MICHAEL SLEZAK, N.D.
THE CENTER FOR HEALTH
BRANCIFORTE PLAZA
555 SOQUEL AVENUE, SUITE 260
SANTA CRUZ, CA 95062

Michael Slezak, N.D.
NATUROPATHIC MEDICINE

Patient Intake Form

Please fill out this confidential intake questionnaire as completely as possible. Print legibly, and place a question mark next to any item you are unsure of. It is very important that you bring this completed form with you to your first visit.

Personal Information

Today's Date _____
Name _____ Age _____ Date of Birth ____/____/____
Phone – Day (___)_____ Evening (___)_____ Mobile (___)_____
Preferred ____Day ____Evening ___Mobile Is it OK to leave messages? ____Yes ____No
Address_____ Apt. # _____
City _____ State _____ Zip Code_____

Email address _____

Are you interested in receiving an email newsletter or notifications of lectures? ____Yes ____No

If the patient is under the age of 18:

Name(s) of legal guardians _____
Contact numbers if different from above _____

Who may I thank for your referral? _____

Current Health Care Provider(s) _____
_____
_____

Current Health Concerns,
in order of importance _____
_____
_____
_____
_____
_____

Emergency Contact Name _____ Relationship _____

Daytime contact number (____)_____

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Health History

Known Allergies (environmental, food, drug) _____

_____

_____

Please list all medications that you take, whether current, occasional, or recently discontinued, including over the counter drugs like pain relievers. Also include all supplements and natural medicines.

Medication/Substance	Dosage	Dates/Frequency	Reason for taking

*Please use separate sheet if needed.

If the following apply to you, please indicate the approximate dates they were last performed:

General Physical_____
Screening Labs _____
Gyn. Exam _____
Colonoscopy _____
MRI/CT scan _____

Hospitalization _____
Surgery _____
Mammogram _____
X-ray _____
Other _____

For the following conditions and symptoms, please indicate any that apply to you by marking a "C" for current or "P" for past:

___ Skin Rash
___ Abnormal lab results
___ High Blood Pressure
___ Heart Symptoms
___ Constipation
___ Metal fillings
___ Muscle spasms/ cramps
___ Vision problems
___ Depression/anxiety
___ Fatigue
___ Numbness / tingling
___ Sleep problems
___ Breathing Problems
___ Eating disorder
___ Root Canals
___ Joint aches
___ Hearing problems
___ Gastrointestinal symptoms
___ Headache
___ Cancer
___ Chest Pain
___ Allergies
___ Chronic infection
___ Sinus problems
___ Body soreness
___ Body coldness
___ Significant trauma

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Have you received all the standard childhood vaccines? ____ Yes ____ No
Which ones haven't you received?_____
Please indicate any major health issues suffered by parents, grandparents, spouse, children or grandchildren (Indicate which relative):

_____
_____
_____
_____

For Men Only

Please check all that apply to you:

___ Prostate exam ____ / ____ / ____
___ Regular self testicular exam
___ Impaired fertility
___ Sexual Abuse
___ Abnormal discharge from penis
___ Pain or lump in scrotum
___ Prostate problem
___ Sexually transmitted disease

For Women Only

Please check all that apply to you:

Last Menses ____ / ____ / _____
Last pap smear ____ / ____ / _____
Age menses began _____
Number of pregnancies_____
Number of live births _____

If you are still having periods:
Average number of days of bleeding _____
Average number of days in cycle _____
Bleeding is ___ regular ___ irregular
___ light ___ medium ___ heavy
Symptoms ___ bleeding btn periods ___ Mood swings
___ PMS ___ Painful menses ___ Breast tenderness

If you are no longer having periods:

___ Hot flashes
___ Dry skin
___ Spotting
___ Facial hair
___ Hair loss
___ Incontinence
___ Vaginal dryness
___ Changes in memory
___ Changes in libido
___ Changes in mood
___ Hormone replacement therapy
___ Urinary tract infections

___ Hysterectomy ____ / ____ / _____
___ Abnormal pap smear
___ Breast pain / lump / discharge
___ Sexual difficulties
___ Frequent vaginitis
___ Abnormal vaginal discharge
___ Endometriosis
___ Polycystic ovary syndrome
___ Sexually transmitted infection
___ Pelvic Inflammatory disease
___ Uterine fibroids
___ Impaired fertility
___ Sexual abuse
___ Regular self-breast exam
___ Sexually active
___ Oral contraception

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Lifestyle History

Please check any that apply to you and fill in corresponding details:

___ Exercise _____ hours per week
Type_____
___ Watch TV _____ hours per week
___ Tobacco Use _____ packs daily
___ Alcohol Use _____ drinks weekly
___ Recreational drug use
___ Toxic exposure
___ Drink 8 glasses water daily ___ less ___ more
___ Drink soda
___ Eat margarine

Height _____
Weight _____
Weight one year ago _____
Maximum weight _____
when? _____
Sleep _____ hours per night
Meals per day _____
___ Eat meat
___ Eat fast food regularly
___ Cook meals

Rate your average level of stress on the scale below with an "X"

1 ----------2----------3----------4----------5---------6----------7----------8---------9-------- 10

What affects your stress level the most? _____

What do you think is happening with your health?

_____
_____
_____

What do you feel you need to do to recover?

_____
_____
_____

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Consent for Naturopathic Medical Treatment

I, (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic. I understand that the methods of treatment that are permitted under the California Naturopathic Doctors Act include but are not limited to nutrition and lifestyle counseling, herbal medicine, homeopathy, nutritional supplements, physical treatments, hydrotherapy, and hormone replacement therapy.

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that the modalities outlined above may pose a small level of risk, as do all forms of treatment. I am aware that I have the right to refuse any treatment, and to inquire about the risks associated with any treatment recommendation.

The herbs, homeopathic medicines and nutritional that have been recommended are considered safe when taken as instructed in the practice of naturopathic medicine. It is important that you follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements. Some of these can be toxic when taken in excessively large doses. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify Dr. Slezak if I become aware that I am pregnant.

I will immediately inform Dr. Slezak if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by him. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. If an emergency medical condition arises, I will seek treatment immediately by calling 9-1-1, or going to my local hospital.

I have read, or have had read to me this consent form. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures provided by Dr. Slezak. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME, (printed)_____

PATIENT / GUARDIAN SIGNATURE _____**Date**: _____

Indicate relationship if signing on behalf of patient _____

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