

PATIENT INTAKE

Name _____ **M or F** Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

SSN _____ Home phone _____ Cell _____

Occupation _____ Employer _____

Work phone _____ Email Address _____

Insurance:

Subscriber's name _____ Relationship _____

Subscriber's birth date (mm/dd/yy) _____ Employer _____

Primary Care Physician:

Name/Group _____ Phone _____

Address _____ Date of last physical _____

Date of recent/last lab work & imaging _____

Emergency Contact:

Name (Relation) _____ Phone _____

Family Information:

Marital Status: Single Married Partner Divorced Widow(er)
Spouse's name _____ Children: Y N Number _____ Ages _____

How did you hear about our practice? _____

Present Health Concerns (in order of importance):

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

Allergies to drugs, environmental, food, etc (state reaction):

Hospitalizations, Procedures, Injuries (surgeries/special diagnostic studies):

Date	Procedure	Reason	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Medications (including O-T-C):

Name of Drug	Reason for taking	Dose	Date Started	Prescribed by
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current supplements, vitamins, & Herbs:

Name of Drug	Reason for taking	Dose	Date Started	Prescribed by
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Females only (indicate what is applicable):

Are you pregnant? Y N Date of last menstrual period? _____ Menopausal
 Date of last GYN Exam: _____ Normal Abnormal Gynecologist _____
 Date of last mammogram _____ Normal Abnormal Other imaging _____
 Number of pregnancies _____ C-section: Y N Are you considering pregnancy? Y N
 Form of birth control _____ Age of first period _____ Length of cycle _____ days
 Interval between periods _____ days Any changes in flow (heavier, scant, clots) _____

Family History: indicate whether a family member or your self have the following conditions

I = Self M= Mother F=Father S=Sibling C= Child G= Grandparent

Allergies		Diabetes		Lung Disease	
Alcoholism		Digestive Disorder		Mental Disorder	
Anemia		Epilepsy		Multiple Sclerosis	
Arthritis		Heart Disease		Obesity	
Asthma		High Blood Pressure		Osteoporosis	
Autoimmune Disease		High Cholesterol		Spinal Condition	
Bleeding Tendency		Kidney Disease		Stroke	
Cancer ()		Liver/Gallbladder		Urinary Disorder	
Cancer ()		Other ()		Other ()	

Comments: (Use the space provided to address any other health conditions not covered above)

LIFESTYLE

Health Habits:

Tobacco -#cigarettes/day _____ Past Smoker _____ Recreational Drugs-current or past IV drugs
Alcohol: Wine #glasses/day or wk _____ Beer #glasses/day or wk _____ Liquor #ounces/day or wk _____
Caffeine: Coffee #6oz cups/day _____ Tea #6oz cups/day _____ Soda with caffeine #cans/day _____
Water: #8oz glasses/day _____ Herbal teas _____ Other beverages _____

Nutrition and Diet:

Omnivore (animal and plant based) Vegetarian Vegan Fat restriction Salt restriction
Carbohydrate restriction Specific restrictions: Wheat Dairy Soy Gluten Other _____
Number of Servings per day of: Fruits _____ Dark Green/Yellow Orange Vegetables _____ Grains _____
Beans _____ Nuts _____ Dairy _____ Eggs _____ Poultry _____ Fish _____ Meat _____
Eating Habits: Skip Meals (which ones) _____ One meal/day Two meals/day Three meals/day
Eat on the run Eat small frequent meals Eat constantly whether hungry or not

Exercise:

5-7 days/wk 3-4days/wk 1-2days/wk 45min or more duration per workout 30-45min less than 30min
walk-#days/wk _____ run/aerobic-#days/wk _____ weights-#days/wk _____ stretching _____ other _____

Stress:

Circle the level of stress you are usually experiencing (1 is the lowest) 1 2 3 4 5 6 7 8 9 10
Indicate the causes of stress: Work Family Relationship Financial Residence Legal problems

Body Composition:

Do you consider yourself: underweight overweight just right out of shape
Have you had an unintentional weight loss or gain of 10 pounds or more in the last 3 months? yes no

Environment:

Is your job associated with any harmful chemicals (pesticides, industrial chemicals, radioactivity) or hazardous, life threatening activity (firefighter)? yes no Please explain _____
In and around your residence, do you use? pesticides herbicides cleaning chemicals like tilex, mildew removers natural cleaning products organic lawn care air fresheners/plug-ins scented candles
Do you?: get your hair colored or highlighted wear acrylic nails perfumes artificially scented products

I WOULD LIKE TO:

Energy/Vitality:

Feel more vital Have more energy Have more endurance Be less tired after lunch
Sleep better Be free of pain Get less colds and flus Get rid of allergies Improve sex drive
Not be dependent on over the counter meds like antihistamines, aspirin, sleeping aids, etc
Stop using laxatives and stool softeners

Body Composition:

Lose weight Burn more fat Be stronger Have better muscle tone Be more flexible

Stress, Mental, Emotional:

Learn how to reduce stress Think more clearly and be more focused Improve memory
Be less depressed Be less moody Be less indecisive Feel more motivated

Life Enrichment:

Reduce my risk of degenerative disease Maintain a healthier life longer
Slow down accelerated aging Change from treating illness orientation to creating wellness lifestyle

HOW MUCH CHANGE ARE YOU WILLING TO MAKE?

Whatever it takes

Diet changes: Eliminate certain foods Change pattern of eating Eat healthier foods

Lifestyle changes: Quit smoking Work less Sleep more Stress reduction techniques

Take supplements: Pills only Medical foods -powdered drinks Chewable vitamins only

Activity: Gentle movement therapy Exercise program

Other comments _____

Review of Systems. (Circle if you now have or had previously any of the following)

General/Endocrine:

Weight Change	Fever/Chills	Weakness/Paralysis	Fatigue	Sweating/Nightsweats
Lymph node Enlargement	Sleep problems	Freq. infections	Goiter	Heat/cold intolerance

Skin:

Hair/Nail changes	Rashes/Eczema	Itching	Brittle Nails	Dry skin	Hives
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Head, Eyes, Ears, Nose:

Headache	Trauma	Vision changes/Glasses	Blurring	Eye Pain/Discharge
Ears ringing	Ear Infections	Hearing problems	Sinusitis	Postnasal drip
Loss of smell	Nosebleeds	Nose Discharge	Hayfever	

Mouth:

Sores	Gum bleeding	Loss of taste	Hoarseness	Sore throat/infections
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Lungs:

Trouble breathing	Chest pain	Cough/Wheeze	Coughing blood/sputum	
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Cardiovascular:

Chest pain	Palpitations	Murmur	Cyanosis (Blue skin)	Pain in legs
Edema/Swelling	Cold feet/hands	Poor circulation	Varicose veins	Anemia

Gastrointestinal:

Change in appetite	Hernia	Nausea/vomiting	Indigestion/ Heartburn	Gas/Bloating
Abdominal pain	Blood in stool	Hemorrhoids	Diarrhea/Constipation	Jaundice
Trouble swallowing	Stool changes	Anal discomfort	Ulcers	

Bones, Joints, Muscles:

Arm pain	Back pain	Bursitis	Hip pain	Numbness/tingling
Neck pain/stiffness	Leg pain	Muscle pain	Joint pain	Bone pain
Sciatica	TMJ pain			

Neurological:

Fainting/Loss of balance	Convulsions	Speech	Gait/coordination	Dizziness/Tremor
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Genitourinary:

Blood in urine	Pain	Incontinence	Increased frequency	Urgency
Urination at night	Prostate problem	Erectile dysfunction	Decreased sex drive	

Breasts/GYN:

Breast lumps/pain/discharge	Vaginal infections	Fibrocystic breasts	Irregular periods	Low sex drive
Menstrual cramps	Infertility	PMS	Fibroids/Ovarian cysts	Pain w/ intercourse

Psychological:

Anxiety/ Irritability	Depression	Mood problems	Concentration problems	Memory loss
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PATIENT SIGNATURE

DATE