



Heidi Peterson, ND

4444 SW Corbett Ave., Portland, OR 97239

p: 503 224 2590 f: 503 224 2592 e: heidi@doctorheidi.com w: doctorheidi.com

PATIENT INTAKE

Name _____ Age _____ Date of Birth _____

What brings you into the office today? _____

What expectations do you have for this visit? _____

What are your major health concerns in order of importance? _____

Date of last physical exam: _____

Date of last dental exam: _____

List any medications, over the counter drugs, vitamins, or other supplements you are taking. Feel free to use an additional page.

List any allergies to drugs, food, or chemicals. _____

List any medical problems that you have had in the past. Have you ever been hospitalized or had surgery? If so, when and why?

Family Medical History:

Please note the diseases that each of the following members of your family has or had. If they are deceased please note the age at which they died and the cause of their death.

Mother: _____

Father: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Siblings: _____

Diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Number of alcoholic beverages consumed per week?: _____ Do you smoke or use illegal drugs? Yes No

Sleep:

Hours of sleep a night? _____ Do you wake rested? Yes No

Exercise:

Hours spent in physical activity per week? _____

Types of exercise? _____

Toxicity Exposure:

Number of fillings and crowns? _____ How many are mercury (silver)? _____

Hobbies? _____

Have you ever lived near or worked in agriculture, or major industry? Yes No

Any known toxic exposures? _____