Patient Intake Form

Patient Name____________________ DOB_____________

Date___________

Please list your health concerns in order of importance:

1) ____________________ 2)____________________ 3)______________

4) ____________________ 5)____________________ 6)______________

Name, address, telephone number

of Primary Care physician:____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:	______	______	______	______	______	______
Age when died:	______	______	______	______	______	______
Reason for death:	______	______	______	______	______	______
Cancer type:						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1) ______________________________ 2) ______________________________

3) ______________________________ 4) ______________________________

Please Note When & Why You Have Had Each of the Following:

X-Rays: _______________ MRI/Cat Scans: _______________ Ultrasounds: _______________

Accidents: _______________ TB Test: _______________ HCV: _______________

HIV: _______________ Last Dental Visit: _______________ Last Eye Exam: _______________

Did you have the following Disease (**D**), Get Immunized (**I**), or Neither (**N**):

Measles: D I N **Chicken Pox:** D I N **Hemophilus (Hib):** D I N

Rubella: D I N **Tetanus:** D I N **Whooping Cough:** D I N

Mumps: D I N **Hepatitis B:** D I N

Any vaccination reactions: ____

Allergies

List all known Allergies (food, drugs, environment): ______________________________

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List Yes (Y), No (N) or Past (P) regarding use of the following:

Antacids: Y N P **Steroids:** Y N P **Smoking:** Y N P **Packs per day & number of years:**___

Analgesics: Y N P **Laxatives:** Y N P **Coffee:** Y N P **Cups per day if Yes/Past:** _______

Soda : Y N P **Ounces per day if Yes/Past:** ______________________________

Alcohol: Y N P **How often & how much if Yes/Past:** ______________________________

Alcohol Addiction: Y N P **Alcohol Treatment:** Y N P **Recreational Drugs:** Y N P

Drug Addictions: Y N P **Drug Treatment:** Y N P **Type of Drugs**____________________

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and including dosage:

____

____

Review of Systems:

Present Weight: ________ **Weight one year ago:** ________ **Height:** ________

Maximum weight and when: ____________ **Minimum weight as adult & when:** ____________

REGARDING THE NEXT LONG SECTION: Please circle **(Y)** if you have the problem currently, **(N)** if you've **NEVER** had the problem, **(P)** if you had the problem in the **PAST**.

Good Energy: Y N P **Fatigue:** Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst? ______________

If you have fatigue, can you do what you need to during the day? Y N

SKIN

Rash:	Y N P	**Color Change:**	Y N P
Hives:	Y N P	**Lump:**	Y N P
Psoriasis/eczema:	Y N P	**Itchy:**	Y N P
Dry:	Y N P	**Warts/moles:**	Y N P
Cancer:	Y N P	**Perspiration:**	Y N P

HEAD

Headache:	Y N P	**Migraine:**	Y N P
Dandruff:	Y N P	**Head Injury:**	Y N P
Oil/dry hair:	Y N P	**Hair loss:**	Y N P

NOSE

Frequent Colds:	Y N P	**Nosebleeds:**	Y N P
Congestion:	Y N P	**Post Nasal Drip:**	Y N P
Polyps:	Y N P	**Seasonal Allergies:**	Y N P

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EYES

Dry/Watery:	Y	N	P	Blurry Vision:	Y	N	P
Double Vision	Y	N	P	Cataracts:	Y	N	P
Glaucoma:	Y	N	P	Styes:	Y	N	P
Strain:	Y	N	P	Discharge:	Y	N	P
Itchy:	Y	N	P	Dark under Eyelid:	Y	N	P

MOUTH/THROAT

Canker sores:	Y	N	P	Cold sores:	Y	N	P
Sore Throat:	Y	N	P	Gum disease:	Y	N	P
Dentures:	Y	N	P	Cavities:	Y	N	P
Loss of taste:	Y	N	P	Hoarseness:	Y	N	P

NECK

Stiffness:	Y	N	P	Swollen Glands:	Y	N	P
Full movement:	Y	N	P	Tension:	Y	N	P

RESPIRATORY

Cough:	Y	N	P	TB:	Y	N	P
Shortness of breath w/ exertion:	Y	N	P	Bronchitis:	Y	N	P
Shortness of breath sitting:	Y	N	P	Pneumonia:	Y	N	P
Shortness of breath lying down:	Y	N	P	Asthma:	Y	N	P
Wheezing:	Y	N	P	Painful breathing:	Y	N	P

CARDIOVASCULAR

High Blood Pressure:	Y	N	P	Rheumatic Fever:	Y	N	P
Low Blood Pressure	Y	N	P	Murmurs:	Y	N	P
Arrhythmias:	Y	N	P	Palpitations:	Y	N	P
Edema:	Y	N	P	Chest Pain:	Y	N	P

URINARY TRACT

Incontinence:	Y	N	P	Pain w/ Urination	Y	N	P
Frequent Infections:	Y	N	P	Kidney Stones	Y	N	P
Urgency:	Y	N	P	Discharge/Blood:	Y	N	P

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GASTROINTESTINAL

Heartburn:	Y N P	Bowel Movement Freq:	
Indigestion:	Y N P	Recent BM Change:	Y N P
Bloating:	Y N P	Diarrhea/Constipation:	Y N P
Nausea:	Y N P	Hemorrhoids:	Y N P
Vomiting:	Y N P	Gall Bladder Disease	Y N P
Change in Appetite:	Y N P	Liver Disease:	Y N P
Pancreatitis:	Y N P	Ulcer	Y N P

MALE

Testicular pain/swelling:	Y N P	Sexually Active:	Y N P
Hernia:	Y N P	S.T.D.:	Y N P
Discharge:	Y N P	Prostate Disease/Symptoms:	Y N P
Impotency:	Y N P	Sexual Orientation	

FEMALE

Age Period Began:		How Often Period Occurs:	
How long period lasts:		Heavy menstrual bleeding:	Y N P
Menstrual cramping:	Y N P	Menstrual Pain:	Y N P
PMS:	Y N P	Food cravings:	Y N P
Times Pregnant:		How many births:	
Miscarriages:		Abortions:	
Last Pap Smear:		Sexual Orientation:	
Any abnormal paps:	Y N P	When was abnormal:	
Menopausal since what age:		Use of hormones:	Y N P
Type of hormones used:		Libido:	Y N P
Dry vagina:	Y N P	Sexually Active:	Y N P
Pain w/ Intercourse:	Y N P	Vaginitis:	Y N P
S.T.D.:	Y N P	Mammography:	Y N P
Bone Density Test:	Y N P	If Yes, what were results:	

Please list any birth control used / ages used

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MENTAL/EMOTIONAL

Depression:	Y	N	P	Anger/irritability:	Y	N	P
Suicidal:	Y	N	P	High-strung/ tense/ stressed:	Y	N	P
Homicidal:	Y	N	P				
Anxiety:	Y	N	P	Fear/Panic	Y	N	P
Eating disorder:	Y	N	P	Psych Hospitalization:	Y	N	P

NEUROLGICAL

Paralysis:	Y	N	P	Sciatica:	Y	N	P
Tingling/numbness:	Y	N	P	Carpal tunnel syndrome:	Y	N	P
Seizures:	Y	N	P	Fainting:	Y	N	P

MUSCULOSKELETAL

Weakness:	Y	N	P	Arthritis:	Y	N	P
Stiffness:	Y	N	P	Leg Cramps:	Y	N	P
Tremors:	Y	N	P	Pain:	Y	N	P

Exercise

How often do you exercise? ________________ What type of exercise? ________________________

For how long? ________________________ Hobbies: ________________________________

IF IN PAIN NOW, PLEASE COMPLETE THE SECTION BELOW. IF NOT CURRENTLY IN PAIN, PLEASE SKIP TO THE NEXT PAGE

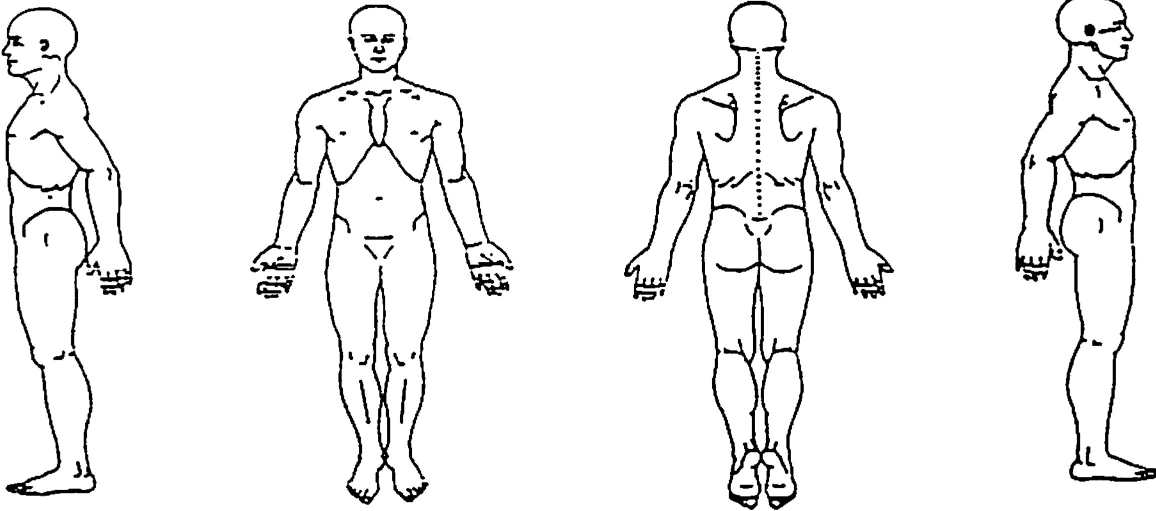
I AM CURRENTLY IN PAIN [] yes []no

PAIN DRAWING AND PAIN SCALE

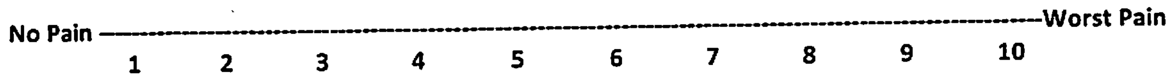
Please locate and mark the quality of your pain on the body outlines provided.

Please use the code letters as indicated below:

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing X = Other



Please Mark Your Level of Pain Below:



What percent of the time is your pain at this level? ________%

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Sleep

How long per night? __________ If you wake up frequently, what is the reason? ________________

Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P

Sleep walk: Y N P Grind teeth: Y N P Snore: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? ____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? ____

Are you particularly sensitive to perfumes, gasoline or other vapors? ____________________

Do you use pesticides, herbicides or other chemicals around your home? ________________

Social Life

Do you work? Y N P What is your job?____________________ Enjoy job: Y N P

Hours worked per week: ________ Highest Level of Education: __________ Active spiritual practice: Y N P

Quality of significant relationship: ______________________________

History of sexual, mental/emotional, physical abuse: Y N P

What is your greatest health concern:________________ How does it limit you the most: ____________

How committed are you towards making valuable changes: Little Moderately Very

Additional Information

Please list any additional information/topics which you believe is important we address during your office visit:

____

____

____

The information provided in this questionnaire accurately describes my health concerns and history.

Name______________________________ **Date**________________________