# 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 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______________________________________________________________________________
_________________________________________________________________________________________

**<u>Review of Systems.</u> (Circle if you now have or had any of the following in the last 6 months)**

**General/Endocrine:**

Weight Change | Fever/Chills | Weakness/Parlaysis | 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

**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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