Lylen Ferris
NATUROPATHIC PHYSICIAN

New Patient Intake Form

Please fill this form out entirely and email it back to Dr. Ferris before your first office visit.

Today's Date: _____

Name: _____

Date of Birth: _____ Gender:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone:_____ Work Phone: _____

Cell Phone: _____ Email: _____

Occupation: _____

Employer: _____

Describe your work: _____

Hours worked per week: _____ Do you live alone? _____

If no, with whom do you live? _____

Parents names if under 18 years old: _____

Emergency Contact Information

Name of Contact: _____

Phone number of contact: _____

Relation to Contact: _____

Dr. Ferris will need to reach you by phone/email from time to time. In order to ensure your privacy, please select the place you would like messages left for you.

☐Home message machine ☐Email ☐w/ family members ☐Cell phone voicemail ☐Work

drylylenferris@gmail.com // www.drlylenferris.com

Lylen Ferris
NATUROPATHIC PHYSICIAN

New Patient Intake Form

What are your long term personal goals for our working together? _____

_____

_____

_____

What are your primary health concerns? _____

_____

_____

When was the last time you received medical care and why? _____

_____

_____

Are you currently under a physician's care? _____

If yes, physician's name: _____

Date of last physical exam: _____ Date of last blood work: _____

Women

Last annual exam: _____ Last menstrual period: _____

Number of pregnancies: _____ Birth control history: _____

_____

Children (names and ages): _____

_____

_____

drylylenferris@gmail.com // www.drlylenferris.com

Lylen Ferris
NATUROPATHIC PHYSICIAN

New Patient Intake Form

General Information

Blood Type: _____ Height: _____ Weight: _____

Weight 1 year ago: _____ Maximum weight: _____

When were you at your maximum weight? _____

When during the day is your energy and alertness *best?* _____

When during the day is your energy and alertness *worst?* _____

Primary interests and hobbies. What do you do to relax? _____

_____

_____

_____

Exercise (type and frequency): _____

_____

_____

How many hours of sleep do you get per day? _____

What is your quality of sleep? _____

Describe any sleep problems you may have: _____

_____

_____

What are the major stressors in your life? _____

_____

_____

drylylenferris@gmail.com // www.drlylenferris.com

Lylen Ferris
NATUROPATHIC PHYSICIAN

New Patient Intake Form

Do you consume tobacco? Yes/No

If yes, how much per day: _____

How long have you been using tobacco? _____

Do you consume caffeine? Yes/No

If yes, how much per day: _____

How long have you been using caffeine? _____

Do you consume alcohol? Yes/No

If yes, how many drinks per day: _____

How long have you been using alcohol? _____

How much water do you drink per day? _____

List your typical diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Do you avoid foods for any reason? _____

drylylenferris@gmail.com // www.drlylenferris.com

Lylen Ferris
NATUROPATHIC PHYSICIAN

New Patient Intake Form

How many bowel movements per day: _____

Any bowel concerns? _____

Are you aware of having allergies to any of the following? If so, describe your reaction to each one:

Drugs: _____

Foods: _____

Chemicals/Perfumes: _____

Animals: _____

Other: _____

Which diagnostic studies have you had in the past year?

☐Electrocardiogram (EKG)
☐Electroencephalogram (EEG)
☐XRay
☐Mammogram
☐Bone Density Scan (DEXA)
☐MRI
☐CT Scan
☐Other: _____

Which medications, either by prescription or over-the-counter, are you taking or have you taken in the past 6 months?

☐Laxatives
☐Antibiotics
☐Pain Relievers
☐Tranquilizers
☐H2 Blockers/Ulcer Medication
☐Thyroid medication
☐Antacids
☐Cholesterol-lowering medication
☐Cortisone/Prednisone
☐Sleeping medication
☐Appetite Suppressants
☐Other_____
☐Antidepressants

drylylenferris@gmail.com // www.drlylenferris.com

Lylen Ferris
NATUROPATHIC PHYSICIAN

New Patient Intake Form

Please list all medications (prescription and overthecounter) and vitamins/supplements/herbs you are currently taking (and tell me why you are taking them). Include dosage, if known.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

drylylenferris@gmail.com // www.drlylenferris.com

Lylen Ferris
NATUROPATHIC PHYSICIAN

New Patient Intake Form

Initial Health Systems Checklist

As a new patient, please check any items that have concerned you in the last YEAR. We will use this sheet to track progress over future visits.

General	☐No Complaints	☐Weight Loss	☐Fatigue	☐Mood Changes	☐Harder Time Exercising
	☐Stress	☐Weight Gain	☐Insomnia	☐Changes in Strength	☐Other: _____
Head/Ear	☐No Complaints	☐Dizziness	☐Head Trauma	☐Changes in Hearing	☐Other: _____
	☐Mental Fog	☐Headaches	☐Ringing in Ears	☐Bleeding from Ears	
Eyes	☐No Complaints	☐Double Vision	☐Eye Pain	☐Blurring of Vision	☐Other: _____
	☐Changes in Vision	☐Excessive Tearing	☐Blind Spots	☐Corrective Lenses	
Nose/Mouth	☐No Complaints	☐Frequent Bleeding	☐Bleeding Gums	☐Cold/Canker Sores	☐Other: _____
	☐Congestion	☐Nasal Discharge	☐Nasal Obstruction	☐Use of Dentures	
Neck/Throat	☐No Complaints	☐Neck Pain	☐Lumps/Bumps	☐Difficulty Swallowing	
	☐Neck Stiffness	☐Neck Tenderness	☐Sore Throat	☐Other: _____	
Breast	☐No Complaints	☐Tenderness	☐Pain	☐Other: _____	
	☐Lumps	☐Swelling	☐Nipple Discharge		
Chest/Lung	☐No Complaints	☐Cough	☐Spitting up Blood	☐Pain with Breathing	
	☐Wheezing	☐Short of Breath	☐Many Infections	☐Other: _____	
Cardiovascular	☐No Complaints	☐High Cholesterol	☐Leg Swelling	☐High Blood Pressure	☐Short of Breath w/ laying
	☐Chest Pain	☐Irregular Beat	☐Cold Hands/Feet	☐Loss of Consciousness	☐Other: _____
Abdomen/Digestion	☐No Complaints	☐Abdominal Pain	☐Diarrhea	☐Heartburn	☐Bowel Movements/Day
	☐Nausea/Vomiting	☐Change in Appetite	☐Constipation	☐Blood in Stool	☐Other: _____
Urination	☐No Complaints	☐Frequency	☐Urgency	☐Frequent Infections	☐Other: _____
	☐Painful Urination	☐Incontinence	☐Dribbling	Incomplete Emptying	
Women's Health	☐No Complaints	☐Pain with Menses	☐Pelvic Pain	☐Difficulty Conceiving	☐Cycle Length: Days
	☐Change in Menses	☐Vaginal Discharge	☐Cramping	☐Spotting	☐Other: _____
Musculoskeletal	☐No Complaints	☐Muscle Soreness	☐Muscle Tension	☐Numbness/Tingling	☐Other: _____
	☐Muscle Cramps	☐Muscle Weakness	☐Joint Pain	Limited Range of Motion	
Neurological	☐No complaints	☐Seizures	☐Change in Sleep	☐Loss of Coordination	☐Depression
	☐Tremor	☐Mental Changes	☐Memory Changes	☐Cognitive Impairment	☐Other: _____
Skin/Hair	☐No Complaints	☐Easy bruising	☐Rash	☐Texture Changes	☐Changes in Nails
	☐Dryness	☐Slow healing	☐Color Changes	☐Thinning Hair	☐Other: _____

drylylenferris@gmail.com // www.drlylenferris.com

Lylen Ferris
NATUROPATHIC PHYSICIAN

New Patient Intake Form

Major illnesses/injuries/surgeries/hospitalizations (describe and date):

_____

_____

_____

_____

Significant family history (cancer, cardiovascular disease, mental health concerns, thyroid issues, etc):

_____

_____

_____

Other information you would like me to know: _____

_____

_____

_____

Thank you! I look forward to working with you!

- Dr. Ferris

drylylenferris@gmail.com // www.drlylenferris.com