



# PRIMARY CARE ALTERNATIVE MEDICINE <sup>P.A.</sup>

Dr. Sarah Kotzur, ND

---

## PATIENT INFORMATION

Date of First Visit \_\_\_ / \_\_\_ / \_\_\_

Name of Patient

Name of Parent(s)/Guardian(s) (if applicable)

Relationship to patient:

Age \_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_

Gender (circle) Female Male

Marital Status (circle) Married Separated Divorced Widowed Single Partnership

Live with (circle) Spouse Partner Parents Children Friends Alone

---

---

## CONTACT DETAILS

Address City: State: Zip:

Telephone Home: Cell: Work:

Email Would you like to receive our newsletter? Y N

How did you hear about our clinic?

---

---

## EMERGENCY CONTACT

Relationship

Telephone

Address City: State: Zip:

---

---

## OCCUPATION

What is your occupation?

Hours per week \_\_\_\_\_

Employer Address City: State: Zip:

---

---

**NEW PATIENT INTAKE FORM**

---

Successful health care and preventive medicine are made possible when Dr Kotzur has a comprehensive understanding of her patients. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything you don't understand with a question mark. If a section or question does not apply, skip it and proceed to the next question.

---

**Y** = a condition you have now    **P** = a condition you have had in the past    **N** = have never had

---

---

**CURRENT HEALTHCARE**

---

Are you currently receiving healthcare?    Y    N

If yes, where and from whom?

If no, when and where did you last receive medical or health care?

What was the reason?

---

---

**WHAT ARE YOUR MOST IMPORTANT HEALTH PROBLEMS?**

---

List as many as you can in order of importance.

1.

2.

3.

4.

5.

Do you have any known contagious diseases at this time?    Y    N

If yes, what?

---

---

**WHAT ARE YOUR TREATMENT GOALS AND EXPECTATIONS**

---

Please provide a basic explanation of what you hope to get out of your treatment at Primary Care Alternative Medicine.

---

**CURRENT MEDICATIONS**

Please list any prescription or over-the-counter medications you are taking, with dosages.

1.

2.

3.

4.

5.

6.

Please list any vitamins or other supplements you are taking, with dosages.

1.

5.

2.

6.

3.

7.

4.

8.

**ALLERGIES & HYPERSENSITIVITIES**

Do you have allergies or hypersensitivities to any: (please list)

Drugs?

Foods?

Environment?

Have you lived in a home or worked in an occupation where you were exposed to:

Solvents

Y N

Heavy metals

Y N

Fumes

Y N

Other toxic materials (please provide details below)

Y N

Have you experienced health problems when you:

Put in new carpeting?

Y N

Painted your home?

Y N

Installed new cabinets or other refurbishing?

Y N

Do you have sensitivities to:

Perfumes

Y N

Gasoline

Y N

Other vapors

Y N

**SLEEP**

Do you average 6-8 hrs sleep? Y P N

Sleep well? Y P N

If you wake up frequently, what is the reason?

Nightmares Y P N

Sleep walk Y P N

Nap during the day Y P N

Grind teeth Y P N

Snore Y P N

Talk in your sleep Y P N

Awaken rested? Y P N

Do you spend time outside? Y P N

**TOBACCO USE**

Do you use tobacco? Y N

Smoked previously? Y N

How many years? \_\_\_\_\_

How many packs per day? \_\_\_\_\_

**HEIGHT AND WEIGHT**

Height: \_\_\_\_\_ ' \_\_\_\_\_ "

Weight: \_\_\_\_\_ lbs

Weight 1 year ago: \_\_\_\_\_ lbs

Maximum weight: \_\_\_\_\_ lbs When?

**DIETARY****Typical Food Intake**

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

To drink \_\_\_\_\_

**Number servings per week**

Fish \_\_\_\_\_ Red meat \_\_\_\_\_ Chicken \_\_\_\_\_ Alcohol \_\_\_\_\_

**Number of servings per day**

Vegetables \_\_\_\_\_ Fruit \_\_\_\_\_ Caffeine \_\_\_\_\_ Water \_\_\_\_\_

Do you drink black or green tea? Y N

Do you drink cola or other sodas? Y N

Do you eat refined sugar? Y N

Do you add salt? Y N

Do you go on diets often? Y N

Do you eat three meals a day? Y N

Do you drink coffee? Y N

Do you eat out often? Y N

**HOSPITALIZATIONS AND SURGERIES**

What hospitalizations or surgeries have you had? (brief description)

*	date: ___ / ___
*	date: ___ / ___
*	date: ___ / ___

**XRAYS AND SPECIALTY IMAGING**

What x-rays and specialty imaging have you had? (brief description)

X-rays -  
 CAT scans -  
 Other imaging -

**CHILDHOOD ILLNESSES**

Scarlet fever	Y	N
Diphtheria	Y	N
Rheumatic fever	Y	N
Mumps	Y	N
Measles	Y	N
German measles	Y	N

**IMMUNIZATIONS**

Polio	Y	N
Pertussis	Y	N
Tetanus shot	Y	N
Diphtheria	Y	N
Measles/Mumps/Rubella	Y	N
Any reactions to vaccinations?	Y	N

**FAMILY HISTORY**  
(place an 'x')

	FATHER	MOTHER	GRAND PARENTS	SIBLINGS	PARTNER	YOUR CHILDREN
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lyme disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MENTAL AND EMOTIONAL**

Treated for emotional problems	Y	P	N
Depression	Y	P	N
Mood Swings	Y	P	N
Anxiety or nervousness	Y	P	N
Memory problems	Y	P	N
Tension	Y	P	N
Poor concentration	Y	P	N
Seasonal depression	Y	P	N

**MOUTH AND THROAT**

Frequent sore throat	Y	P	N
Copious saliva	Y	P	N
Teeth grinding	Y	P	N
Sore tongue/lips	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Dental cavities	Y	P	N
Jaw clicks	Y	P	N

**NEUROLOGICAL**

Seizures	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness or tingling	Y	P	N
Loss of memory	Y	P	N
Loss of balance	Y	P	N
Vertigo or dizziness	Y	P	N

**ENDOCRINE**

Hypothyroid	Y	P	N
Heat or cold intolerance	Y	P	N
Hypoglycemia	Y	P	N
Diabetes	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
Fatigue	Y	P	N

**NECK**

Lumps	Y	P	N
Swollen glands	Y	P	N
Goiter (enlarged thyroid)	Y	P	N
Pain or stiffness	Y	P	N

**IMMUNE FUNCTION**

Chronic Fatigue Syndrome	Y	P	N
Chronic infections	Y	P	N
Chronically swollen glands	Y	P	N
Slow wound healing	Y	P	N

**HEAD**

Headaches	Y	P	N
Migraines	Y	P	N
Head Injury	Y	P	N
Jaw/TMJ problems	Y	P	N

**EARS**

Impaired hearing	Y	P	N
Ringing	Y	P	N
Earaches	Y	P	N
Dizziness	Y	P	N

**MUSCULOSKELETAL**

Joint pain or stiffness	Y	P	N
Arthritis	Y	P	N
Broken bones	Y	P	N
Weakness	Y	P	N
Muscle spasms or cramps	Y	P	N
Sciatica	Y	P	N

**URINARY**

Pain on urination	Y	P	N
Increased frequency	Y	P	N
Frequency at night	Y	P	N
Inability to hold urine	Y	P	N
Frequent infections	Y	P	N
Kidney stones	Y	P	N

**SKIN**

Rashes	Y	P	N
Eczema, Hives	Y	P	N
Acne	Y	P	N
Boils	Y	P	N
Itching	Y	P	N
Color Change	Y	P	N
Perpetual Hair Loss	Y	P	N
Lumps	Y	P	N

**EYES**

Spots in Eyes	Y	P	N
Cataracts	Y	P	N
Impaired vision	Y	P	N
Glasses or contacts	Y	P	N
Blurriness	Y	P	N
Eye pain/strain	Y	P	N
Color blindness	Y	P	N
Tearing or dryness	Y	P	N
Double Vision	Y	P	N
Glaucoma	Y	P	N

**RESPIRATORY**

Cough	Y	P	N
Sputum	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N
Asthma	Y	P	N
Bronchitis	Y	P	N
Pneumonia	Y	P	N
Tuberculosis	Y	P	N
Emphysema	Y	P	N
Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N
Shortness of breath	Y	P	N
Shortness of breath at night	Y	P	N
Shortness of breath lying down	Y	P	N

**CARDIOVASCULAR**

Heart disease	Y	P	N
Angina	Y	P	N
High/Low Blood Pressure	Y	P	N
Murmurs	Y	P	N
Blood clots	Y	P	N
Fainting	Y	P	N
Phlebitis	Y	P	N
Palpitations/Fluttering	Y	P	N
Rheumatic Fever	Y	P	N
Chest pain	Y	P	N
Swelling in ankles	Y	P	N

**BLOOD/PERIPHERAL VASCULAR**

Easy bleeding or bruising	Y	P	N
Anemia	Y	P	N
Deep leg pain	Y	P	N
Cold hands/feet	Y	P	N
Varicose veins	Y	P	N

**GASTROINTESTINAL**

Trouble swallowing	Y	P	N	
Heartburn	Y	P	N	
Change in thirst	Y	P	N	
Change in appetite	Y	P	N	
Nausea	Y	P	N	
Vomiting	Y	P	N	
Vomiting blood	Y	P	N	
Bowel movements	How often? _____			
	Is this a change?	Y	P	N
Blood in stool	Y	P	N	
Pain or cramps	Y	P	N	
Constipation	Y	P	N	
Belching or passing gas	Y	P	N	
Diarrhea	Y	P	N	
Black stools	Y	P	N	
Gall Bladder disease	Y	P	N	
Jaundice (yellow skin)	Y	P	N	
Ulcer	Y	P	N	
Liver Disease	Y	P	N	
Hemorrhoids	Y	P	N	

**MALE REPRODUCTION**

Hernias	Y	P	N
Testicular masses	Y	P	N
Testicular pain	Y	P	N
Prostate disease	Y	P	N
Discharge or sores	Y	P	N
Sexually transmitted infections	Y	P	N
Are you sexually active?	Y	P	N
Birth control	Y	P	N
	Type _____		
Impotence	Y	P	N
Premature ejaculation	Y	P	N
Genital warts	Y	P	N
Herpes	Y	P	N

**FEMALE REPRODUCTION / BREASTS**

Age of first menses	_____			Birth control	Y	P	N
First day of last menses	_____			Type	_____		
Are cycles regular	Y	P	N	Difficulty conceiving	Y	P	N
# of days in between menses	_____			Number of pregnancies	_____		
# of days your menses last	_____			Number of live births	_____		
Bleeding between cycles	Y	P	N	Endometriosis	Y	P	N
Painful menses	Y	P	N	Ovarian cysts	Y	P	N
Clotting	Y	P	N	Menopausal symptoms	Y	P	N
Heavy or excessive flow	Y	P	N	Abnormal PAP	Y	P	N
Discharge	Y	P	N	Sexually transmitted infection	Y	P	N
Are you sexually active?	Y		N	Genital warts	Y	P	N
Sexual difficulties	Y	P	N	Herpes	Y	P	N
Pain during intercourse	Y	P	N	Do you perform breast self-exams?	Y	P	N
PMS	Y	P	N	Breast lumps	Y	P	N
If yes, please list symptoms below				Breast pain/tenderness	Y	P	N
				Nipple discharge	Y	P	N

**GENERAL**

**When during the day is your energy:**

Best:

Worst:

**Main interests and hobbies?**

**Do you exercise?**    Y    N

What kind?

How often?

**Is there anything else that you feel has not been covered?**

Please provide additional information below

**TREATMENT CONSENT**

**By signing this form, I consent to be treated by Dr. Sarah Kotzur, ND.**

**By my signature, I also agree to the office policy of payment in full on the day services are rendered.**

**Name:** \_\_\_\_\_

**Date:**    /    /

**Signature:** \_\_\_\_\_