

Patient Intake Form

Patient Name _____

DOB _____

Date _____

Please list your concerns in order of importance:

- 1) _____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____

Name, address, telephone number
of Primary Care physician: _____

Name, address, telephone number
of Psychiatrist _____

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
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

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: _____

Allergies

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

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

STATE OF TEXAS

County of _____

Know all men by these presents, that _____ of the County of _____ State of Texas, for and in consideration of the sum of _____ Dollars, to _____ in hand paid by _____ the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said _____ of the County of _____ State of Texas, all that certain _____

WITNESSETH

Given	Received	Witnessed	Subscribed	Witnessed	Subscribed	Witnessed	Subscribed
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Witness my hand and seal of office this _____ day of _____ 19____.

Notary Public in and for the State of Texas

Subscribed and sworn to before me this _____ day of _____ 19____.

Notary Public in and for the State of Texas

My commission expires this _____ day of _____ 19____.

Witness my hand and seal of office this _____ day of _____ 19____.

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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 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

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

Manic episode Y N P

Anxiety: Y N P

Eating disorder: Y N P

Fear/Panic Y N P

Poor Memory Y N P

Poor attention Y N P

Psych Hospitalization Y N P

Poor concentration Y N P

NEUROLOGICAL

Seizures: Y N P

Migraines Y N P

Tics Y N P

Other

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: _____

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

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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: _____

How often to you socialize per week _____ Do you have close friends/family/a support system Y N P

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

What is your greatest health or mental 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 _____