\_\_

Is it difficult to have a bowel movement? \_\_\_\_\_ Does it contain blood or mucus? \_\_\_\_\_

Do you urinate frequently or wake in the night to urinate? \_\_\_\_\_

Do you experience incontinence or burning/pain with urination? \_\_\_\_\_

(Females) Date of last menstrual period \_\_\_\_\_ Number of Pregnancies \_\_\_\_\_

Miscarriges \_\_\_\_\_ Complications with Pregnancy \_\_\_\_\_

(Men) Difficult urinary flow? \_\_\_\_\_ Erectile Dysfunction? \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Date of last blood work/labs \_\_\_\_\_

How is your energy level? \_\_\_\_\_

How many hours a night do you sleep? \_\_\_\_\_ Do you have trouble falling asleep or staying asleep?

**Habits:**

Smoking  Currently  Previously Amount/Frequency \_\_\_\_\_

Alcohol  Currently  Previously Amount/Frequency \_\_\_\_\_

Recreational Drugs  Currently  Previously Amount/Frequency \_\_\_\_\_