Dr. Cheri King
NATUROPATHIC DOCTOR

80 Garden Center #162
Broomfield, CO 80020
drking@drcheriking.com

P | 720-899-6237
F | 720-715-8945
www.drcheriking.com

Patient Intake Form

Last name:_____ First name:_____

Date of birth:_____Age:_____Gender (sex):_____Email:_____

Address:_____City:_____State:_____Zip:_____

Home phone:_____ May we leave a confidential message at this number? Yes ☐ No ☐

Work/cell phone:_____May we leave a confidential message at this number? Yes ☐ No ☐

Emergency contact:_____Phone:_____Relation:_____

Are you (circle one) Single Married Partnered Separated Divorced Widowed

Do you have children? Y / N (names and ages):_____

Your occupation:_____Your education:_____

How did you hear about us?_____

*Email will only be used to contact you or to send you newsletters. It will not be shared with anyone.

Present Health Concerns (in order of importance): **Duration:**

1_____

2_____

3_____

Please describe what you think is the cause of your health conditions:

_____

_____

_____

Please list any vitamins/herbs/supplements that you are taking:

Name Reason for taking Dose/day For how long Who prescribed

_____

_____

_____

_____

Please list any prescription drugs or over-the-counter medicines that you are taking:

Name Reason for taking Dose/day For how long Who prescribed

_____

_____

_____

_____

Allergies: (Please circle any which are life-threatening)

_____

Are you sensitive to chemical smells?_____ Have you had repeated exposure to any chemicals, fumes, dust? (if so, please specify)_____

Medical History:
Primary Care Doctor/Provider:_____Date last seen:_____
Reason for seeing:_____
Doctor's Address:_____
Doctor's phone:_____Fax:_____
Date of your last physical exam:_____Results:_____
Date of last blood work:_____Results:_____
Date of last PAP/pelvic exam:_____Results:_____
Date of last mammogram:_____Results:_____
Date of last prostate exam:_____Results:_____
When was your last menstrual period?_____Are you pregnant?_____How far along?_____
Are you sexually active? (circle one) Yes / No If yes, is it with (circle one): male female both
Do you or your partner(s) use any form of contraception? Yes / No If so, what type(s)?_____

Family History: Please designate which family members have had the following health conditions.
M=Mother F=Father B=Brother S=Sister G=Grandparent C=Child

Allergies	Diabetes	Mood/Mental disorder
Alcoholism	Cancer	Neurological disease
Anemia	Endometriosis	Obesity
Arthritis-Rheumatoid	Heart Disease	Skin problems
Arthritis-Osteo	High Blood Pressure	Stroke
Autoimmune disease	High Cholesterol	Thyroid disease
Depression	Kidney disease	Tuberculosis

Exercise: (Please specify what type of exercise, duration, and frequency per week)
_____
_____
_____

Sleep Habits:
How many hours do you sleep per night?_____Do you wake refreshed?_____
Do you have problems: falling asleep staying asleep waking up in the morning

Energy Level: (Please circle your average daily energy level)
(lowest energy) 1 2 3 4 5 6 7 8 9 10 (highest energy)

Stress Level: (Please circle your average daily stress level)
(lowest stress) 1 2 3 4 5 6 7 8 9 10 (highest stress)
How do you cope with stress?_____

_____

Review of Systems (please circle any symptoms you have experienced in the last 6 months)

General	Skin/EENT	Heart/Lung	Gastrointestinal	Endocrine
Weight change	Itching	High blood pressure	Poor appetite	Diabetes
Fever/chills	Rashes	Low blood pressure	Heartburn/GERD	Hypothyroid
Weakness	Hives	Heart palpitations	Constipation	Hyperthyroid
Fatigue	Eczema	Heart attack	Diarrhea	Goiter
Night sweats	Vision changes	Heart disease	Gas/bloating	Hypoglycemia
Dizziness	Dental problems	Shortness of breath	Nausea/vomiting	Hot flashes
Memory loss	Ringing in ears	Wheezing	Hemorrhoids	Increase thirst
Mood changes	Earaches	Chronic coughing	Ulcers	High appetite
Sleep issues	Sinus infections	Stroke	Blood in stool	Hair loss
Anxiety/Depression	Sore throats	Swollen ankles	Anal discomfort	Weight gain

Genitourinary	Musculoskeletal	Female Only	Male Only	Other
Low back pain	Neck pain	PMS	Breast lumps	Anemia
Painful urination	Low back pain	Breast lumps	Erection difficulty	Osteoporosis
Blood in urine	Hip pain	Heavy menses	Pain in testicles	Cancer
Frequent urination	Foot pain	Hot flashes	Penis discharge	Fibromyalgia
No bladder control	Shoulder pain	Painful intercourse	Sores on penis	Crohn's dz
Nighttime urination	Arm pain	Hysterectomy	Infertility	Colitis
Bladder infections	Arthritis	Fibroids	Low libido	STDs
Kidney infections	Tendonitis	Abnormal pap	Swelling of testes	ADD/ADHD
Kidney stones	Strain/sprain	Low libido	Hernia	Mood disorder
Renal failure	Spasm/Swelling	Vaginal infections		Eating disorder

Diet History:

How many meals do you eat per day? (please circle) One Two Three Four or more

How much water do you drink per day? (please circle) None 8-24oz 24-64oz 64oz or more

Coffee: (Number of cups per day)_____Soda (Number of cans per day)_____

Tea: (Specify type and number of cups per day)_____

Please list any food allergies that you have and the type (anaphylactic or food intolerances)

_____

Please specify a typical daily diet:

Meal	Time	Food and Amount	Beverages
Breakfast			
Snack			
Lunch			
Snack			
Dinner			

Personal Habits: (Please specify current or past usage of these substances and how much)

Tobacco:_____

Alcohol:_____

Caffeine:_____

Recreational drugs:_____

Digestive Health:

Any stomach upset, bloating, burping, flatulence (gas), nausea, or rectal itching after food? (please circle or specify):_____

Bowel movement frequency:(how often)_____Consistency:(hard, soft, watery, normal)_____

Do you experience constipation or diarrhea? (please circle or specify)_____

Do you have blood or mucus in the stool? (please circle or specify)_____

Eliminations:

Do you experience pain with urination, incontinence, other urinary symptoms? (please circle or specify)?

_____

Urination frequency: (how often per 24 hour period)_____

Color of urine: (dark yellow, light yellow, green, colorless) _____Blood in urine?_____

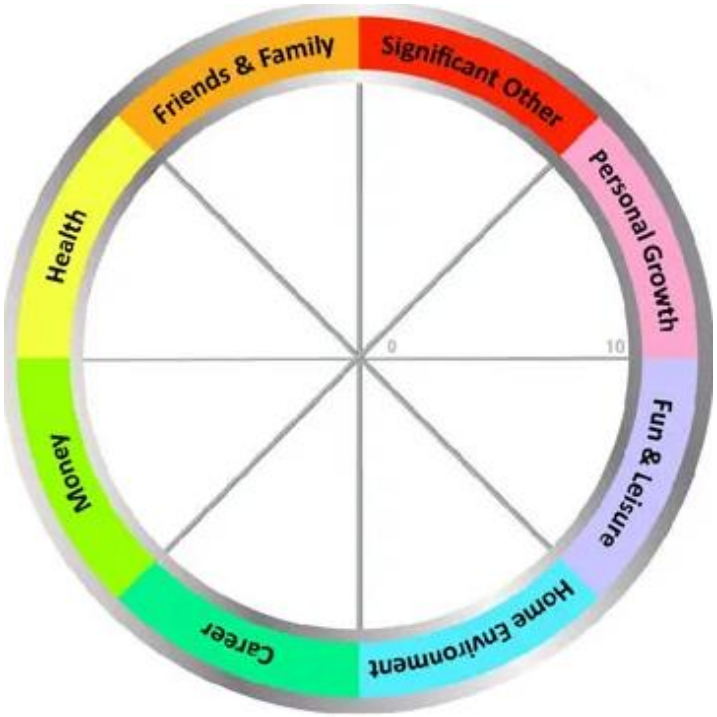
Menses: (female)

Are your menses regular (average every 28 days)?_____

Do you experience cramps, excessive menstrual flow, hot flashes, fibrocystic breasts, mood issues, bloating and swelling, bleeding in between menstrual cycles, other PMS issues? (please circle or specify)

_____

WHEEL Of LIFE



How satisfied are you with different areas of your life? Color in the "pie piece" in the Wheel of Life to the extent of satisfaction that you feel in each area. For instance, if you are 100% satisfied, then color in the entire tringle.

Context of Care Review

Successful health care and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. Your response to the following questions will assist the doctor's understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid the doctor to assist your health needs.

1. Why did you choose to come to this clinic?

2. What do you know about my approach?

3. What are your wellness goals?

4. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0-10, 10 being 100% committed.)

1 2 3 4 5 6 7 8 9 10

5. What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

6. What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive?