Bay Area Naturopathic Medicine, Inc.
2100 Curtner Ave., Suite G
San Jose, CA 95124
Tel: 408-963-6993 Fax: 408-963-6796
Tracy Chan, ND, L.Ac Kevan Q. Huynh, ND, L.Ac

Adult Initial Intake

Contact Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact

Name: _____ Relationship:_____

Home Phone: _____ Cell Phone: _____

Personal Information

Age: _____ Date of Birth: _____ Gender: Female / Male

Relationship Status (please circle): Married/Separated/Divorced/Widowed/Single/Partnership

Live with (please circle): Spouse/Partner/Parents/Children/Friends/Alone

Education: _____

Occupation: _____ Hours per week: _____ Retired: _____

Employer: _____

Work address: _____

How did you hear about our clinic? _____

If on the internet, please name website: _____

Has any other family member already been a patient at the clinic? _____

Health Information

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

1) _____

2) _____

3) _____

Are you currently receiving healthcare? Y / N

If yes, where and from whom: _____

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

What was the reason? _____

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

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum Weight: _____ When: _____

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

2) 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 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

3) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

4) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

5) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Family History
Do you or your family have a history of any of the following (please circle)?

Cancer	Diabetes	Heart Disease	Anemia	Stroke	High Blood Pressure
Kidney	Disease	Epilepsy	Arthritis	Glaucoma	Tuberculosis
Asthma	Hayfever	Hives	Mental Illness		

Any other relevant family history? _____

What is your heritage? _____

Childhood Illnesses
Please circle whether you had any of these as a child:

Scarlet fever	Diphtheria	Rheumatic fever	Mumps	Measles	German measles

Hospitalization, Surgery, Imaging
What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

Allergies
Are you hypersensitive or allergic to...
Any drugs? _____

Any foods? _____

Any environmentals or chemicals? _____

Current Medications
Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list all current medications/over the counter medications/supplements/vitamins/herbs you're taking:

Medication/Supplement	What is it for?	Dosage	Frequency

Thank you!