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 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 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** _____