Patient Intake Form

Today's date: _____

Name_____

Date of birth_____ Age_____ Sex: ☐ Male ☐ Female

Health Concerns: Please list your main health concerns in order of importance.

1. Describe your primary concern _____

When did it start? _____

Has this condition been diagnosed? ☐ yes ☐ no Diagnosis_____

Are you currently receiving any treatment for this condition? *Please describe*:_____

_____

2. Other concerns _____

_____

What would you most like to accomplish on your first visit? _____

_____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health?

_____

Healthcare Providers Information

Who is your primary care physician? Name/phone #_____

When was your last physical exam? _____

Are you currently under the care of or seeing a specialist?

1: _____

(Name) **(**Address/Phone)

2: _____

(Name) **(**Address/Phone)

What is your height?_____

	Current	Last year	5 years ago	Ideal
Weight				

Iluminar, PLLC
480.338.8070 (p)

Metabolic Health
480.314.5133

C. R. Bosch, NMD
iluminartherapy.com

Have you had any of the following in the last ten years?

Test	When	Results
Bone Density (DEXA)		
CT scan		
Colonoscopy		
EKG		
Endoscopy		
MRI		
Ultrasound		
X-ray		

Past Medical History Hospitalizations / Surgeries *(including tonsils, gallbladder, appendix, cosmetic)*

Procedure	Year

Accident/Injury

	Year

Have you received all of your childhood vaccinations? ☐ Yes ☐ No

☐ Polio ☐ Rubella ☐ Flu Vaccine ☐ Tetanus ☐ Measles ☐ Diphtheria
☐ Smallpox ☐ Mumps ☐ Hepatitis B ☐ Pertussis ☐ Other: _____

Have you received the vaccination for chicken pox? ☐ Yes ☐ No

Have you received any vaccinations for travel? ☐ Yes ☐ No

If yes which vaccinations and when?_____

Have you ever been a victim of abuse? (Physical, Verbal, Emotional) ☐ Yes ☐ No

To what extent are you open to changes in lifestyle to address your health concerns?
☐ I will do whatever it takes
☐ I am willing to make some changes
☐ I am willing to consider changes

Patient Name: _____ **DOB:** _____ **Page 2**

ALLERGIES

Please list all known allergies (medications, supplements, food, environmental, vaccinations):

_____

_____

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

Medications	Reason	Date began	Dose	Effective? (yes/no)

Supplements	Reason	Date began	Dose	Effective? (yes/no)

Lifestyle

Relationships ☐ Single ☐ Married/Partnership ☐ Separated ☐ Divorced ☐ Widowed
If Married/Partnership how long have you been together? _____

Are you sexually active? ☐ Yes ☐ No
If yes, with (check one): ☐ Male ☐ Female ☐ Both

Do you or your partner(s) use contraception? ☐ Yes ☐ No
If so, what type(s)?_____

Are you pregnant? ☐ Yes ☐ No
Trying to get pregnant? ☐ Yes ☐ No
If yes, for how long? _____

Do you have children? ☐ Yes ☐ No How many? _____
Names and ages of your children? _____
_____
_____

Social History

Have you ever been a smoker? ☐ No ☐ Yes (current or past) How long have you smoked?_____
How often do you drink alcohol?_____
Do you use recreational drugs? ☐ Yes ☐ No

How often do you exercise? _____ What kind of exercise do you do?_____For how long?_____
What do you do to relax?_____
Describe your supportive network_____
Do you have a spiritual practice? _____

What is your occupation?_____
Do you like your job? ☐ Yes ☐ No
How many hours a week do you work?_____

How many hours a night do you sleep?_____
Do you have trouble falling/staying asleep? ☐ Yes ☐ No Falling/Staying/Both?_____
Do you wake refreshed? ☐ Yes ☐ No

Diet: Please describe a typical day's diet for you

Breakfast	Lunch	Dinner	Snacks (what hour)

How many meals do you eat daily?_____
How much water do you drink daily?_____
What type of water do you drink?_____
How many sodas, coffees and teas with caffeine do you drink per week?_____
Do you eat organic food? ☐ Yes ☐ No
Do you have dietary restrictions? ☐ Yes ☐ No DESCRIBE:_____
Are you satisfied with your current diet? ☐ Yes ☐ No

Environmental Exposure

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home, at work or when traveling?	☐ Yes ☐ No
Have you ever experienced health problems after putting down new carpets, painting, doing renovations or having your lawn sprayed with herbicide?	☐ Yes ☐ No
Are you sensitive to perfume, gasoline or other vapors?	☐ Yes ☐ No
Have you ever lived near a refinery or polluted area?	☐ Yes ☐ No
Have you ever lived in a home more than 50 years old?	☐ Yes ☐ No
Do you have mercury dental fillings? How many? _____	☐ Yes ☐ No
Have you had any dental root canal procedures?	☐ Yes ☐ No
Do you live near power lines?	☐ Yes ☐ No

Review of Systems

Y = presently have N = never have had P = have had in the past

General

Chills	☐ Y ☐ N ☐ P
Fever	☐ Y ☐ N ☐ P
Fatigue	☐ Y ☐ N ☐ P
Frequent Colds	☐ Y ☐ N ☐ P
Night Sweats	☐ Y ☐ N ☐ P
Weight Loss	☐ Y ☐ N ☐ P

Skin

Acne	☐ Y ☐ N ☐ P
Bruise easily	☐ Y ☐ N ☐ P
Eczema	☐ Y ☐ N ☐ P
Itching	☐ Y ☐ N ☐ P
Lumps	☐ Y ☐ N ☐ P
Mole color change	☐ Y ☐ N ☐ P
Rashes	☐ Y ☐ N ☐ P

Immune

Cold sores	☐ Y ☐ N ☐ P
Chronic infections	☐ Y ☐ N ☐ P
Frequent antibiotics	☐ Y ☐ N ☐ P
Frequent colds/flus	☐ Y ☐ N ☐ P
Frequent sore throat	☐ Y ☐ N ☐ P
Cold sores	☐ Y ☐ N ☐ P
Shingles	☐ Y ☐ N ☐ P
Slow wound healing	☐ Y ☐ N ☐ P
Swollen glands or lymph nodes	☐ Y ☐ N ☐ P

GastroIntestinal

Belching / Gas	☐ Y ☐ N ☐ P
Bloating	☐ Y ☐ N ☐ P
Change in thirst	☐ Y ☐ N ☐ P
Constipation	☐ Y ☐ N ☐ P
Diarrhea	☐ Y ☐ N ☐ P
Heartburn	☐ Y ☐ N ☐ P
Jaundice	☐ Y ☐ N ☐ P
Nausea	☐ Y ☐ N ☐ P
Trouble swallowing	☐ Y ☐ N ☐ P
Ulcer	☐ Y ☐ N ☐ P
Undigested food in stool	☐ Y ☐ N ☐ P
Vomiting	☐ Y ☐ N ☐ P
Gallbladder Disease	☐ Y ☐ N ☐ P
Liver Disease	☐ Y ☐ N ☐ P

Urinary

Frequent infections	☐ Y ☐ N ☐ P
Increased frequency	☐ Y ☐ N ☐ P
Inability to hold Urine	☐ Y ☐ N ☐ P
Kidney stones	☐ Y ☐ N ☐ P
Difficulty when urinating	☐ Y ☐ N ☐ P

Head/ Eyes / Ears / Nose / Throat

Headaches/ Migraines	☐ Y ☐ N ☐ P
Cataracts	☐ Y ☐ N ☐ P
Dryness	☐ Y ☐ N ☐ P
Eye pain	☐ Y ☐ N ☐ P
Glasses /Contacts	☐ Y ☐ N ☐ P
Glaucoma	☐ Y ☐ N ☐ P
Tearing	☐ Y ☐ N ☐ P
Vision problems	☐ Y ☐ N ☐ P
Ear pain	☐ Y ☐ N ☐ P
Impaired hearing	☐ Y ☐ N ☐ P
Ringing	☐ Y ☐ N ☐ P
Nosebleeds	☐ Y ☐ N ☐ P
Post nasal drip	☐ Y ☐ N ☐ P
Sinus problems	☐ Y ☐ N ☐ P
Frequent sore throat	☐ Y ☐ N ☐ P
Goiter	☐ Y ☐ N ☐ P
Gum problems	☐ Y ☐ N ☐ P
Hoarseness	☐ Y ☐ N ☐ P
Jaw clicking /pain	☐ Y ☐ N ☐ P
Lumps/Swollen Glands	☐ Y ☐ N ☐ P
Neck pain /Stiffness	☐ Y ☐ N ☐ P
Sore tongue	☐ Y ☐ N ☐ P

Nuerologic

Loss of balance	☐ Y ☐ N ☐ P
Loss of memory	☐ Y ☐ N ☐ P
Muscle weakness	☐ Y ☐ N ☐ P
Numbness	☐ Y ☐ N ☐ P
Paralysis	☐ Y ☐ N ☐ P
Tingling	☐ Y ☐ N ☐ P

Respiratory

Asthma	☐ Y ☐ N ☐ P
Cough	☐ Y ☐ N ☐ P
Difficult breathing/ Shortness of Breath	☐ Y ☐ N ☐ P
Emphysema	☐ Y ☐ N ☐ P
Positive TB test	☐ Y ☐ N

Cardiovascular

Anemia	☐ Y ☐ N ☐ P
Chest pain	☐ Y ☐ N ☐ P
Cold hands/feet	☐ Y ☐ N ☐ P
Heart Disease	☐ Y ☐ N ☐ P
Hemorrhoids	☐ Y ☐ N ☐ P
High blood pressure	☐ Y ☐ N ☐ P
Low blood pressure	☐ Y ☐ N ☐ P
Leg cramps	☐ Y ☐ N ☐ P
Murmur	☐ Y ☐ N ☐ P
Palpitations	☐ Y ☐ N ☐ P
Poor circulation	☐ Y ☐ N ☐ P
Swelling of feet	☐ Y ☐ N ☐ P
Varicose vein	☐ Y ☐ N ☐ P

Endocrine

Generally feel cold	☐ Y ☐ N ☐ P
Generally feel hot	☐ Y ☐ N ☐ P
Low blood sugar/Diabetes	☐ Y ☐ N ☐ P
Recently lost or gained weight	☐ Y ☐ N ☐ P
Sluggish after eating	☐ Y ☐ N ☐ P

Male Only

Hernia	☐ Y ☐ N ☐ P
Discharge or sores	☐ Y ☐ N ☐ P
Testicular mass	☐ Y ☐ N ☐ P
STD	☐ Y ☐ N ☐ P
Hernia	☐ Y ☐ N ☐ P
Discharge or sores	☐ Y ☐ N ☐ P
Testicular pain	☐ Y ☐ N ☐ P
Erectile dysfunction	☐ Y ☐ N ☐ P
Trouble with urination (frequency, hesitancy, pain, dribbling)	☐ Y ☐ N ☐ P
Prostate conditions	☐ Y ☐ N ☐ P
Date of last prostate exam	

Female Only

Discharge/Itching	☐ Y ☐ N ☐ P
Vaginal dryness	☐ Y ☐ N ☐ P
STD	☐ Y ☐ N ☐ P
Irregular Menses	☐ Y ☐ N ☐ P
Pain during intercourse	☐ Y ☐ N ☐ P
Fibrocystic breasts	☐ Y ☐ N ☐ P
Cancer: Cervical/Ovarian/Breast	☐ Y ☐ N

Family History

Relative	Age if living	Age/Cause of death	Ailments
Mother			
Father			
Siblings			
Grandmother			
Grandfather			

Date of last pap smear?_____ Abnormal pap? _____
Date of last period _____ Bleeding is ☐ Heavy ☐ Moderate ☐ Light
Onset of first menses was age_____
Periods generally last _____ days and occur every _____days
Do you perform monthly self breast exams? ☐ Yes ☐ No
When was your last breast exam? _____ Do you have regular mammograms? ☐ Yes ☐ No

Other Family Conditions:_____

Signature:_____ Date:_____

Thank you for taking the time to fill out this form. We look forward to seeing you.

Patient Information

Name: _____

DOB: _____

Mailing Address: _____
Day Phone Number: _____
Evening Phone Number: _____
Email: _____

At what number may phone messages be left? _____

Emergency Contact Person
Name: _____
Phone Number: _____
Relationship: _____

Iluminar, PLLC
480.338.8070 (p)

Metabolic Health
480.314.5133

C. R. Bosch, NMD
iluminartherapy.com