HUDSON
NATUROPATHIC CLINIC

Intake Form #1

Patient's name: _____ Date of birth: _____

Onset of symptoms: _____
Diagnosed with ADD/ADHD? Yes/No (please circle)
Date of diagnosis: _____

Name of diagnosing doctor/psychologist(s): _____

Medications?

	Medication	Past Use? Yes/No	Current Use? Yes/No	On	Off	Highest Total Daily Dosage	Current Total Daily Dosage	Weekend Use? Yes/No	Summer Use? Yes/No
Med 1									
Med 2									
Med 3									
Med 4									
Med 5									
Med 6									

Psychological testing? Yes/No (please circle)
When? _____
What tests? _____
_____

Diagnosed with learning disorder? Yes/No What kinds (if can remember)?
_____

Any other diagnoses, such as depression or anxiety? _____
_____

Is there a history of suicidal attempts or plans? _____
_____

Family history of depression, anxiety, ADD/ADHD, suicide? _____
_____

Psychological Therapy? Yes/No (circle one)

Therapy	In the past? Yes/No	Current? Yes/No	On	Off	Frequency?
Child only					
Parent only					
Parent and child					
Family					
Other psychosocial (i.e. School Counselor)					

Comments? _____
_____
_____

Alternative Therapy? Yes/No (circle one)

Therapy/Supplement	In the past? Yes/No	Current? Yes/No	On	Off	Dosage?	Prescribed by (self or doctor)?

Comments? _____
_____
_____

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