

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				

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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

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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? _____

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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever experienced health problems after putting down new carpets, painting, doing renovations or having your lawn sprayed with herbicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you sensitive to perfume, gasoline or other vapors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever lived near a refinery or polluted area?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever lived in a home more than 50 years old?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have mercury dental fillings? How many? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any dental root canal procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you live near power lines?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Review of Systems

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

General

Chills	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Fever	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent Colds	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Night Sweats	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Skin

Acne	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Bruise easily	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Eczema	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Itching	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Mole color change	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Rashes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Immune

Cold sores	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Chronic infections	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent antibiotics	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent colds/flu	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent sore throat	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cold sores	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Shingles	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Slow wound healing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Swollen glands or lymph nodes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

GastroIntestinal

Belching / Gas	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Bloating	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Change in thirst	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Constipation	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Heartburn	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Nausea	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Trouble swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Ulcer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Undigested food in stool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Gallbladder Disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

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Urinary

Frequent infections	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Increased frequency	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Inability to hold Urine	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Kidney stones	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Difficulty when urinating	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Head/ Eyes / Ears / Nose / Throat

Headaches/ Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cataracts	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Dryness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Eye pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Glasses /Contacts	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Tearing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Vision problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Ear pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Impaired hearing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Ringling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Nosebleeds	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Post nasal drip	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sinus problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent sore throat	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Goiter	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Gum problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Jaw clicking /pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Lumps/Swollen Glands	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Neck pain /Stiffness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sore tongue	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Nuerologic

Loss of balance	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Loss of memory	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Muscle weakness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Numbness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Paralysis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Tingling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Respiratory

Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cough	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Difficult breathing/ Shortness of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Positive TB test	<input type="checkbox"/> Y <input type="checkbox"/> N

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Cardiovascular

Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Chest pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cold hands/feet	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hemorrhoids	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Low blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Leg cramps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Palpitations	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Poor circulation	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Swelling of feet	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Varicose vein	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Endocrine

Generally feel cold	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Generally feel hot	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Low blood sugar/Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Recently lost or gained weight	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sluggish after eating	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Male Only

Hernia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Discharge or sores	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Testicular mass	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
STD	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hernia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Discharge or sores	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Testicular pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Erectile dysfunction	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Trouble with urination (frequency, hesitancy, pain, dribbling)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Prostate conditions	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Date of last prostate exam	

Female Only

Discharge/Itching	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Vaginal dryness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
STD	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Irregular Menses	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Pain during intercourse	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Fibrocystic breasts	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cancer: Cervical/Ovarian/Breast	<input type="checkbox"/> Y <input type="checkbox"/> N

Patient Name: _____ **DOB:** _____

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 Name: _____ DOB: _____

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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: _____

Patient Name: _____ DOB: _____

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