



Welcome! We're so glad you're here and honored to support you on your journey to better health.

Our team of licensed Naturopathic Doctors specializes in natural, preventive, and personalized care. Your first step is completing this intake form, which helps us understand your health history, goals, and current concerns. This information allows us to deliver individualized care as unique as you are. **If you need help with these forms please call us at 970-237-1062.**

To help us prepare for your visit:

- Please fill out all forms completely and **submit them at least 24 hours before your appointment. Failure to do so will result in your appointment being rescheduled.**
- **If applicable, please have your last 2 years of labs ready for us to review**
 - You can bring hard copies into the clinic before or at the time of your appointment.
 - You can upload and share them in our patient portal. To do this you will click on documents, upload the labs and then be sure to click the **share** button. Please note; if you are pulling labs from another portal, you will have to download them first, then follow the above prompts within our portal.
 - You can email them to reception@rockymountain-naturalmedicine.com

We look forward to working together toward better health.

Warmly,

Drs. Holly German, Sarah Kashdan, Jason Barker, and Lorraine Caron

Financial & Cancellation Policy Agreement

Thank you for choosing **Rocky Mountain Natural Medicine**. We are committed to providing you with exceptional care. Please review our financial and cancellation policies below. Your acknowledgment is required to keep your appointment.

Financial Policy

- Payment is due at the time of service. We accept cash, checks, and major credit cards.
- A credit card is securely collected and stored when scheduling your initial visit.
- We reserve the right to charge your card on file for:
 - Phone/TeleHealth appointments
 - Missed appointments or late cancellations
- Our services are not covered by insurance in Colorado. You are responsible for all charges.
- We can provide applicable codes if you wish to submit a claim to your insurer.
- You may try to use a Health Savings Account (HSA) for some prescribed supplements.
- After 2 years of no appointments, you are then moved to “inactive” patient status and will need to repeat your new patient visit to become active again.

Service Fees (estimates):

- New Teen/Adult Patient Visit: \$385
- New Patient Pediatric Visit: \$285-\$385
- Initial Well Child Visit: \$250
- Follow-Up Naturopathic Visits: \$99- \$210 (based on length of time + complexity)
- New Acupuncture Patient: \$175
- Acupuncture Follow-Up: \$90
- B12 shot \$30
- Cupping/Gua Sha \$45-60

Lab Testing Estimates (discussed during your visit):

- Hormone Profiles: \$250–\$600
 - Food Intolerance Tests: \$275–\$375
 - GI Testing: \$310–\$555
 - Bloodwork Panels: \$75-350
 - Many other functional labs we have access to will fall within these same fee ranges
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Cancellation & Missed Appointment Policy

New Patients:

- A \$200 deposit is required at booking a new naturopathic visit, it will be applied to your visit
- A \$100 deposit is required at booking a new acupuncture visit, it will be applied to your visit.
- 48-hour cancellation notice is required for all new patient visits
- Late cancellations, no shows or a late reschedule (less than 48 hours) will result in forfeiture of the deposit
- Intake forms must be completed at least 24 hours prior to your appointment. If not, your appointment will be rescheduled.

Returning Patients:

- A 24-hour cancellation notice is required.
- Same-day cancellations or no shows will be charged a \$100 fee to the card on file.

I have read the cancellation and financial policies above and I understand and agree with these policies

Print Name: _____

Signature: _____

Date: _____

Consent to Naturopathic Care, Notice of Privacy Practices, and Required Disclosures

This document provides information about our services and policies, outlines your rights, and obtains your consent to care. Please read thoroughly and ask any questions before signing.

1. CONSENT FOR TREATMENT

I voluntarily consent to receive care from the naturopathic doctors at RMNM. This care may include physical exams, diagnostic lab testing, nutrition and lifestyle counseling, botanical or nutritional supplements, and manual therapies as indicated. I understand that the scope of naturopathic medicine is individualized and emphasizes prevention and the support of the body's natural healing ability.

I understand that no guarantees or promises of cure or specific results have been made.

If the patient is a minor, I confirm that I am the parent or legal guardian and authorize the naturopathic doctors at RMNM to evaluate and treat my child. I understand that treatment recommendations may include the same types of services listed above, tailored appropriately for a minor, and that I may be asked to provide additional consent for specific therapies.

2. SCOPE OF SERVICES

Naturopathic Medicine is a distinct branch of the healing arts that includes:

- Prevention, diagnosis, and treatment of conditions using non-pharmaceutical approaches
- Nutrition and lifestyle recommendations
- Botanical medicine and natural health products
- Manual therapies (soft tissue techniques, mobilizations)
- Evaluation of laboratory results and functional lab testing

RMNM's Naturopathic Doctors (NDs) are registered in the state of Colorado under the Colorado Naturopathic Doctor Act. They are not licensed Medical Doctors (MD), Doctors of Osteopathy

(DO), Chiropractors (DC), or Nurse Practitioners (NP), and do not prescribe or administer controlled substances, perform surgery, or use ionizing radiation.

At this time, RMNM does not provide naturopathic care for children under 2 years old. We recommend that all pediatric patients maintain care with a licensed pediatric provider and follow the CDC's recommended vaccination schedule.

3. RISKS

I understand that while naturopathic medicine is generally considered safe, it may involve some risks. These may include, but are not limited to:

- Allergic reactions to herbs, supplements, or treatments
- Side effects such as digestive upset, skin irritation, fatigue, or discomfort
- Temporary worsening of symptoms
- Changes in mood or energy
- Physical risks such as bruising or soreness after manual therapy, injections, or acupuncture
- In rare cases, serious adverse effects (e.g., pneumothorax with manual treatment or acupuncture)

I also understand that some naturopathic interventions may interact with prescription medications, and that naturopathic care may not be appropriate during certain phases of pregnancy or for specific medical conditions.

4. ALTERNATIVES AND COLLABORATION

I understand that alternatives to naturopathic care include:

- Choosing not to pursue any treatment

- Receiving care from licensed conventional providers, such as MDs or DOs
- Exploring other licensed healthcare modalities

I acknowledge that naturopathic care is not a substitute for conventional medical treatment. I am encouraged to maintain a relationship with a primary care physician or specialist, and to seek immediate medical attention for urgent or emergency conditions. I may also authorize RMNM to collaborate with my other providers upon request.

Optional: Provider(s) you would like us to collaborate with:

Name: _____ **Phone:** _____

5. EMERGENCIES

RMNM is not a primary care or urgent care clinic and does not provide 24-hour or emergency care.

If you are experiencing a medical emergency, **call 911 or go to the nearest emergency room.**

6. NO GUARANTEE

I understand that every individual responds differently to treatment. I acknowledge that no outcome can be guaranteed, and that naturopathic care may or may not improve my condition.

PATIENT ACKNOWLEDGMENT

By signing below, I confirm that:

- I have read and understood the information above
- I have had the opportunity to ask questions and receive answers
- I understand the nature, scope, and risks of naturopathic care
- I consent to treatment with the providers at Rocky Mountain Natural Medicine

Patient Name (print): _____

Signature: _____ **Date:** _____

If signed by someone other than the patient:

Name of Legal Representative: _____

Relationship to Patient: _____

1. PRIVACY PRACTICES (HIPAA NOTICE)

I have been provided access to Rocky Mountain Natural Medicine's **Notice of Privacy Practices**, which describes how my protected health information (PHI) may be used and disclosed, and how I can access this information. I understand:

- I may request a paper or electronic copy of the notice at any time.
 - I have the right to request limits on the use or disclosure of my PHI.
 - RMNM may share my PHI for treatment, billing, clinic operations, or when required by law.
 - RMNM is committed to maintaining the confidentiality and security of my health records and will notify me if a breach of my PHI occurs.
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2. COLORADO SURPRISE/BALANCE BILLING DISCLOSURE

I acknowledge that:

- Rocky Mountain Natural Medicine is **an out-of-network provider** and does not bill or contract with any insurance plans.
- I am responsible for the full cost of services rendered at this facility.
- Under Colorado law, I am protected from "surprise billing" for emergency services or services received unintentionally from out-of-network providers at in-network facilities.

- These protections do not apply to nonemergency, elective care at RMNM, where services are intentionally sought out-of-network.

I understand that I have the right to receive care from an in-network provider and am under no obligation to receive services at RMNM.

PATIENT ACKNOWLEDGMENT & CONSENT

By signing below, I confirm the following:

- I have read and understood this document in full.
- I consent to receive naturopathic medical care from RMNM.
- I acknowledge receipt of the Notice of Privacy Practices and Colorado Surprise Billing Disclosure (these are on our website, in your patient portal, and available in hard copy form at our front desk)
- I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (print): _____

Patient Signature: _____

Date: _____

I acknowledge receipt of the HIPAA Notice of Privacy Practices

I acknowledge receipt of the Colorado Surprise Billing Disclosure

If signed by someone other than the patient:

Name of Guardian or Legal Representative: _____

Relationship to Patient: _____

New Patient Intake Form

Name you go by: _____ Date: _____

Legal Name (if different): _____

Pronouns (check all that apply): she/her/hers he/him/his they/them/theirs
 Not listed (please specify): _____ Prefer not to answer

DOB: _____ Age: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone (home): _____ Work: _____ Cell: _____

Email: _____

Preferred contact method: home work cell email text

May we leave a message? home work cell email text

Gender: _____ Prefer not to answer

Sex assigned at birth: Female Male Intersex, assigned intersex
 Intersex, assigned female Intersex, assigned male Unsure

Legal sex/gender: (sex/gender on driver's license or on record with insurance company)

Female Male Intersex Nonbinary Not listed (please specify): _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Use the name I go by, pronouns, honorific, etc. provided on my general intake form when communicating with this emergency contact.

Use your legal information to refer to me with this emergency contact whenever possible

Current Primary Care Provider: _____

Contact Information: _____

Other specialists/providers involved in your care:

Have you seen a naturopathic doctor before? Yes When? _____ No

How did you hear about us? _____

If someone referred you, who? _____ Do we have permission to send them a thank you note? _____

Primary Health Concerns

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

What is your top priority for today? _____ (*Chief Complaint)

Allergies

Are you allergic or sensitive to:

- **Drugs:**(drug allergy widget?) _____
 - **Foods:** _____
 - **Environmental/Chemicals:** _____
-

Social History

Relationship status: (check all that apply)

- Single Married Separated Divorced Widowed
- In relationship(s) but not married In relationship(s) with multiple partners
- Not listed (please specify): _____

What is your home/living situation? _____

Do you live with other people or pets and if so, who? _____

Is there someone who can care for you at home? Yes No

What is your occupation? _____ Hours per week _____

Interests/ hobbies/ leisure activities: _____

Exercise? Yes Type: _____

Do you recover well after exertion? Yes No

Do you have a socially/ emotionally supportive community? Yes No

Family History

Check any that apply in your family:

Cancer (If yes, what kinds? _____)

Epilepsy Diabetes Arthritis Asthma Allergies

Anemia Heart disease Glaucoma Stroke Substance Abuse Mental health

Osteoporosis Kidney disease High blood pressure Tuberculosis High cholesterol Thyroid Disease Celiac Clotting Disorder Genetic Disease

Gastrointestinal concerns Reproductive Disease Migraines Neurodevelopmental

Mother's age (or age of death): _____ Overall Health: _____

Father's age (or age of death): _____ Overall Health: _____

Other relevant family history: _____

Adopted or unaware of family history? _____ Ethnic heritage: _____

Childhood Illnesses

Measles Chickenpox Mumps Rheumatic Fever Diphtheria

Scarlet Fever German Measles Asthma Eczema Strep Mono/EBV

Immunizations:

Are you up to date on current immunizations? Yes No Some

Medical History

Hospitalizations/Surgeries/Special Diagnostic Tests:

- _____ Year: _____
- _____ Year: _____
- _____ Year: _____

Dates of last screening exams (if applicable):

- Dental Recently In the last year More than a year ago Never I can't recall
- Eye Recently In the last year More than a year ago Never I can't recall
- Mammo Recently In the last year More than a year ago Never I can't recall
- Breast exam Recently In the last year More than a year ago Never I can't recall
- PAP Recently In the last year More than a year ago Never I can't recall
- Colonoscopy Recently In the last year More than a year ago Never I can't recall
- PE Recently In the last year More than a year ago Never I can't recall
- DEXA Recently In the last year More than a year ago Never I can't recall
- Bloodwork Recently In the last year More than a year ago Never I can't recall
- Prostate Recently In the last year More than a year ago Never I can't recall
- If there are other specialists/providers in your care, when was the last time you saw them? Recently In the last year More than a year ago Never I can't recall

Medications/Supplements (please list all, include over the counter meds):

Do you use any of the following regularly?:

- Laxatives Antacids Pain Relievers Hormonal Birth Control IUD
 Corticosteroids Antibiotics Sleeping Pills Hormone Replacement Nasal Sprays
 Inhalers Topical medications Medicated shampoo Intravaginal or Intrarectal medications Medical marijuana

Do you have a history of frequent antibiotic use? Yes No

Do you have a history of frequent steroid use (topical, injections, oral, inhaled)? Yes No

Height: _____ **Weight:** _____

- Prefer not to answer/Don't know Prefer not to have weight taken

Have you had a significant recent weight change (increase or decrease)? Yes No

Best time of day for energy: _____ **Worst:** _____

Average energy level: (1–10) _____

Smoke/Vape? Current Past Never **Packs/cartridges/day:** _____

How many years? _____

Other tobacco use? Current Past Never

Recreational drug use? Current Past Never

What kind? _____

Treated for substance dependence? Yes No **When?** _____

Alcohol use? Current Past Never

Frequency? _____ **Any concerns about dependency?** _____

Environmental History:

Any past or present exposure to water damage or mold? Current Past Never

Any exposure to herbicides and pesticides? Current Past Never

Any exposure to heavy metals (lead, cadmium, arsenic etc)? Current Past Never

Do you have any metal implants? Yes No

Exposure to wildfire smoke? Yes No

Exposure to radon, asbestos, carbon monoxide? Yes No

Do you live near a golf course or fracking location? Current Past Never

Do you have mercury dental fillings? Current Past Never

Any known tick-bites? Recent Past Never

Do you use any scented products (e.g., air fresheners, candles, cleaning sprays)? Current
 Past Never

What is your drinking water source (s)? Tap Well Filtered Bottled

Do you have any occupation-related chemical or biological exposures? Current Past
Never

Diet:

Do you eat 3 meals/day? Yes No

Is your relationship with food: Easy Neutral Difficult

Eat out often? Yes No

Typical meals:

- Breakfast: _____
- Lunch: _____

- Dinner: _____
- Snacks: _____
- Drinks: _____

Dietary Habits:

- Special diet? _____
- How often do you consume:
 - Soft drinks (incl. diet soda): _____
 - Artificial sweeteners _____
 - Caffeinated Drinks (coffee, soda, tea, energy drinks): _____
 - Processed meats: _____
- Gluten: _____
- Dairy: _____
- Water intake: _____ 8oz glasses/day
- Do you have frequent cravings? What for? _____
- Do you have any known food intolerances? Or foods that make you feel poorly?

Review of Systems

Mark each symptom as current (C) or past (P) by checking the boxes.

C = Current P = Past If never, simply skip that section.

Eyes

Symptom	C	P	Symptom	C	P
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Impaired vision	<input type="checkbox"/>	<input type="checkbox"/>	Glasses/ contacts	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Spots in vision	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Color blindness	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain/strain	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Tearing or dryness	<input type="checkbox"/>	<input type="checkbox"/>	Itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>
Dark circles under eyes	<input type="checkbox"/>	<input type="checkbox"/>	Yellowing of eyes	<input type="checkbox"/>	<input type="checkbox"/>

Ears & Mouth

Symptom	C	P	Symptom	C	P
Impaired hearing	<input type="checkbox"/>	<input type="checkbox"/>	Ringing or buzzing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Ear fullness	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth		
Jaw/TMJ problems	<input type="checkbox"/>	<input type="checkbox"/>	Teeth grinding	<input type="checkbox"/>	<input type="checkbox"/>
Dental cavities	<input type="checkbox"/>	<input type="checkbox"/>	Canker sores	<input type="checkbox"/>	<input type="checkbox"/>
Sore gums	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
Sore tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>	Cracked lips	<input type="checkbox"/>	<input type="checkbox"/>
Change in taste	<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Bad taste in mouth	<input type="checkbox"/>	<input type="checkbox"/>

Nose & Throat

Symptom	C	P	Symptom	C	P
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Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Loss of or change in smell	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Bad odor in nose	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Burning in throat	<input type="checkbox"/>	<input type="checkbox"/>	Sore throats		
Post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>

Head, Neck & Neurological

Symptom	C	P	Symptom	C	P
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands/ Lumps in neck	<input type="checkbox"/>	<input type="checkbox"/>	Pain/stiff neck	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/vertigo/ lightheaded	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/ Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	Speech difficulty	<input type="checkbox"/>	<input type="checkbox"/>

Brain Fog

Gastrointestinal / Digestive

Symptom	C	P	Symptom	C	P
Appetite changes	<input type="checkbox"/>	<input type="checkbox"/>	Thirst changes	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/reflux	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain or discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Belching/gas/bloating	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	IBS	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Gallbladder or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>
Blood or mucus in stool	<input type="checkbox"/>	<input type="checkbox"/>	Undigested food in stool	<input type="checkbox"/>	<input type="checkbox"/>
Parasitic Infection	<input type="checkbox"/>	<input type="checkbox"/>			
Food Poisoning	<input type="checkbox"/>	<input type="checkbox"/>	Painful Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>

Bowel movement frequency? _____x/week

Stool Consistency? Hard
Formed Soft
Watery Oily

Stool Color: Brown
 Green Yellow Black
 Pale Orange

Cardiovascular & Respiratory

Symptom	C	P	Symptom	C	P
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Murmurs	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack (MI)	<input type="checkbox"/>	<input type="checkbox"/>	High triglycerides	<input type="checkbox"/>	<input type="checkbox"/>
High/Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Calf pain	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in ankles/feet	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Sputum	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Painful/difficult breathing	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis/emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia/pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Raynaud's		
POTS	<input type="checkbox"/>	<input type="checkbox"/>			

Skin

Symptom	C	P	Symptom	C	P
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Itching/rashes	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Dry/cracked skin	<input type="checkbox"/>	<input type="checkbox"/>	Bumps on back of arms	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	Acne/boils	<input type="checkbox"/>	<input type="checkbox"/>
Warts/lumps	<input type="checkbox"/>	<input type="checkbox"/>	Color/texture changes	<input type="checkbox"/>	<input type="checkbox"/>
Hair/nail changes	<input type="checkbox"/>	<input type="checkbox"/>	Strong body odor	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Dandruff	<input type="checkbox"/>	<input type="checkbox"/>	type: _____		

Endocrine & Blood/Immune

Symptom	C	P	Symptom	C	P
Diabetes/hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Hunger/thirst changes	<input type="checkbox"/>	<input type="checkbox"/>			
Hot/cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Hair distribution changes	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding/bruising	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Chronic infections	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent fever	<input type="checkbox"/>	<input type="checkbox"/>	Frequent illness	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Vaccine reactions	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Wound healing issues	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Sensitivity		

Urinary

Symptom	C	P	Symptom	C	P
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Nocturia (at night)	<input type="checkbox"/>	<input type="checkbox"/>
Urgency/incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty starting urine	<input type="checkbox"/>	<input type="checkbox"/>
Painful/burning urination	<input type="checkbox"/>	<input type="checkbox"/>	Frequent UTIs	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

Mental / Emotional / Sleep

Symptom	C	P	Symptom	C	P
Poor concentration/memory	<input type="checkbox"/>	<input type="checkbox"/>	Tension	<input type="checkbox"/>	<input type="checkbox"/>
			Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Phobias	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/panic	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	Frequent crying	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts/attempts	<input type="checkbox"/>	<input type="checkbox"/>	Disordered eating	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	Body dysmorphia or dysphoria	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia/nightmares	<input type="checkbox"/>	<input type="checkbox"/>	Abuse history	<input type="checkbox"/>	<input type="checkbox"/>

Sleep details:

- Hours/night: _____ Wake rested? Yes No

- Sleep position: _____

Musculoskeletal

Symptom	C	P	Symptom	C	P
Joint pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Delayed onset muscle soreness	<input type="checkbox"/>	<input type="checkbox"/>	Muscle cramps/twitching	<input type="checkbox"/>	<input type="checkbox"/>
Neck/shoulder/back pain	<input type="checkbox"/>	<input type="checkbox"/>	Arm/wrist/leg/foot pain	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia/osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>			

Breast

Symptom	C	P	Symptom	C	P
Self breast exams	<input type="checkbox"/>	<input type="checkbox"/>	Breastfeeding How long? _____	<input type="checkbox"/>	<input type="checkbox"/>
Breast pain	<input type="checkbox"/>	<input type="checkbox"/>	Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>	Breast cysts	<input type="checkbox"/>	<input type="checkbox"/>

Nipple discharge Nipple Pain

Change in Enlarged breasts
breasts/nipples

Breast implants Breast reduction

Prostate (skip if N/A)

Symptom	C	P
Prostate enlargement	<input type="checkbox"/>	<input type="checkbox"/>
Prostate infection	<input type="checkbox"/>	<input type="checkbox"/>

Uterus & Ovaries (skip if N/A)

Symptom	C	P	Symptom	C	P
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
Partial/Full (circle One)					
Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>	Cervical dysplasia	<input type="checkbox"/>	<input type="checkbox"/>

Ovarian cysts Polycystic ovarian syndrome (PCOS)

PMS PMDD

Vulva & Vagina (skip if N/A)

Symptom	C	P	Symptom	C	P
Vulvar pain	<input type="checkbox"/>	<input type="checkbox"/>	Vulvar itching	<input type="checkbox"/>	<input type="checkbox"/>
Vulvar rash or sores	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal pain	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
Yeast infection	<input type="checkbox"/>	<input type="checkbox"/>	Pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>

Penis & Testicles (skip if N/A)

Symptom	C	P	Symptom	C	P
Orchiectomy	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>

Testicular pain Lump in scrotum

Rash or sores (genital) Penile pain

Penile discharge Self testicular exam

Erectile Dysfunction

Menstruation (skip if N/A)

Symptom	C	P	Symptom	C	P
Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	Skipped periods	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding after menopause	<input type="checkbox"/>	<input type="checkbox"/>
Heavy/excessive flow	<input type="checkbox"/>	<input type="checkbox"/>	Light/scanty flow	<input type="checkbox"/>	<input type="checkbox"/>
Clotting	<input type="checkbox"/>	<input type="checkbox"/>	Painful periods	<input type="checkbox"/>	<input type="checkbox"/>

Additional fields:

- Age of first period: _____
- Date of last period (if menopausal): _____

- Date of most recent period: _____
 - Average days of monthly bleeding: _____
 - Average cycle length: _____
-

Sexual History

Symptom	C	P	Symptom	C	P
STI (sexually transmitted infections)	<input type="checkbox"/>	<input type="checkbox"/>	Low sex drive	<input type="checkbox"/>	<input type="checkbox"/>
Sexual difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with arousal and/or orgasm	<input type="checkbox"/>	<input type="checkbox"/>

Additional fields:

- Sexual orientation: _____
- Gender(s) of current/recent sexual partners: _____
- Are you sexually active? Yes No
- Do you use birth control and/or contraception? Yes No
Type(s): _____
- How many total years have you been on hormonal contraception (the pill, patch, implant, shot, hormonal IUD)? _____
- Are you on PrEP? Yes No
- Do you have questions about contraception? Yes No

- Would you like to discuss STI/STD testing? Yes No
-

Pregnancy History (skip if N/A)

Fields to complete:

- Currently pregnant? Yes No
 - Trying to conceive? Yes No
 - Difficulty conceiving? Yes No
 - Number of pregnancies: _____
 - Number of children: _____
 - Miscarriages: _____
 - Still births: _____
 - Abortions: _____
-