PATIENT INTAKE FORM

All information is confidential. Please print and bring with you to your first appointment.

PERSONAL

Name _____ Date _____

Age _____ Date of Birth (m/d/y) _____ Gender _____

Occupation _____ Number of work hours per week _____

Mailing Address _____

Phone: h. _____ c. _____ w. _____

Email _____ May we leave phone messages for you? Y/ N

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about our clinic? _____

**Your email is kept confidential and used to activate your patient portal on our electronic medical records software and to send you any important clinic notices.*

MEDICAL

Primary Care Doctor _____ Address _____ Phone _____

Date of last blood work (m/d/y) _____

Other Health Care Providers _____

What are your main health concerns?

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

Please list all allergies _____

_____

Please list any prescription medications, vitamins or supplements you are currently taking:

Medication/ Supplement	Prescribed for/ Taking for	Dosage

*if you are taking any others please list on the back of this form

Please list any over the counter medications you are taking _____

_____

Please list major injuries, illnesses or surgery (with approximate dates) _____

_____

_____

ENVIRONMENTAL

Do you react to strong scents (perfume, gasoline, tobacco, etc.)? _____

Have you reacted to a vaccination in the past? _____

Please list any toxic substances you are exposed to _____

_____

LIFESTYLE

Sleep (hours/night) _____ Quality? _____ Do you feel rested on waking? _____

Exercise (type, duration, frequency) _____

Water (glasses/day) _____ Coffee (cups/day) _____ Tea (cups/day) _____

Alcohol (drinks per day/week – circle one) _____ Soda (glasses/day) _____

Tobacco (type, # per day) _____ Recreational drugs _____

Hobbies _____

What are the significant stressors in your life? _____

_____

DIET

Do you have any dietary restrictions? _____

How many cups of vegetables do you consume each day? _____

Please list all they food you have consumed in the past 24 hours:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

OVERVIEW OF BODY SYSTEMS

Y condition you have NOW N condition you NEVER HAD P condition you had in the PAST

1. GENERAL	Y	N	P
Height			
Weight			
High blood pressure			
Low blood pressure			
Fatigue/weakness			
Fever/chills			
2. SKIN	Y	N	P
Rashes			
Eczema			
Acne			
Psoriasis			
Itching			
Nail changes			
3. HEAD	Y	N	P
Headache/migraine (please circle)			
Head Injury			
Dizziness			
4. EYES	Y	N	P
Impaired vision			
Watery/dry (please circle)			
Itching			
Blurring			
5. EARS	Y	N	P
Earache			
Discharge			
Infection			
Tinnitus (ringing in ears)			
6. NOSE & SINUS	Y	N	P
Congestion			
Runny nose			
Loss of smell			
7. MOUTH & THROAT	Y	N	P
Frequent sore throat			
Bleeding gums			
Canker sores			
Swollen glands			
Tonsil issues			
8. CARDIOVASCULAR	Y	N	P
Heart disease			
Chest pain/angina			
Heart flutters/palpitations			
Murmurs			
9. RESPIRATORY	Y	N	P
Cough			
Asthma			
Bronchitis/pneumonia			
Shortness of breath			
COPD			

10. BREASTS	Y	N	P
Lumps			
Fibrocystic breasts			
Pain			
11. URINARY	Y	N	P
Pain			
Increased/decreased frequency			
Frequency at night			
Inability to hold urine			
Frequent infections			
Kidney stones			
Blood in urine			
Urgency			
Hesitancy			
12. GASTROINTESTINAL	Y	N	P
Heartburn/reflux			
Nausea/vomiting			
Regular bowel movements			
Frequency: per day per week			
Blood in stool/black stool			
Undigested food in stool			
Excess gas/bloating			
Gallbladder disease			
Liver disease			
Ulcer			
Abdominal pain			
Hemorrhoids			
Rectal itchiness			
13. MALE REPRODUCTIVE	Y	N	P
Testicular masses			
Testicular pain			
Are you sexually active?			
Sexual difficulties			
Low libido			
Sexually transmitted infection			
Discharge or sores			
Prostate issues			
Date of last prostate exam:			
14. FEMALE REPRODUCTIVE	Y	N	P
Age menses began			
Regular cycles			
Duration of menstrual flow days			
Length of entire menstrual cycle days			
Bleeding/spotting between periods			
Excessive flow			
PMS symptoms			
Are you sexually active?			
Sexual difficulties			
Low libido			
Sexually transmitted infection			

Vaginal discharge			
Vaginal itching			
Number of yeast infections			
Abnormal cells on Pap test			
Difficulty conceiving			
Number of pregnancies			
Number of miscarriages			
Number of abortions			
15. MUSCULOSKELETAL	Y	N	P
Joint pain/stiffness			
Arthritis			
Muscle spasms/cramps			
Restless legs			
Weakness			
Back pain/neck pain			
Motor vehicle accident			
16. PERIPHERAL VASCULAR	Y	N	P
Cold hands/feet			
Varicose veins			
Easy bleeding/bruising			
Anemia			
Swollen ankles			
17. ENDOCRINE	Y	N	P
Heat/cold intolerance			
Thyroid issues			
Excessive sweating			
Diabetes			
Hypoglycemia (low blood sugar)			
Difficulty gaining/losing weight			
18. NEUROLOGICAL	Y	N	P
Fainting			

Stroke			
Seizures/convulsions			
Numbness/tingling			
Brain fog			
Memory issues			
Balance issues			
Sleep problems			
19. EMOTIONAL	Y	N	P
Depression			
Anxiety			
ADD/ADHD			
Alcohol/drug abuse/addiction			
Child abuse			
Physical abuse			
Emotional abuse			
Sexual abuse			
Excess stress			
Do you enjoy your job? Y / N			
20. IMMUNITY	Y	N	P
Serious infection			
Warts			
Hepatitis			
Parasites			
Yeast overgrowth			
Fungal infections			
Cancer			
Frequent Colds			
Autoimmune disease			
Lifetime # of antibiotic treatments			

FAMILY HISTORY - Please list any significant family history:

Mother:_____

Father:_____

Siblings:_____

Children:_____

Grandparents:_____

PAIN Please indicate on the diagram any areas where you are currently experiencing pain or discomfort.