Dr. Renee Mammone, N.D. ***Naturopathic & Acupuncture Health Center*** ***John Mammone, L.Ac.***
Dr. Marie Mammone, N.D. ***274 Silas Deane Hwy*** ***Licensed Acupuncturist***
Naturopathic Physicians ***Wethersfield, CT 06109***

PATIENT INTAKE FORM

Date_____ ***email:***_____

Name_____Blood Type_____

Age_____Date of Birth_____ Gender:female_____male_____

Address_____City_____State_____Zip_____

Telephone (H)_____(W)_____(cell)_____

Occupation_____Hours per week_____ Retired_____

Employer_____

Marital Status:_____Number of children:_____

Next of Kin or other to reach in an emergency_____

Relationship_____phone_____

Address_____

How did you hear about me?_____

Health History Questionnaire

Are you currently receiving healthcare? Yes_____No_____

If yes, from whom_____

If no, when did you last receive medical or health care? _____

What was the reason? _____

When was your last physical exam? _____

What condition(s) is your primary concern in coming to see us? _____

_____

_____

What are your most important health problems? List in order of importance:

(1)_____

(2)_____

(3)_____

(4)_____

(5)_____

Do you have any contagious disease at this time? Yes_____No_____
If yes, what? _____

General Information:

Weight now_____
Weight 1 year ago_____MaximumWeight_____When_____
Height_____

When during the day is your energy the best? _____worst? _____

Family History

	Father	Mother	Brothers	Sisters	Spouse	Child
Age if living						
Health(G=good P=poor)						
Age at death						
Cause of death						
Check (those applicable) Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hayfever						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Other						

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Medical History

Circle yes (Y) or No (N)

Childhood Illnesses

Scarlet fever	Y	N	Diphtheria	Y	N	Rheumatic fever	Y	N
Mumps	Y	N	Measles	Y	N	German measles	Y	N

Hospitalization and Surgery

What hospitalizations or surgeries have you had?

_____

_____

X-rays and Special Studies **(bring copies of any blood lab work to appointment)**

X-rays, CAT scans, or other studies you have had:_____

Electrocardiogram Y N Electroencephalogram Y N

Immunizations

Polio	Y	N	Pertussis	Y	N
Tetanus shot	Y	N	Diphtheria	Y	N
Measles/Mumps/Rubella	Y	N	Others_____		

Allergies

Are you hypersensitive or allergic to…

Any drugs?_____
Any foods?_____

Current Medications

Do you take or use?

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite suppressants	Y	N	Antibiotic	Y	N
Tranquilizers	Y	N	Thyroid Medication	Y	N	Sleeping pills	Y	N

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking? Including herbal teas **(Please list)**_____

- _____
- _____
- _____
- _____
- _____

Please bring any supplement and medication bottles with you to appointment.

Typical Food Intake
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Water drank daily_____

Habits:
Main interest and hobbies?_____

Do you exercise? Yes or No
If yes, what kind?_____

Do you have a religious or spiritual practice? Yes or No If yes, what?_____

Do you eat three meals a day?	Yes or No	Average 6-8 hours sleep?	Yes or No
Sleep well	Yes or No	Awake rested	Yes or No
Enjoy you work	Yes or No	Spend time outside	Yes or No
Watch television	Yes or No	Read?	Yes or No
How many hours?_____		How many hours? _____	

Take vacations ? Yes or No Any major traumas?_____
Have a supportive relationship? Yes or No Have a history of abuse? Yes or No
Have you ever been treated for drug dependence? Yes or No

Use recreational drugs?	Yes or No	Use alcoholic beverages	Yes or No
Been treated for alcoholism?	Yes or No	Do you use tobacco?	Yes or No
Do you drink coffee?	Yes, No, past	Smoked previously?	Yes or No
Do you drink Black Tea?	Yes or No	how many years?	
Do you drink cola (soda)	Yes or No	how many packs per day?_____	
Do you eat sugar?	Yes or No	Do you eat out often?	Yes or No
Do you eat salt?	Yes or No	Do you go on diets often?	Yes or No

How does you condition affect you?

What do you think is happening? Why?

What do you feel needs to happen for you to get better?

What do you enjoy most in your life?

How much change are you willing to make at this time for improving your health?

Minimal Some Complete

Is there any information about your health you would like to add?