Dr. Amy Hawkins, ND
NATUROPATHIC FAMILY WELLNESS
natural health for the whole family

Thank you for scheduling an appointment with Dr. Amy Hawkins, ND.

Please be sure to set aside some time to **complete the following forms and upload them to your ChARM portal prior to your first appointment**. If you are unable to scan and upload the forms to the portal, then you can instead fax them to Dr. Hawkins at 910.795.1365. If you are unable to complete this packet prior to your first appointment, then we will need to reschedule.

It is extremely helpful to **also upload any recent blood work, imaging results and any applicable assessments or reports to your portal prior to your first appointment.** If necessary, you can print the Authorization to Release Medical Information form from the website, fill it out and send it to your other doctors to have records sent directly to my office.

If you are unable to keep your scheduled appointment time, please provide me with at least 48 hours notice so that other clients may utilize that appointment time.

Thank you for entrusting me with your health. I look forward to meeting you and working together!

Adult Client Registration

Client Registration

Client..... Sex ❑ M ❑ F DOB .....SS#.....

Address ..... Home #..... Cell #.....

City/State/Zip ..... Email .....

Employer ..... Work #.....

Emergency Contact ..... Relation ..... Phone # .....

How did you hear about the practice? .....

Insurance Information

Primary ..... Claim Address.....

Policy #..... Group# .....Co-pay.....

Secondary..... Claim Address.....

Policy #..... Group# .....Co-pay.....

Name of Insured ..... DOB .....Relation .....

Dr. Amy Hawkins, ND
Naturopathic Family Wellness

ADULT INTAKE FORM

CLIENT INFORMATION

Name_____Date of Birth _____

Date of First Consult_____Age_____

My current gender identity is:_____ My sexual orientation is: _____

My sex assigned at birth is: _____ My pronouns are: _____

HEALTHCARE PROVIDERS

Primary Health Care Physician:_____Phone: _____

When was your last physical exam? _____

Are you currently under the care of a specialist? _____

Name:_____Specialty:_____Phone: _____

Name:_____Specialty:_____Phone: _____

List your primary health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you experienced any traumatic life events that you feel may be associated with any of your health concerns?

_____

_____

PERSONAL OVERVIEW

1. Improving health by addressing underlying imbalances often requires a commitment to lifestyle change and willingness to follow therapeutic protocols. How would you describe your present level of commitment? Rate on a scale from 1 to 10, with 10 indicating 100% commitment. (0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

2. Are there any potential obstacles you foresee in addressing the lifestyle factors that are undermining your health or in adhering to the therapeutic protocols that I will be sharing with you?

3. What expectations do you have of Dr. Amy Hawkins, ND?

HEALTH HISTORY

How would you describe your current state of health? Excellent Good Fair Poor

Are you currently being treated for a health care concern by other healthcare practitioners? Please explain.

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

List any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that you have experienced, along with the approximate date.

	Date		Date

List any X-rays, CT scans, blood work or other studies that you have had, along with the approximate date.

Study	Date	Study	Date

Has there been an event or illness from which you have never fully recovered?

Vitamins and Supplements

Please list all vitamin/mineral supplements, herbs, and homeopathic remedies you are currently taking:

Supplement (include brand)	Total daily dose	Reason for Use	Duration of Use

Prescription Medications

Please list all current medications and indicate the total dosage taken in one day:

Current Medications	Total daily dose	Reason for Use	Duration of Use

Please list any medications used in the past 12 months, but have now discontinued.

Medications

Do you regularly use any of the following?

Laxatives Pain Relievers Antacids Sleeping Pills Birth Control Pills

Did you receive antibiotics frequently as a child? _____

Have you ever taken antibiotics for an extended period of time? _____

How many times have you received antibiotics in the past five years? _____

Which vaccinations have you had? (please circle) Standard Childhood Vaccines and/or Other (please list)

Please list all medication allergies:

_____

_____

Have you ever had an anaphylactic reaction to a medication? _____

Adverse Reactions

Please describe any adverse reactions, allergies, or sensitivities you have experienced with prescription or over-the-counter medications, recreational drugs, vaccinations (childhood, travel, flu, hepatitis) or natural medicines (herbs, vitamins, minerals, homeopathics)

Name of drug, vaccine or natural medicine	Describe the reaction

Illnesses

Please indicate if you've had any of the following illnesses:

Scarlet fever_____Diphtheria_____Rheumatic fever_____Mumps_____Measles _____

German measles_____Chicken pox_____Shingles_____Tuberculosis _____

Family Medical History

	Father	Mother	Grandparents	Brothers	Sisters	Spouse	Child
Age (if living)							
Age when died							
Reason for death							

Do you have a family history that includes any of the following?

(Please circle and note Father (F), Mother (M), Maternal Grandmother (MGM), Paternal Grandmother (PGM), Child (C), etc.)

Alcoholism_____
Drug Addiction_____
Cancer (list type)_____
High Blood Pressure_____
Heart Disease_____
Heart Attack_____
Stroke_____
Anxiety_____
Depression_____
Other Mental Illness_____
Diabetes_____
Thyroid Disorder_____
Other Endocrine Disorder_____
Asthma_____
Tuberculosis_____
Other Respiratory Disorder_____
Allergies_____
Autoimmune Disease_____
Other Immune Disorder_____
Osteoporosis_____
Other Bone Disorder_____

Do you have any other significant family history that Dr. Hawkins should consider?

Nutrition & Diet

Do you follow a specific diet? (Vegetarian, Vegan, Pescatarian, Paleo, Keto, Gluten-free, etc)

What is your general approach to your nutrition? (Organic, Natural, Local, Home-cooked, Convenience, Take-out, etc)

What do you usually drink? (Water, Tea, Soda, etc)

Approximately how many servings of the following do you have each day:

Fruits & Vegetables	Luncheon/Smoked Meats	Coffee
Dairy Products	Meal Replacement bars/drinks	Soda
Bread and Baked Goods	Artificial Sweeteners	Wine/beer
Soy products (tofu, soy milk, etc)	Salty snack foods (chips, etc)	Other alcoholic drinks
Fast food	Sweets (candies, cookies, etc)	Glasses of water

Please use this space to do a dietary recall and list what you have had to eat and drink over the past 72 hours:

Breakfast	Lunch	Dinner	Snacks and/or Desserts

Breakfast	Lunch	Dinner	Snacks and/or Desserts

Breakfast	Lunch	Dinner	Snacks and/or Desserts

Is there anything about your diet you would like to change? _____

_____

On average how many meals do you have per day? 1 2 3 4 5 5+

List any foods that you crave regularly: _____

List any foods that you exclude from your diet: _____

Any known food allergies/intolerances/sensitivities? _____

_____

Lifestyle

Do you exercise? Y N What type and how often? _____

Do you spend time outdoors? Y N How much? _____

_____

How would you describe the emotional climate of your home?

_____

How would you rate your stress level? Low 1 2 3 4 5 6 7 8 9 10 High

How well do you handle these stressors? _____

_____

Please list the 5 most significant stressful events in your life, from most recent to most distant (include date):

1. _____
2. _____
3. _____
4. _____
5. _____

How would you rate your energy? Low 1 2 3 4 5 6 7 8 9 10 High

Has your energy level changed recently? Y N _____

Has your weight changed by more than 10lbs in the past 6 months? Y N _____

Do you utilize any mindfulness techniques? (Meditation, Yoga, Prayer, etc) Y N _____ How often? _____

Do you have a religious or spiritual practice? _____

Sleep

How many hours of sleep do you typically get? _____

Do you fall asleep easily and sleep soundly? Y N _____

Do you feel refreshed upon waking? Y N _____

Do you have a regular sleep routine? Y N _____

Other

Do you drink alcohol? Y N How many drinks per day/week? _____

Do you smoke cigarettes? Y N How many per day and for how many years? _____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Y N If so, please describe.

Do you have any other significant lifestyle factors that Dr. Hawkins should consider? If so, please describe:

MEDICAL HISTORY & REVIEW OF SYSTEMS

Please circle symptoms that you are experiencing and/or positive history items.

General
- Weight loss
- Weight gain
- Fatigue
- Difficulty sleeping
- Chronic pain
- Fevers
- Chills
- Sweats

Skin and Hair
- Hair loss
- Rash
- Sores that don't heal
- Lesion or mole changing in size, shape, or color
- Itching
- Dry skin

Vision
- Chronic or past eye disorders
- Decrease in vision
- Change in vision
- Blurry vision
- Double vision
- Eye pain
- Eye discharge
- Red eye
- Dry eye

Head and Neck
- Chronic or past head and neck disorders
- Pain
- Sores or non-healing ulcers in/around mouth
- Masses or growths
- Change in hearing acuity
- Ear pain
- Ear discharge
- Nasal congestion
- Nasal discharge
- Post nasal drip
- Change in voice
- Hoarseness
- Tooth pain or problems
- Sense of lump or mass in throat with swallowing

Pulmonary
- Chronic or past pulmonary (lung) disorders
- Shortness of breath – at rest or with exertion
- Chest pain
- Cough
- Hemoptysis (coughing up blood)
- Wheezing
- Snoring
- Sleep apnea

Cardiovascular
- Chronic or past cardiovascular disorders or cardiac events
- Chest pain or pressure
- Hypertension
- High cholesterol
- Shortness of breath – at rest or with exertion
- Orthopnea (shortness of breath when lying down)
- Swelling and/or edema of hands/feet/other
- Syncope (sudden loss of consciousness)
- Heart palpitations (sense of rapid or irregular heartbeat)
- Calf and/or leg pain and/or cramps with walking
- Wounds or ulcers on feet
- Wounds or ulcers that are difficult or slow to heal
- Deep leg pain
- Varicose veins
- Cold hands/feet/other
- Numbness or tingling in hands/feet/other

Gastrointestinal
- Chronic or past GI disorders
- Heartburn/reflux
- Abdominal pain
- Difficulty swallowing
- Pain with swallowing
- Nausea or vomiting
- Abdominal swelling or distention
- Jaundice (yellowish coloration or skin)
- Hematemesis (vomiting blood)
- Black/tarry stool OR grey stool OR yellow stool
- Bloody stool
- Constipation or diarrhea
- Flatulence or eructation (burping)
- Other change in bowel habits

MEDICAL HISTORY & REVIEW OF SYSTEMS (continued)

Genitourinary

- Chronic or past GU disorders
- Blood in urine
- Burning with urination
- Nocturia (urination at night)
- Incontinence (unintentional loss of urine)
- Urinary urgency
- Urinary frequency
- Incomplete urinary emptying
- Urinary hesitancy
- Decreased force of stream
- Need to void soon after urinating

Male Genitourinary

- Erectile dysfunction (ED)
- Penile discharge or pain
- Testicular pain or swelling or mass
- Prostate pain or enlargement or prostatis
- Penile ulcers or growths
- Fertility problems
- History of STI (sexually transmitted illness)
- Are you sexually active? Y N How many partners do you have?

Do you have a history of sexual abuse and/or trauma?

If so, are you comfortable discussing this with Dr. Hawkins as part of your overall care?

Female Genitourinary/OBGYN/Breast

Age at first menses?	Are you sexually active?
Age at last menses? (if menopausal)	How many partners do you have?
Typical duration of bleed? (days)	Birth control? What type?
Typical length of cycle? (days)	Difficulty conceiving?
Are cycles regular?	Pain during intercourse?
PMS?	Number of pregnancies?
Painful menses?	Number of live births?
Heavy or excessive flow?	Number of miscarriages?
Bleeding between periods?	Number of abortions?
Clotting during menses?	Chlamydia?
Unusual vaginal discharge?	Herpes?
Vaginal itching?	Condyloma? (i.e. genital warts)
Vaginal dryness?	Syphilis?
Date of last PAP?	History of other STI (sexually transmitted illness)?
Abnormal PAP?	Have you had a DEXA bone scan?
Cervical dysplasia?	Have you had a mammogram(s)?
Endometriosis?	Do you do breast self-exams?
Ovarian cysts?	Breast pain or tenderness?
Menopausal Symptoms? (list below)	Breast lumps?
	Nipple Discharge

Do you have a history of sexual abuse and/or trauma?

If so, are you comfortable discussing this with Dr. Hawkins as part of your overall care?

MEDICAL HISTORY REVIEW OF SYSTEMS (continued)

Hematology/Oncology
- o Chronic or past blood disorder
- o Chronic or past oncologic disease (cancer)
- o Anemia
- o Easy bleeding or bruising
- o Fever, chills, sweats, weight loss
- o New or growing lumps or bumps
- o Hypercoagulability (clotting)
- o Bleeding disorder
- o History of blood transfusion

Neurological
- o Chronic or past neurological disorder
- o Sudden loss of neurological function
- o Abrupt loss/change in level of consciousness
- o Seizure activity
- o Numbness or tingling in hands/feet/other
- o Weakness
- o Dizziness
- o Balance problems
- o Speech problems
- o Involuntary movement(s)
- o Headache
- o Memory loss
- o Loss or change in smell or taste sensation

Endocrine
- o Known endocrine disorder
- o Polyuria (excessive urination)
- o Polydipsia (excessive thirst)
- o Polyphagia (excessive appetite)
- o Hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar)
- o Heat or cold intolerance
- o History of chronic stress
- o History of significant blood loss

Immune & Infectious Disease
- o Known immune or autoimmune disorder
- o Known infectious disease
- o Fatigue
- o Fever, chills, sweats, weight loss
- o History of tick or Lyme exposure
- o History of mold exposure
- o History of mononucleosis
- o Chronically swollen glands
- o Frequent cold/flu
- o Chronic infection(s)
- o Allergies

Musculoskeletal
- o Known musculoskeletal disease
- o Joint pain or stiffness
- o Joint swelling
- o Localized muscle pain or spasms
- o Generalized muscle pain
- o Weakness
- o Neck pain
- o Back pain (location)
- o Hand/Wrist/Elbow/Shoulder/Foot/Knee/Hip pain (circle specific location)

Mental/Emotional
- o Current diagnosis of mental health disorder
- o Mood swings
- o Poor concentration
- o Memory loss
- o Phobias
- o Anxiety or nervousness
- o Depression
- o Seasonal depression
- o Considered or attempted suicide
- o Alcohol or other substance abuse

Allergies (medication, environmental, food):_____

_____

_____

_____

Is there anything else that you would like to add or comment on?