

DR. KENNA BROOKE, ND

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Patient Intake Form

Patient Name: _____

DOB: _____

List Your Health Concerns in Order of Importance:

Age: _____

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Context of Care

Why did you choose Dr. Kenna Brooke, ND?

What do you know about Dr. Brooke's approach to your healthcare?

What 3 expectations do you have for your *first* visit?

What are your *longterm* goals in working with Dr. Brooke?

What is your present level of commitment to address any underlying causes of your symptoms related to your lifestyle?
Please rate from 0 to 10, 10 being 100% committed: _____

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe negatively impact your health?

What potential obstacles do you foresee in addressing any lifestyle factors that may be undermining your health or adhering to the therapeutic protocols recommended?

What do you love to do?

Rate your level of *fulfillment* in the following areas of your life. 0 – no fulfillment/10 – great fulfillment

Career	1	2	3	4	5	6	7	8	9	10
Money	1	2	3	4	5	6	7	8	9	10
Health	1	2	3	4	5	6	7	8	9	10
Relationship	1	2	3	4	5	6	7	8	9	10
Fun & Recreation	1	2	3	4	5	6	7	8	9	10
Family & Friends	1	2	3	4	5	6	7	8	9	10
Physical	1	2	3	4	5	6	7	8	9	10
Environment	1	2	3	4	5	6	7	8	9	10
Spiritual Practice	1	2	3	4	5	6	7	8	9	10

Primary Care Physician (PCP): _____

Are You Currently Receiving Healthcare: Y N If yes, from whom: _____

If No, When, Where and For What Reason Did You Last Receive Medical or Healthcare: _____

Date of Most Recent Blood Work: _____

Family History

Cancer (Indicate Type) High Blood Pressure Heart Disease/Heart Attack/Stroke Asthma/Allergies Mental Illness
Auto Immune Disease Diabetes Mellitus Osteoporosis Thyroid Condition Addiction

	Age	Age Died	Reason for Death	List Above Conditions and Age at Diagnosis
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sibling				
Sibling				
Sibling				
Child				
Child				
Other Relevant Family				
Other Relevant Family				

Personal History

List All Surgeries and Hospitalizations Including Date:

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

Please Note When and Why You Have Had Each of the Following:

X-Rays: _____ MRI/Cat Scans: _____
Ultrasounds: _____ Accidents: _____
TB Test: _____ HIV: _____
Last Eye Exam: _____ Last Dental Visit: _____

Did You Have the Following Disease (D), Get Immunized (I) or Neither (N):

Measles: D I N Chicken Pox: D I N Mumps: D I N Rubella: D I N
Tetanus: D I N Whooping Cough: D I N Hemophilus (Hib): D I N Hepatitis B: D I N
German Measles: D I N Any Vaccination Reactions: _____

List Yes (Y), No (N) or Past (P) Regarding Use of the Following:

Antacids:	Y N P	Smoking:	Y N P	Packs Per Day and Number of Years:	_____
Analgesics:	Y N P	Coffee:	Y N P	Cups Per Day if Yes:	_____
Laxatives:	Y N P	Soda Pop:	Y N P	Ounces Per Day if Yes:	_____
Alcohol:	Y N P	How Often and How Much if Yes/Past:	_____		
Alcohol Related Addiction:	Y N P	If Yes, Alcohol Treatment:	Y N P		
Recreational Drugs:	Y N P	Drug Related Addiction:	Y N P	If Yes, Drug Treatment:	Y N P

List All Prescription Medicines, Over the Counter Medicines (OTC) and Nutrient Supplements or Herbs You Currently Take:

NAME	DOSAGE	PURPOSE	PRESCRIBING DOCTOR	DURATION USED
1) _____				
2) _____				
3) _____				
4) _____				
5) _____				
6) _____				
7) _____				
8) _____				
9) _____				
10) _____				

continue on separate page if more room is needed

List All Known Allergies, Intolerances and/or Sensitivities:

Foods: _____

Drugs: _____

Chemicals: _____

Lifestyle

Exercise

How Often Do You Exercise: _____ Type: _____ Duration: _____

Sleep

Hours Per Night: _____ If You Wake Frequently, What is the Reason: _____

Nightmares: Y N P Wake Refreshed: Y N P Must Nap During the Day: Y N P

Sleep Walk: Y N P Grind Teeth: Y N P Snore: Y N P

Feet Out of Covers: Y N Favorite Sleeping Position: _____

Social Life

Enjoy Your Work: Y N Hours Work Per Week: _____ Highest Level of Education: _____

Type of Work: _____

In a Supportive Relationship: Y N Who Do You Live With: _____

History of Abuse: Y N P If So, Type, What Age and By Whom: _____

If So, Received Counseling: Y N Religious or Spiritual Practice: Y N Spend Time Outside Daily: Y N

Good Energy: Y N P If No, Can You Still Do What You Need to During the Day: Y N

Fatigue: Y N P If So, Time Worst (Morning, Afternoon, Evening): _____

Review of Systems

Present Weight: _____

Height: _____

Ideal Weight: _____

Weight 1 Year Ago: _____

Maximum Weight and When: _____

REGARDING THE NEXT LONG SECTION:

Circle (Y) if you **CURRENTLY** have the symptom, (N) if you've **NEVER** had the symptom, (P) if you had the symptom in the **PAST**.

		SKIN	
Rash	Y N P		Color Change Y N P
Hives	Y N P		Lump Y N P
Psoriasis/Eczema	Y N P		Itchy Y N P
Dry	Y N P		Warts/Moles Y N P
Cancer	Y N P		Perspiration Y N P
		HEAD	
Headache	Y N P		Migraine Y N P
Dandruff	Y N P		Head Injury Y N P
Oily/Dry Hair	Y N P		Hair Loss Y N P
		NOSE	
Frequent Colds	Y N P		Nosebleeds Y N P
Congestion	Y N P		Post Nasal Drip Y N P
Polyps	Y N P		Seasonal Allergies Y N P
		EYES	
Dry/Watery	Y N P		Blurry Vision Y N P
Double Vision	Y N P		Cataracts Y N P
Glaucoma	Y N P		Styes Y N P
Strain	Y N P		Discharge Y N P
Itchy	Y N P		Dark Under Eyelid Y N P
		MOUTH/THROAT	
Canker Sores	Y N P		Cold Sores Y N P
Sore Throat	Y N P		Gum Disease Y N P
Dentures	Y N P		Cavities Y N P
Loss of Taste	Y N P		Hoarseness Y N P
		NECK	
Stiffness	Y N P		Swollen Glands Y N P
Full Movement	Y N P		Tension Y N P
		RESPIRATORY	

Cough	Y N P		TB	Y N P
Shortness of Breath with Exertion	Y N P		Bronchitis	Y N P
Shortness of Breath Sitting	Y N P		Pneumonia	Y N P
Shortness of Breath Lying Down	Y N P		Asthma	Y N P
Wheezing	Y N P		Painful Breathing	Y N P
		CARDIOVASCULAR		
High Blood Pressure	Y N P		Rheumatic Fever	Y N P
Low Blood Pressure	Y N P		Murmurs	Y N P
Arrhythmias	Y N P		Palpitations	Y N P
Edema	Y N P		Chest Pain	Y N P
		URINARY TRACT		
Incontinence	Y N P		Pain with Urination	Y N P
Frequent Infections	Y N P		Kidney Stones	Y N P
Urgency	Y N P		Discharge/Blood	Y N P

		GASTROINTESTINAL		
Heartburn	Y N P		Bowel Movement Freq	
Indigestion	Y N P		Recent BM Change	Y N P
Bloating	Y N P		Diarrhea/Constipation	Y N P
Nausea	Y N P		Hemorrhoids	Y N P
Vomiting	Y N P		Gall Bladder Disease	Y N P
Change in Appetite	Y N P		Liver Disease	Y N P
Pancreatitis	Y N P		Ulcer	Y N P
		MALE GENITALIA		
Testicular Pain/Swelling	Y N P		Sexually Active	Y N P
Hernia	Y N P		S.T.D.	Y N P
Discharge	Y N P		Prostate Disease/Symptoms	Y N P
Impotency	Y N P		Sexual Orientation	Hetero Homo Bi
		FEMALE GENITALIA		
Age Period Began			How Often Period Occurs	
Duration of Period			Heavy Menstrual Bleeding	Y N P
Menstrual Cramping	Y N P		Menstrual Pain	Y N P
PMS	Y N P		Food Cravings	Y N P
Times Pregnant			How Many Births	
Miscarriages			Abortions	
Last Pap Smear			Diagnosis	
Any Abnormal Paps	Y N P		When Was Abnormal	
Menopausal Since Age			Use of Hormones	Y N P
Type of Hormones Used			Healthy Libido	Y N P
Dry Vagina	Y N P		Sexually Active	Y N P
Pain with Intercourse	Y N P		Vaginitis	Y N P
S.T.D.	Y N P		Mammography	Y N P
Dexa Scan	Y N P		If Yes, Results	

Please List Any Birth Control Used and Ages Used: _____

		MUSCULOSKELETAL		
Weakness	Y N P		Arthritis	Y N P
Stiffness	Y N P		Leg Cramps	Y N P
Tremors	Y N P		Pain	Y N P
		NERVOUS		
Paralysis	Y N P		Sciatica	Y N P
Tingling/Numbness	Y N P		Carpal Tunnel Syndrome	Y N P
Seizures	Y N P		Fainting	Y N P
		MENTAL/EMOTIONAL		
Depression	Y N P		Anger/Irritability	Y N P
Suicidal	Y N P		High-Strung/Tense	Y N P
Anxiety	Y N P		Fear/Panic	Y N P
Eating Disorder	Y N P		Psych Hospitalization	Y N P

Thank you for your time in filling out this paperwork. If there is anything you feel Dr. Kenna Brooke, ND should know or additional information you'd like to share you may do so in the space below.