PATIENT INTAKE

Name _____Gender_____ 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):

Whole Health Associates, LLC
120 Simsbury Rd, Suite B Avon, CT 06001
Telephone: 860-674-0111
Fax: 860-677-5406

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 fresherners/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/night sweats

Lymph node enlargement	Sleep problems	Freq. infections	Goiter	Heat/cold intolerance	
Skin:					
Hair/Nail changes	Rashes/Eczema	Itching	Brittle Nails	Dry skin	Hives
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	
Lungs:					
Trouble breathing	Chest pain	Cough/Wheeze	Coughing blood/sputum		
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	
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	

PATIENT SIGNATURE **DATE**

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