Dr. Christina Sahni Radie
1730 SW Skyline Blvd. Suite #110 Portland, OR 97221
(503) 404-2333

Intake Form

Today's Date:_____
Name: _____
Address: _____ City, State, Zip _____
Telephone Number:_____ Cell Number: _____
Email address: _____ Date of Birth: _____ Gender: _____
Marital Status (circle one): Married Divorced Separated Single Widowed Partnership
Current living situation: _____
Occupation: _____ Employer: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone Number: _____
How did you hear about us? _____
Please list your most important current health problems, in order of importance:

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

How committed are you to your health?

0 1 2 3 4 5 6 7 8 9 10
Not at all Very committed

How open are you to lifestyle changes such as changes to your current diet and exercise regimen?

0 1 2 3 4 5 6 7 8 9 10
Not at all Very open

Personal health history:

Allergies (including drugs, antibiotics, foods, environmental): _____
_____
Current medications (please list all current medications including supplements and over the counter medications, how much you are taking and how often):
_____
_____
_____
Current diet: Please list what you typically eat for
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Water intake: _____ Other Beverages: _____
Alcohol Use: Y N If yes, how many drinks per week? _____
Tobacco use: Y N If yes, please indicate what time and how much: _____
Exercise: Do you currently exercise? Y N Times per week: _____ Activities:_____ _____
_____
Sleep: Hours per night _____ Do you wake feeling rested? Y N
Stress, please describe your biggest stressors: _____
Previous hospitalizations/Surgeries: _____
Other accidents: _____
Current Primary Care Physician Name & Phone #: _____
Please list any other physicians, including chiropractors, acupuncturists, etc. that you are currently seeing:
_____
_____

Current/Past Symptoms: Please indicate whether you currently experience this symptom (Y), have experienced it in the past (P) or have never experienced it (N)

Gastrointestinal:			
Nausea	Y	P	N
Vomiting	Y	P	N
Diarrhea	Y	P	N
Constipation	Y	P	N
Abdominal Pain	Y	P	N
Gas/indigestion	Y	P	N
Heartburn	Y	P	N
Cardiovascular:			
Chest Pain	Y	P	N
Heart palpitations	Y	P	N
Varicose veins	Y	P	N
Blood clots	Y	P	N
Foot/ankle swelling	Y	P	N
Respiratory:			
Shortness of breath	Y	P	N
Cough	Y	P	N
Asthma	Y	P	N
Wheezing	Y	P	N
Neurological:			
Numbness/tingling	Y	P	N
Vertigo/dizziness	Y	P	N
Loss of consciousness/fainting	Y	P	N
Seizures	Y	P	N
Skin:			
Rashes	Y	P	N
Itching	Y	P	N
Hair loss	Y	P	N
Eczema	Y	P	N
Acne	Y	P	N
Color changes	Y	P	N
Musculoskeletal:			
Joint pain	Y	P	N
Muscle pain	Y	P	N
Back pain	Y	P	N
Neck pain	Y	P	N
Muscle spasms	Y	P	N
Muscle weakness	Y	P	N
HEENT:			
Headache	Y	P	N
Migraines	Y	P	N
Head injury	Y	P	N
TMJ problems	Y	P	N
Teeth grinding	Y	P	N
Blurred vision	Y	P	N
Double vision	Y	P	N
Impaired hearing	Y	P	N
Ear pain	Y	P	N
Ringing in ears	Y	P	N
Sinus infections	Y	P	N
Nasal congestion	Y	P	N
Frequent colds	Y	P	N
Nose bleeds	Y	P	N
Hay fever/ seasonal allergies	Y	P	N
Gum/tooth problems	Y	P	N
Mouth sores	Y	P	N
Swollen glands	Y	P	N
Difficulty swallowing	Y	P	N
Urinary:			
Frequent Urination	Y	P	N
Frequent Infections	Y	P	N
Kidney Stones	Y	P	N
Pain with urination	Y	P	N
Blood in urine	Y	P	N
Male Reproductive:			
Frequent Urination	Y	P	N
Pain with urination	Y	P	N
Urination at night	Y	P	N
Inability to hold urine	Y	P	N
Frequent infections	Y	P	N
STI: _____	Y	P	N
Female Reproductive:			
Pain with cycle	Y	P	N
Irregular cycle	Y	P	N
Vaginal discharge	Y	P	N
Frequent infections	Y	P	N
Breast pain	Y	P	N
Breast lumps	Y	P	N
Nipple discharge	Y	P	N
Pain with intercourse	Y	P	N
Date of Last menstrual period: _____			
Length of cycle: _____ Length of period: _____			
Age of first period: _____			
Number of:			
Live births _____ dates: _____			
Pregnancies _____ dates: _____			
Miscarriages _____ dates: _____			
STI: _____	Y	P	N

Current/Past Ailments: Please indicate which of the following conditions you currently have (Y), have had in the past (P), or have never had (N)

High blood pressure	Y	P	N	Cataracts	Y	P	N
Heart disease	Y	P	N	Glaucoma	Y	P	N
Stroke	Y	P	N	Macular degeneration	Y	P	N

Rheumatic fever	Y	P	N	Thyroid disease (hyper- or hypo-)	Y	P	N
Heart murmur	Y	P	N	Inflammatory Bowel Disease (IBD)	Y	P	N
Ear infections	Y	P	N	Diabetes- Type I or II	Y	P	N
Anemia	Y	P	N	Cancer _____	Y	P	N

Family history: Please indicate who in your family has or had any of the following conditions

High blood pressure	Y	N	_____
Heart disease	Y	N	_____
Diabetes- Type I or II	Y	N	_____
Heart murmur	Y	N	_____
Stroke	Y	N	_____
Rheumatic fever	Y	N	_____
Thyroid disease (hyper- or hypo-)	Y	N	_____
Macular degeneration	Y	N	_____
Glaucoma	Y	N	_____
Cataracts	Y	N	_____
Cancer _____	Y	N	_____

Financial Policy:
Payment is due at time of service.
Upon request, a bill can be provided to submit to your insurance company in the event that the services provided at this clinic will be covered by reimbursement. No refunds will be provided after the time of service.

Cancellation Policy:
At least 24 hour notice is required to cancel your appointment. If it is not cancelled at least 24 hours prior to your scheduled appointment, you may be charged up to 100% of the missed appointment.

All of the above information is true to the best of my knowledge and I agree to the financial and cancellation policies of this office as stated above.

_____ _____

Patient Signature (or Parent or Legal Guardian if patient is under 18) Date

_____

Printed Name

Dr. Christina Sahni Radie
1730 SW Skyline Blvd. Suite 110
Portland, OR 97221
(503) 404-2333 (phone/fax)

Informed Consent: PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.

Consent to Treatment

The therapeutic procedures of naturopathic medicine are considered safe and effective methods of care. Any procedure intended to help may also have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Please read and sign below that you understand the following procedures:

Nutritional supplements, herbs, and homeopathy may be used to aid in healing. Be sure to inform your practitioner about all medications you are taking to minimize drug/supplement interactions. If you believe you are experiencing any side effects from your supplements/herbs/homeopathy be sure to alert your health care provider.

____ Initial and circle if you have any severe food allergies to shellfish, gluten, soy, dairy, or other (fill in) _____.

Naturopathic Manipulation is a form of physical medicine. The practitioner uses gentle force to manipulate spinal segments or bones in the extremities to re-establish normal movement and function. Please alert your provider if you have previously had negative effects with naturopathic manipulation or chiropractic adjustments.

Applied Kinesiology is a safe and non-invasive natural method of analyzing the body's physical and nutritional needs. It is not a method of "diagnosing" or "treating" any particular disease.

I understand, and am informed that in the practice of medicine and naturopathy, there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read and understand the above statements and have had the opportunity to ask questions. I understand that the health improvement program recommended to me is not for the "cure" of any particular disease. No promise or guarantee has been made regarding the results of Applied Kinesiology, or any natural health, nutritional or dietary programs. Rather, the above will be used for bringing about a more optimum state of health. By signing this form you consent to the treatments provided by the doctor(s) practicing at Christina Sahni Radie, ND, LLC.

_____

Print Name Signature of Patient/Guardian Date