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Naturopathic Physician and Acupuncturist**

*Empowering Individuals to Meet Their Health Care Goals*

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**Intake Form  
Naturopathic Medicine and Acupuncture**

Please take the time to fill in the following document. In order for Dr. Allott to assist you in meeting your health care goals, we both need accurate information. This document, which summarizes your current and past health history, will help us focus your care at Dynamic Paths.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: Female \_\_\_\_\_ Male \_\_\_\_\_ Transgender \_\_\_\_\_ Occupation: \_\_\_\_\_

**Major Complaints (in order of importance)**

Complaint	When did it begin?	On scale of 1 to 10, how much does it affect you?	Are there health records associated with this condition?	Practitioner's name and phone number

**Are you willing to change your daily habits to improve your health? Yes No**

**Preventive Health Care**

Please indicate the last time you had the following care.

Preventive Care	Date	Doctor	Clinic	Phone Number
Physical exam				
Blood pressure				
Blood tests				
Urinalysis				
Stool tests				
Rectal exam				
Colonoscopy				
Skin exam				
Dental exam				
PAP/Pelvic exam				
Mammogram				
Bone density test				
Testicular exam				
PSA/prostate exam				
STD tests				
Chest x-ray				
EKG				
Tetanus booster				
TB skin test				
Vision/Glaucoma exam				
Hearing exam				
Monthly breast self examination				

**Current Medications and Supplements**

Please list all current medications and supplements including any pills, teas, or creams. Please include any over-the-counter medications such as antacids, pain medication, decongestants, and laxatives.

Medication	Dosage	Doctor	Supplement	Dosage

**Any past allergic reactions to medications?**

**Other allergies?**

## Review of Systems

Circle if the symptom has occurred in the last year.

Place a check mark if the symptom has occurred in the past.

<b>General</b>	Weight gain Weight loss Significant weight loss or gain History of dieting	Chronic fatigue Fatigue in the afternoon Weakness Excessive thirst	Spontaneous sweating Night sweats Fever/Chills Sick more than 1 time/year	Intolerance to heat Intolerance to cold Cold hands/feet Other
<b>Skin</b>	Dry skin Itchy skin Rashes Hives Moist skin Bruising easily	Acne Eczema Psoriasis Shingles Ringworm	Athlete's foot Moles Bumpy skin on back of arms Spider/varicose veins	Changes to nails Changes to skin color Changes to moles Nail fungus Nail ridges Other
<b>Head</b>	Headaches Migraines	Dizziness Vertigo	Trauma Hair loss	Other
<b>Eyes</b>	Dry eyes Watery eyes Itchy eyes Eye pain Red eyes Discharge from eyes	Floaters/Hallo/flashes Blurred vision Impaired vision Double vision Eyes sensitive to light Poor night vision	Sties Cataracts Vision loss Other	Vision correction:  Vision: Near__ Far__ Contacts Glasses Laser
<b>Ears</b>	Ear pain Itchy ears Waxy ears	Discharge from ear Ringing in ears Hearing loss	Ear infections Ear infections as a child	Other
<b>Nose &amp; Sinuses</b>	Itchy nose Discharge from nose Congested nose/sinuses	Postnasal drip Nosebleeds Loss of smell	Breathes through mouth  Snores	Other
<b>Mouth &amp; Throat</b>	Dry mouth Itchy mouth/throat Sores on mouth/lips Hay fever/allergies Bad breath	Frequent sore throat Coughing up blood Persistent cough Difficulty swallowing Loss of Taste Hoarseness	Dentures Inflamed/bleeding gums Cavities Braces Teeth sensitivity	Jaw clicks TMJ Other dental concerns Treatment for strep. infections as a child Other
<b>Neck</b>	Neck pain or stiffness	Swollen glands	Trauma	Other
<b>Respiratory</b>	Shortness of breath Wheezing Pain with breathing Chronic cough Coughing up blood	Asthma Allergies Bronchitis/ pneumonia Positive TB test History of smoking	Exposure to chemicals Exposure to solvents Exposure to particulates	History of secondhand smoke  Other
<b>Cardiovascular</b>	High blood pressure Low blood pressure High cholesterol High glucose Chest pain Heaviness in legs Cold hands/feet	Feel heart racing Chest tightness Difficulty breathing at night Palpitations Swelling in ankles Heart fluttering Purple fingers/lips	Irregular heartbeat Heart murmur Dizziness upon standing Exhaustion with minor exertion	Varicose veins Hemorrhoids Spider veins Calf pain at night Calf pain walking Other
<b>Gastrointestinal</b>	Poor appetite Excessive appetite Changes in appetite Excessive thirst Trouble swallowing Stomach pain Nausea/ vomiting Vomiting blood Burping/ belching Abdominal pain Abdominal bloating Gas/flatulence Indigestion Heartburn/ Antacid use	Constipation (<1 stool/day) Stools that are hard to pass Foul-smelling stools Loose stools (break up when hit water) Diarrhea Blood in stools Black tar in stools Mucous in stools Undigested food in stools	Stool shape: One piece Hard little pellets Breaks up when in water Other  Color: Yellow Green Light brown Dark brown	Intolerance to specific foods Fatigue after eating Food sensitivity Anal itching Liver disease Gallbladder disease Treated for parasites Ulcers Hemorrhoids Other

<b>Neurological</b>	Fainting Dizziness/vertigo Numbness or tingling Trembling hands	Head trauma Poor concentration Memory loss Lack of mental alertness	Loss of grip strength Loss of muscle tone Muscle weakness Heavy head Heavy extremities	Other
<b>Urinary</b>	Frequent urination Urinate < 3 times/day Can't hold urine Urination with cough or sneeze	Light yellow urine Yellow urine Yellow dark urine Red urine Cloudy urine Strong smelling urine	Kidney or bladder infections Urination at night Painful/burning urination	Dripping after urination Bed-wetting Other
<b>Musculoskeletal</b>	Pain in: Arms Shoulders Upper back Lower back Legs Hips Neck Hands Feet	Painful bones Tight shoulder muscles Swollen knees/elbows Numbness Tingling Burning Spasms/cramps Morning stiffness	Chronic pain Loss of height Unable to sit straight Activities limited due to pain	Arthritis Herniated/slipped disk Tendonitis Osteoporosis Broken bone Other
<b>Women Only</b>	Age of first menses:  Length of period:  Length of cycle:  Date of last menses:  Heaviest flow day:  # of pads/tampons on heaviest day:  Abnormal Pap?	# of pregnancies:  # of live births:  Currently sexually active? Yes___ No___  Which gender are you sexually active with? Men___Women___ Both___  Type of birth control:  Type of STD control: Condoms Monogamy Other	Spotting between periods Clots with period Menstrual cramps Weight gain with period PMS Irritability Moodiness Crave sweets Tendency to cry Bloating/ swelling Breast tenderness Low back pain Fatigue with period Missed periods Irregular periods Difficulty conceiving Lack of sexual drive	Vaginal itching Vaginal discharge Vaginal odor Yeast infections Vaginal mucosa dry Painful intercourse/masturbation History of STDs? Yes No Have been tested for STDs? Yes No Uterine cyst/fibroids Hysterectomy Use of birth control pill for greater than 10 years
<b>Women only</b>	Monthly breast self-exam Yes No Fibrous breast Breast feed your child Breast implants History of mammograms Abnormal mammogram Nipple discharge	Hot flashes Vaginal dryness Changes in cycle Moodiness Brain fog Menopause Age of menopause:	Use of hormone replacement	Other
<b>Men only</b>	Sense of full bladder Difficulty urinating Burning/pain with urination Wake up to urinate Dripping after urination Increased straining with urination	Discharge from penis Sore on penis History of STDs? Yes No Have been tested for STDs? Yes No  Premature ejaculation Painful ejaculation Erectile dysfunction Infertile Lack of sexual drive Sexual difficulties	Testicular lump Testicular pain Breast lump Monthly testicular/breast exam History of prostatitis Enlarged prostate Have had a prostate exam Have had a PSA Prostate cancer Pain/cold in genital area Hernias	Currently sexually active? Yes___ No___  Which gender are you sexually active with? Men___Women___ Both___  Type of birth control:  Type of STD control: Condoms Monogamy Other



## Past Medical History

Please check and provide the date of occurrence for the following conditions.

Condition	Date of occurrence or diagnosis	Condition	Date of occurrence or diagnosis	Condition	Date of occurrence or diagnosis
AIDS		Glaucoma		Rheumatic fever	
Alcoholism		Hepatitis		Scarlet fever	
Anemia		Hernia		Sexually transmitted disease	
Anorexia		Herpes		Stroke	
Appendicitis		High cholesterol		Suicide attempt	
Arthritis		Kidney disease		Thyroid problems	
Asthma		Liver disease		Tonsillitis	
Bleeding disorders		Measles		Tuberculosis	
Breast lump		Migraine headaches		Typhoid fever	
Bronchitis		Miscarriage		Ulcers	
Bulimia		Mononucleosis		Vaginal infections	
Cancer		Multiple sclerosis		History of motor vehicle accidents	
Cataracts		Mumps		History of physical trauma	
Chemical dependency		Pacemakers		History of physical abuse	
Chicken pox		Pneumonia		History of sexual abuse	
Diabetes		Polio		History of verbal abuse	
Emphysema		Prostate problems		History of violence	
Epilepsy		Psychiatric care		Exposure to toxins	

**Family History**

Relation	Age	State of health	Age of Death	Cause of Death	Condition	Do any of your blood relations have any of the following diseases?
Mother					Arthritis, gout	
Stepmother					Asthma	
Father					Bleeding tendency	
Stepfather					Cancer	
Brothers/stepbrothers					Chemical dependency/ alcoholism	
					Diabetes	
					Epilepsy	
Sisters/step sisters					Heart disease/ strokes	
					High blood pressure	
					High cholesterol	
					Hearing loss	
					Kidney disease	
Children/stepchildren					Mental health issues	
					Osteoporosis	
					Tuberculosis	
					Suicide	
					Other inheritable conditions	

**Personal History**

What are your personal goals?

What do you enjoy the most about your life?

Do you have a spiritual practice or participate in a religion?

What do you consider the strong point in your health or in your life?

What are your health goals?

For your health goals, where are you? (circle one)

- Beginning to think about change
- Know I need to make some changes
- Developing a plan of action
- In the process of taking action
- Refining my plan of action

What is a typical day for you? Please include what you typically eat and drink.

Any else I should know about you?

Thank you for taking the time to review your health history.