New Patient Intake

At Ohmni Naturopathic Family Medicine we care deeply about our patients and their health in its entirety. We also respect your time and recognize this is a thorough intake form. The more information we can collect outside of your first appointment, the more Dr. Walsh can be present and focused on your main concerns during your appointment.

Personal Details

Legal first name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Choose your preferred form of communication

- ☐ Email
- ☐ Text
- ☐ Phone

Gender Identity

- ☐ Male
- ☐ Non-Binary
- ☐ Female
- ☐ Other

Blood Group

Language

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Employment Status

- ☐ Employed
- ☐ Unemployed
- ☐ Retired
- ☐ Full-Time Student
- ☐ Part-Time Student

Do you have insurance? ○ Yes ○ No

If you have insurance what classification is it?

- ☐ HMO
- ☐ PPO
- ☐ Unsure

What is the name of your insurance provider?
This is important, as it helps me know what lab work we can run.

Policy Holder | Legal first name | Last name

Date of birth | Phone number

Sex assigned at birth | Gender

Street | Unit

City | State/Province | Postal code

Insurance Company | Payer Id | Coverage Type

Member Id | Plan Id | Group Id

Copay | Deductible

Emergency Contact

Legal first name | Last name

Relationship

Home phone | Mobile phone | Email address

How did you hear about us?

- [ ] Facebook
- [ ] Instagram

☐ Referral ☐ Google

If you were referred, let us know who we may thank!

List your current health concerns or goals in order of importance

Health Concerns

How motivated are you to play an active role in resolving these concerns or working toward these goals?

1 is not really committed and 10 is highly committed

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

Is there anything that will get in the way of following a treatment plan in order to achieve results?

Some obstacles may be,

What are your expectations or desires for working with Dr. Walsh?

My expectations are

Family History

Family Illnesses

List any medical diagnoses or health concerns among the following family members:

Family Member	Illness

Social History

What is your highest level of education?

- ☐ High School Diploma
- ☐ GED
- ☐ Undergraduate degree
- ☐ Graduate degree
- ☐ Doctorate
- ☐ Other

What is your occupation?

Do you currently have sexual partner(s)?

- ☐ Never
- ☐ With partner(s) in the past
- ☐ Currently with a partner
- ☐ Currently with multiple partners
- ☐ Decline to answer

Do you have sexual intercourse with:

- ☐ Men
- ☐ Women
- ☐ Both
- ☐ Decline to answer

How satisfied are you with your sex life?

- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ Somewhat satisfied
- ☐ Not satisfied

Marital Status

- ☐ Single
- ☐ Married
- ☐ Other

If applicable - please list your spouse or partner's name, age, gender and occupation:

If applicable - please list the name, age and gender of all of your children:

Please describe who lives in your home with you:

Rate your stress level on a scale of 1-10, with 10 being the worst

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

1 = No stress, 10 = Unbearable stress

In what areas of your life do you experience stress?

- ☐ Work
- ☐ Social Life
- ☐ Other
- ☐ Family Life
- ☐ Financial

How. often do you make time for rest and relaxation during your week?

- ☐ Always
- ☐ Often
- ☐ Rarely
- ☐ Very often
- ☐ Sometimes
- ☐ Never

Do you have a belief system in something larger than yourself? If so, briefly explain:

Lifestyle

What behaviors or lifestyle habits do you currently engage in that you believe support health?

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

Please list the three healthiest foods you consume in a week:

Please list the three unhealthiest foods you consume in a week:

What kind of fruits and vegetables do you eat daily?

How many times a week do you eat animal protein?

Describe your relationship with food

Do you avoid any foods or substances due to allergies, intolerances, beliefs or philosophies? If so, briefly explain.

How many ounces of water do you drink daily?
(1 average cup of water is about 8oz)

What is the source of your drinking water?

- ☐ Tap water
- ☐ Bottled water
- ☐ Spring water
- ☐ Reverse Osmosis Water
- ☐ Filtered: Charcoal filter
- ☐ Filtered: other

List other beverages you consume regularly;
Include any flavor or sweetening you add to water

Please describe your bowel movements;
How often are you having one, are they well formed and easy to pass, any noticeable undigested food, do you have to strain?

Do you experience any symptoms after meals?

Smoking Status

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ Current status unknown
- ☐ Unknown if ever smoked

How often are you currently using tobacco?

- ☐ Never
- ☐ Occasionally
- ☐ Moderately
- ☐ Heavily

How often do you consume alcohol?

- ☐ Never
- ☐ A few times a year
- ☐ A few times a week
- ☐ Daily

How often do you currently use illicit drugs?

- ☐ Never
- ☐ Ocasionally
- ☐ Moderately
- ☐ Heavily

How often did you use illicit drugs in the past?

- ☐ Never
- ☐ Ocasionally
- ☐ Moderately
- ☐ Heavily

What best describes your sleep?

- ☐ I generally sleep well
- ☐ I have a hard time falling asleep
- ☐ I have a hard time staying asleep
- ☐ I have a hard time waking up
- ☐ I generally sleep poorly

Do you wake feeling rested? ○ Yes ○ No

How many hours do you sleep a night?

How often do you exercise?

What types of exercise do you do?

Medical History

Medical Diagnosis

Please list any current medical diagnoses

Diagnosis	Current	Date of Onset	Diagnosed by:
	☐		
	☐		
	☐		
	☐		

Past Hospitalizations/Surgeries

Hospitalization/Surgery	Date	Reason

Please list any other major medical concerns or diagnoses you've had since childhood and into your adult lif

Diagnosis	Date of Onset

Medications

List all medications you're currently taking, including dosage and reason for taking

Medication	Dose	Frequency	Start Date	Reason

Supplements

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose	Frequency	Start Date	Reason

Have you ever had shots/vaccinations?

List all that apply (including flu shots)

Please list any allergies you experience;

Allergy	Reaction

Female History

Date of your last PAP

Have you ever had an abnormal PAP?

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Decline to answer

Have you ever had a positive STI? Please list which STIs and when:

STI	Date of Onset

Do you perform self-breast exams?

- ☐ Yes, monthly
- ☐ Occasionally
- ☐ Never
- ☐ I don't know how

Age of first menstruation

Have you gone through menopause? If so, were there any major issues or concerns going through menopause?

Date of last menstrual period

How many days do you bleed?

How many days pass between your menstrual bleeding?

Have you had irregular periods in the past?

- ◯ Yes
- ◯ No
- ◯ Not Sure

Do you currently have irregular periods?

- ◯ Yes
- ◯ No
- ◯ Not Sure

Any pre-menstrual symptoms or concerns? If yes, briefly explain:

Are you trying to conceive?

- ◯ Yes
- ◯ No
- ◯ Not Sure
- ◯ Other

If "Other", please specify

If you are not trying to conceive, what is your current method of birth control?

Select all that apply

- ☐ I don't use any form of birth control
- ☐ Pull out method
- ☐ Patch or Nuvaring
- ☐ Fertility awareness
- ☐ Hormonal implant
- ☐ The pill
- ☐ Condoms
- ☐ Copper IUD
- ☐ Hormonal IUD
- ☐ Female condom or cap

Have you ever taken birth control? ◯ Yes ◯ No

Have you ever had any issues with any birth control in the past? If so, briefly explain:

Have you ever been on hormone replacement therapy? ◯ Yes ◯ No

Do you experience painful intercourse?

- ☐ Never
- ☐ Always
- ☐ Sometimes
- ☐ Not Applicable

Have you ever experienced sexual trauma?

- ☐ Yes
- ☐ Not sure
- ☐ No
- ☐ Decline to answer

Pregnancy History

	Diagnosis
Number of pregnancies	
Number of births	
Number of miscarriages	

Environmental Exposure and Sensitivity

Do you experience symptoms such as fatigue, dizziness, headache, nausea, or irritability around perfume, cleaning products, paints or any other chemical agent?

- ☐ Always
- ☐ Often
- ☐ Rarely
- ☐ Very often
- ☐ Sometimes
- ☐ Never

Rate your level of awareness with regard to health effects of your personal care products, makeup and cleaning agents:

- ☐ Not aware
- ☐ Moderately aware
- ☐ Somewhat aware
- ☐ Very aware

Have you ever had a known exposure to environmental toxins or mold? ◯ Yes ◯ No

Roughly how many rounds of antibiotics have you had in your lifetime?

Have you ever had food poisoning or have you been sick outside of the country? ◯ Yes ◯ No

Where did you grow up?
City or country? ◯ City ◯ Country

Did you ever have mercury/silver dental fillings in your life? ◯ Yes ◯ No

Have you experienced any traumatic events in your life from childhood until now?

- ☐ Yes
- ☐ Not sure
- ☐ No

Do you have any pets? ◯ Yes ◯ No

What type of environment do you/ have you worked in?

Dreams, Passion & Purpose

How do you express your creativity?

What do you do to have fun?

If time and money were unlimited resources and you could do whatever brought you joy, how would you spend your day?

How often do you feel like you incorporate these things into your daily life now?

- ☐ All the time
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Please provide any other information that may be relevant but hasn't been covered:

Thank you for taking the time to make your health a priority. We look forward to seeing you soon!