Joy Sturgill, N.D.
Doctor of Naturopathic Medicine
412.921.8329
www.drjoysturgill.com | info@drjoysturgill.com

Adult Information Form (Part I)

Today's Date:	Email:

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: / /	Age:	Sex: ☐ Male ☐ Female
Do you work full time? ☐ Yes ☐ No		Occupation:
Work Phone #: ( )		Home Phone #: ( )
Street Address:		P.O. Box:
City:	State:	ZIP Code:

Referred by: ☐ Dr. ☐ Internet ☐ Hospital ☐ Family ☐ Friend ☐ Yellow Pages ☐ Other

Other family members seen here:

CONTACT NUMBERS

Spouse/Partner/Parent Name:	Phone #: ( )

CURRENT HEALTH CARE TEAM

Your Primary Care Doctor:		Phone #: ( )
Specialty Doctor:	Type of care:	Phone #: ( )
Specialty Doctor:	Type of care:	Phone #: ( )
Specialty Doctor:	Type of care:	Phone #: ( )

Joy Sturgill, N.D.
Doctor of Naturopathic Medicine
412.921.8329
www.drjoysturgill.com | info@drjoysturgill.com

Patient Intake Form (page 1)

Name (Last, First, M.I.):

What are your goals for this visit?

What prior experiences have you had with alternative or complimentary medicine?

PRIORITIZE YOUR MOST IMPORTANT HEALTH CONCERNS TODAY:

CONCERN	ONSET (DATE)	SEVERITY (MILD/MOD/SEVERE)	FREQUENCY

WITH WHOM DO YOU LIVE? *(Include roommates, friends, partner, spouse, children, parents, relatives, pets)*

NAME	AGE	RELATIONSHIP

WHAT ARE THE MAJOR STRESSORS IN YOUR LIFE?

WHAT DO YOU DO TO RELIEVE STRESS? WHAT INTERESTS/HOBBIES DO YOU HAVE?

Joy Sturgill, N.D.
Doctor of Naturopathic Medicine
412.921.8329
www.drjoysturgill.com | info@drjoysturgill.com

Patient Intake Form (page 2)

WHAT PHYSICAL ACTIVITY DO YOU PARTICIPATE IN AND HOW OFTEN?

Describe your energy level:

Describe your sleep pattern:

DESCRIBE YOUR EXERCISE AND DIET:

Exercise:

- ☐ Sedentary *(no exercise)*
- ☐ Mild *(i.e., climb stairs, walk 3 blocks, golf)*
- ☐ Occasional vigorous *(i.e., work or recreation, less than 4x/week for 30 min.)*
- ☐ Regular vigorous *(i.e., work or recreation, 4x/week for 30 min.)*

Diet:

Are you currently on a special diet? *(foods avoid, vegetarian, etc.)* ☐ Yes ☐ No

Please explain:

# of meals you eat in an average day:

# of servings of fruit you eat in an average day:

# of servings of vegetables you eat in an average day:

What are your sources of protein?

What type of oil or spreads do you add to your food?

How often do you eat out?

Who prepares the meals at home?

Joy Sturgill, N.D.
Doctor of Naturopathic Medicine
412.921.8329
www.drjoysturgill.com | info@drjoysturgill.com

Patient Intake Form (page 3)

HOW WOULD YOU DESCRIBE YOUR RELATIONSHIP WITH FOOD?

DESCRIBE YOUR USE OF CAFFEINE AND ALCOHOL:

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Cola

# of cups/cans you drink per day:

What non-caffeinated beverages do you drink on a typical day?

How many non-caffeinated beverages do you drink on a typical day?

Alcohol: Do you drink alcohol? ☐ Yes ☐ No | If yes, what kind?

# of drinks per week:

DESCRIBE YOUR MENTAL HEALTH:

☐ Yes ☐ No	Is stress a major problem for you?
☐ Yes ☐ No	Do you feel depressed?
☐ Yes ☐ No	Do you panic when stressed?
☐ Yes ☐ No	Do you have problems with eating or your appetite?
☐ Yes ☐ No	Do you cry frequently?
☐ Yes ☐ No	Do you have trouble sleeping?
☐ Yes ☐ No	Have you seen a psychotherapist in the past? If yes, please explain:

Occupation: *(current)*

Occupation: *(past)*

Joy Sturgill, N.D.
Doctor of Naturopathic Medicine
412.921.8329
www.drjoysturgill.com | info@drjoysturgill.com

Patient Intake Form (page 4)

DESCRIBE YOUR PERSONAL HEALTH HISTORY:

Childhood Illnesses:	☐ Measles	☐ Mumps	☐ Rubella
	☐ Chickenpox	☐ Rheumatic Fever	☐ Polio
Immunizations:	☐ Tetanus	☐ Pneumonia	☐ Hepatitis
	☐ Chickenpox	☐ Influenza	☐ MMR Measles, Mumps, Rubella

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED:

SURGERIES:

YEAR	REASON	HOSPITAL

OTHER HOSPITALIZATIONS:

YEAR	REASON	HOSPITAL

☐ Yes ☐ No Have you ever had a blood transfusion?

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS: *(i.e. vitamins, inhalers, etc.)*

DRUG/VITAMIN NAME	STRENGTH	FREQUENCY TAKEN

Continued on next page

Joy Sturgill, N.D.
Doctor of Naturopathic Medicine
412.921.8329
www.drjoysturgill.com | info@drjoysturgill.com

Patient Intake Form (page 5)

(CONT'D.) LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS: *(i.e. vitamins, inhalers, etc.)*

DRUG/VITAMIN NAME	STRENGTH	FREQUENCY TAKEN

ALLERGIES TO MEDICATIONS:

DRUG NAME	REACTION YOU HAD

Please check the following conditions that apply to you. *(If a choice is given, please check the appropriate one.)*

- ☐ Alcoholism or Substance Abuse
- ☐ Anemia
- ☐ Arthritis/Joint Disease
- ☐ Blood Clots/Phlebitis
- ☐ Cancer*
- ☐ Diabetes
- ☐ Digestive *(UC. Crohns, IBS, etc.)*
- ☐ Easy Bleeding
- ☐ Frequent Sinusitis
- ☐ Gall Bladder
- ☐ Hay Fever ☐ Allergy ☐ Eczema
- ☐ Hearing Loss
- ☐ Heart Attack/Disease Failure
- ☐ Heart Murmur
- ☐ Headaches/Migraines
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Infertility
- ☐ Radiation Treatments
- ☐ Serious Injury or Accident*
- ☐ Stroke
- ☐ Urinary Difficulties *(Incontinence, UTI, etc.)*
- ☐ Lung Disease *(Asthma, COPD)*
- ☐ Pneumonia
- ☐ Sexually Transmitted Disease*
- ☐ Thyroid Disease
- ☐ Vision/Eye Problems
- ☐ Seizures/Epilepsy
- ☐ Skin Disease
- ☐ Tuberculosis
- ☐ Other

Notes from above conditions: *(*Types of cancer; serious accidents or injury; sexually transmitted disease)*

Joy Sturgill, N.D.
Doctor of Naturopathic Medicine
412.921.8329
www.drjoysturgill.com | info@drjoysturgill.com

Patient Intake Form (page 6)

WOMEN ONLY:

Age at onset on menstruation:	Date of last menstruation:	Period every how many days:

Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes ☐ No
Are you pregnant or breastfeeding?	☐ Yes ☐ No

Number of pregnancies:	Number of live births:

Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes ☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Any problems with control of urination?	☐ Yes ☐ No
Any hot flashes or sweating at night?	☐ Yes ☐ No
Any menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes ☐ No
Any recent breast tenderness, lumps, or nipple discharge?	☐ Yes ☐ No

Date of last pap and rectal exam:

Other problems:

MEN ONLY:

Do you have prostate problems?	☐ Yes ☐ No
Sexual dysfunction?	☐ Yes ☐ No
Testicular Cancer?	☐ Yes ☐ No
Vasectomy?	☐ Yes ☐ No

Other problems?

Joy Sturgill, N.D.
Doctor of Naturopathic Medicine
412.921.8329
www.drjoysturgill.com | info@drjoysturgill.com

Patient Intake Form (page 7)

REVIEW OF SYMPTOMS:

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Back
☐ Head/Neck	☐ Ears	☐ Eyes
☐ Nose	☐ Throat	☐ Lungs
☐ Intestinal	☐ Bladder	☐ Bowel
☐ Circulation		

Any recent changes in?	☐ Weight	☐ Energy level	☐ Ability to sleep

Other pain/discomfort:

FAMILY HEALTH HISTORY:

RELATION	AGE	SIGNIFICANT HEALTH PROBLEMS	RELATION	AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			***Children***	☐ M ☐ F	
MOTHER				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRANDMOTHER** MATERNAL		
	☐ M ☐ F		**GRANDFATHER** MATERNAL		
	☐ M ☐ F		**GRANDMOTHER** PATERNAL		
	☐ M ☐ F		**GRANDFATHER** PATERNAL		

Please feel free to use the remaining space to discuss anything else you wish me to know about your life, health, emotions, the kind of person you are, goals, concerns, etc. Thank you for taking the time to complete this form.