Dr. Jocelin Whitaker

7427 State Route 13, Bellville, OH 44813

Phone: 567-772-0164 E-mail: drjocelin@drjocelinwhitaker.com

Website: www.drjocelinwhitaker.com

Patient Intake Form

Name: _____ Date of Birth: _____ Age: _____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
What is the preferred way to reach you? _____ Best time to reach you: _____
Is it acceptable to leave a message? Y / N Email: _____
Sex: F / M Occupation: _____
Employer _____ Hours per week? _____
Emergency Contact: _____ Relationship: _____ Phone _____
Marital Status: Married Single Divorced Widowed Other: _____
Do you have children: _____ If yes, number of children _____ Do any still live with you _____

If the patient is under the age of 18:
Name of mother: _____ Phone number: _____
Name of father: _____ Phone number: _____

How did you hear of our clinic? _____
Have you been to a Doctor of Naturopathic Medicine before? _____ If so, when? _____
When did you last receive medical care? _____
Where? _____ Why? _____

What are your top 3 health concerns?

1. _____
2. _____
3. _____

Please list your current medications, including over-the-counter medications. Please include dosages:
_____
_____
_____
_____

Please list any supplements you are currently taking, including manufacturer, form, and dosages:
_____
_____
_____
_____
_____

Do you have any difficulty swallowing pills? Need small sized pills only? Liquids only? Please explain:
_____
_____

Do you have drug allergies? Food allergies? Other allergies? To what? For how long? _____
_____
_____

Where you immunized as a child? _____

Please list any known health issues with your families and indicate deceased or living:
Mother: Age ____ Living or Deceased Health Issues _____
Grandmother: Age ____ Living or Deceased Health Issues _____
Grandfather: Age ____ Living or Deceased Health Issues _____
Father: Age ____ Living or Deceased Health Issues _____
Grandmother: Age ____ Living or Deceased Health Issues _____
Grandfather: Age ____ Living or Deceased Health Issues _____
Siblings: _____

Personal Habits
Do you eat three meals per day? Yes No
Do you have a supportive relationship? Yes No
Have you had any major traumas? Yes No If so, what _____
Do you have a history of abuse? Yes No (physical, emotional or sexual)
Do you smoke? Yes No Year started _____
Have you smoked in the past? Yes No Year started _____ Year stopped _____
Do you now or have you ever used recreational drugs? Yes No
Do you now or have you ever used alcohol? Yes No If yes, frequency_____
Do you enjoy your job? Yes No

Sleep
Usual bedtime _____ Hours slept_____
Problems with falling asleep? Y N Waking up after your fall asleep? Y N Dreams and/or nightmares: Y N
Energy Level (1 = low, 10 = high): When waking up _____ Throughout the day _____

Please describe your normal day's fluid intake & amounts:
Water _____ Alcohol _____ Energy Drinks _____
Juice _____ Coffee/ Tea _____ Beer _____
Soda _____ Other _____
What type of water do you drink (Tap/filtered/spring) _____

Sleep, Rest, Stress, and Work Habits:
How many hours do you sleep (average) _____ Is it sound? _____
Do you wake-up feeling refreshed or tired? _____
Do you wake to void? _____ Do you have urinary urgency? _____
Do you always wake up at a certain time during the night? ____ If so, what time _____
Describe your energy level _____
Do you feel stressed? Yes No
If yes, what is your major stressor _____
What do you do when you are stressed? _____
Do you have a day of rest _____ How many days / hours do you work (per week) _____/_____
What types of exercise do you do? _____
Do you participate regularly in religious services and worship? Yes No
If you feel comfortable, please share what types of activities? _____

_____

How many bowel movements do you have #_____ per (month, week, day) _____

Please list all hospitalizations, surgeries /operations, Major or Minor (include approximate date): _____
_____
_____
_____
Please list all injuries, Major or Minor (include approximate date): _____
_____
_____
_____
Have you had any experiences (traumatic or otherwise) that did or still do affect you deeply? _____
_____
_____
_____

For women only:
Are you pregnant? _____ If so, number of month's _____
# of Pregnancies _____ # of Births _____
Gynecological history: _____
_____
_____
Do you use hormone replacement therapy? _____

Health Goals
What are your health goals? _____
_____
_____
_____
_____
What is your level of motivation regarding your healing? _____
_____
_____
_____
_____
What do you expect from your practitioner? _____
_____
_____
_____
_____

Signature: _____ Date: _____