Rosetta Koach, ND
Patient Intake Form

Name_____Date_____

Age _____Date of Birth_____ Place of birth_____ Gender: female _____male _____

Address_____

City_____State_____Zip Code_____

Telephone # (home) _____ (work/cell) _____E-mail_____

Occupation _____ S.S.# _____

Employer _____Hours per week _____Date retired_____

(Work address) _____

Primary Health Care Physician _____ Phone_____

Live with: Spouse_____Partner_____Parents_____Children_____Friends_____Alone_____

Next of Kin or other to reach in an emergency_____ Relationship _____

Address if different_____ Phone_____

How did you hear about my services? _____

********** INSURANCE CASES **********

Health insurance company _____

Address_____

Telephone number _____Whose name is policy under_____

Policy/Group #_____Identification number_____

"********** AUTO ACCIDENTS**********

Claim #_____Date of Accident_____

Claim Representative_____ Phone #_____

Name and Address of Company representing your claim:

_____

Other physicians who have treated this injury_____

_____

GENERAL INFORMATION

Current weight _____lbs. Any recent weight loss Y N Weight gain Y N How many _____lbs

Current height_____ BP_____ Pulse. _____ Resp. _____Temp. _____

HEALTH HISTORY

What are your most important health problems? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

Are you currently receiving healthcare? Y N
If yes, where and from whom? _____

What is the reason? _____

What treatments have been prescribed? _____

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

Allergies

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental substances? _____

Any previous allergy testing and if so what type? _____

Current Medications

Do you take or use?

Antacids	Y N	Pain relievers	Y N	Tranquilizers	Y N
Laxatives	Y N	Anti-inflammatories	Y N	Sleeping pills	Y N
Diabetic drugs	Y N	Cortisone	Y N	Thyroid medication	Y N
Appetite suppressants	Y N	Antibiotics	Y N	Topical drugs	Y N

Please list prescription medications, over the counter medications, vitamins or other supplements you are taking?

1)_____ 6)_____

2)_____ 7)_____

3)_____ 8)_____

4)_____ 9)_____

5)_____ 10)_____

PERSONAL HISTORY

For the following sections, please circle "Y" for yes or "N" for no or "I" for Immunizations

Childhood Illnesses or Immunizations

Measles	Y	N	I	Diphtheria	Y	N	I	Scarlet fever	Y	N	I
Mumps	Y	N	I	Tetanus shot	Y	N	I	Rheumatic fever	Y	N	I
Rubella	Y	N	I	Pertussis	Y	N	I	Whooping cough	Y	N	I
Chicken pox	Y	N	I	Polio	Y	N	I	Other _____			

Do you have any contagious diseases at this time? Y N
If yes, what? _____

FAMILY HISTORY

✓Check those applicable	Self	Father	Mother	Brothers	Sisters	Children	Spouse
Allergies							
Alzheimer's							
Alcoholism							
Anemia							
Asthma, Hayfever, Hives							
Arthritis							
Atherosclerosis							
Bleeding disorder							
Cancer							
Candida							
Chronic Headaches							
Colitis							
Diabetes							
Eczema/Psoriasis							
Emphysema							
Glaucoma							
Gout							
Heart Disease							
High Blood Pressure							
Hypoglycemia/Hypergycemia							
Kidney Disease							
Liver Disease							
Mental Illness							
Pneumonia							
Seizures/Epilepsy							
Stroke							
Thyroid Problems							
Tuberculosis							
Ulcers							
Venereal Disease							
Weight problems							
Age at death (if deceased)							

Describe food intake for a typical day

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Drink _____

What foods do you crave _____

What foods do you dislike _____

List any foods that you know cause reactions and briefly what the reaction is?_____

_____

_____

How do you feel 15 minutes after eating?_____

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

Are you following a recommended diet from another physician? _____

Are you willing to make changes to improve your health?_____

Do you eat three meals a day? Y N

Do you dine out often? Y N

Do you enjoy eating? Y N

How much water do you drink/day? _____

How much coffee do you drink/day? _____

How much black tea do you drink/day? _____

How much cola do you drink/day? _____

How much alcohol do you drink/day? _____

Have you ever been treated for alcoholism? Y P N

Do you go on diets often? Y P N

Do you eat sugar? Y P N

Do you eat salt? Y P N

Do you experience decreased taste? Y N

Any trouble eating green leafy veggies? Y P N

Any distress from fat greasy foods? Y P N

How much tobacco do you use/day? _____

How many years? _____

How many packs per day? _____

Smoked previously? Y N

Do you use recreational drugs? Y P N

Have you ever been treated for drug dependency? Y P N

Do you exercise? Y N

If yes, what kind?_____

How often?_____

Do you sleep well Y N

How many hours /night? _____

Do you awaken rested? Y N

Do you spend time outside? Y N

How often do you take vacations? _____

Have you traveled abroad? Y N

Do you enjoy your life? Y N

Any major traumas? Y N

Do you have a history of abuse? Y N

Do you have a supportive relationship? Y N

Do you have a physiological therapist? Y N

Do you follow a religious or spiritual practice? Y N

How many hrs/day do you read? _____

How many hrs/day do you watch TV? _____

List main interests and hobbies? _____

_____

_____

_____

Hospitalization, Surgery, X-rays, Special Studies, or blood transfusions

Describe any hospitalizations, surgeries, X-rays, Special Studies, or blood transfusions you have had?

_____

_____