New Patient Intake

Name :_____ Age: _____DOB:_____ Sex: _____

Email:_____ _____

Address:_____City:_____State:_____Zip:_____ _____

Preferred Phone: (____) _____-_____ Best time to contact you: _____

Is it ok to leave a detailed message via phone or email? Yes /No

Check all that apply:

The Clinic may contact me by: _____email_____text in order to send:

___ appointment reminders___ personalized treatment options ___occasional special offers

Who can we thank for referring you?:_____

Emergency Contact:_____
Relationship to patient: _____ Phone: (____) _____-_____

Occupation(s) Present and Past:
_____
_____
_____

Preferred Pharmacy/ Location_____

Priority Health Concerns:

Please list your top 5 major health concerns in **order of importance**:
1._____ _____
2._____

_____
3. _____
_____
4._____
_____
5._____
_____

Medical Conditions:

Please list any conditions you have been previously diagnosed with by another provider:
1._____Date diagnosed:
_____
2._____ Date diagnosed:
_____
3._____ Date diagnosed:
_____
4. _____Date diagnosed:
_____
5. _____Date diagnosed:
_____ 6._____ Date diagnosed: _____
7._____ Date diagnosed:
_____
8._____ Date diagnosed:
_____

Surgeries:

Please list ALL surgeries you've had in your life (include C-sections, Cosmetic, Hernia, Dental, etc)
1._____ Mo/Yr:_____
2._____Mo/Yr:_____
3._____ Mo/Yr:_____
4._____ _____ Mo/Yr:_____
5._____Mo/Yr:_____

6._____ Mo/Yr:_____
7._____ Mo/Yr:_____
8._____Mo/Yr:_____

Pain:

Do you have pain? Yes/No If yes, location(s)

_____

__

Rate on scale of 1-10_____ Pain quality is: sharp/dull/radiating/throbbing/cramping

Other_____

_____

Sleep:

Do you sleep well? Yes/No How many hours per night? _____ Do you nap? Yes/No Have you ever had a sleep study? Yes/No

Circle any which apply to your sleep pattern: Difficulty falling asleep, Awakening intermittently during the night, Excessive Daytime Sleepiness, Snoring, Irregular Breathing While Sleeping, Gasping for Air While Sleeping, Diagnosed with Obstructive Sleep Apnea, Uses CPAP regularly, Should use CPAP but don't use it as prescribed, Uses Oxygen when Sleeping

If you awaken at night what awakens you?

_____

_____

Medication/Supplement/Allergy List

Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Supplements	**Dosage**	**Frequency**
1.		
2.		
3.		
4.		
5.		
6.		

7.		

Allergies:

(Includes: Drugs, Foods, Environmental)

No Known Drug Allergies

1:_____
2:_____

3:_____
4:_____

5:_____ 6:
_____

7:_____
8:_____

9:_____
10:_____

Toxic Exposure: Circle any you have come in contact with currently or in past: Mercury fillings/Artificial Joints or Implants/Lead/Arsenic/Aluminum/Cadmium/ Mercury/Radon/Oil/Mold/ Industrial Chemicals/Roundup/Welding/Mechanic/ Taxidermy/Pesticides/Herbicides/ Construction/Radiation/Other_____

Social History:

Marital Status: Single Married Separated Divorced Widowed

Use of Alcohol: Never 1-5 drinks weekly Daily >15 drinks/weekly

Use of Tobacco/Cigarettes: NeverPreviously-Date quit:_____
Total length of use (years)_____ Packs per day:_____ Type of Tobacco:_____

Use of Recreational Drugs: Never Type(s):_____Frequency:_____
Date last used: _____

Use of Diet Drugs: Never
Type(s):_____Frequency:_____ Date last used:
_____

Excessive exposure at home or at work, to hazardous waste mold or chemicals. No/Yes
Type(s):_____
_____

Family Medical History:

Family Members	Age	Disease(s)	Cause of Death
Father			
Mother			

Siblings			
Children			
Uncle/Aunt Maternal			
Grandmother Maternal			
Grandfather Maternal			
Aunt/Uncle Paternal			
Grandmother Paternal			
Grandfather Paternal			
First Cousins			

Provider Notes_____.

Patient Medical History:

COVID-19 Infection	Yes	No	Skin Conditions	Yes	No
Diabetes	Yes	No	Hereditary Defects	Yes	No
Bleeding Disorders	Yes	No	Clotting Disorders	Yes	No
Kidney Disease	Yes	No	Liver Disease	Yes	No
Hypertension	Yes	No	Low or High Blood Cell Count	Yes	No
Cancer	Yes	No	Hepatitis	Yes	No
Stroke/TIA	Yes	No	Reflux/ Heartburn	Yes	No
Heart Problems	Yes	No	Thyroid disease	Yes	No
Respiratory Problems	Yes	No	Gastrointestinal Conditions	Yes	No
Asthma or Allergies	Yes	No	Genitourinary Conditions	Yes	No

Heart Attack	Yes	No	Autoimmune Conditions	Yes	No
Arthritis/Gout	Yes	No	Mental Health Issues	Yes	No
Seizure	Yes	No	Kidney Stones	Yes	No
Joint Problems	Yes	No	Numbness/ Tingling	Yes	No
Chronic Infection	Yes	No	Neurological Conditions	Yes	No
Acute Infection	Yes	No	Migraines	Yes	No
STD's	Yes	No	Eyes, Ears, Nose, Throat Conditions	Yes	No

Specific information for "yes answers

_____

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Provider Notes:_____

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Females Only:

PMS Mod/Severe	Yes	No	Excessive Hair Growth Face/Body	Yes	No
Menstrual Cramps	Yes	No	Hysterectomy Partial/Full	Yes	No
Pelvic Pain	Yes	No	Decreased Libido	Yes	No
PCOS	Yes	No	Sexual Dysfunction	Yes	No

Pain with Intercourse	Yes	No	Ovarian or Uterine Cancer	Yes	No
Endometriosis	Yes	No	Vaginal Dryness	Yes	No
Uterine Polyps	Yes	No	History of Vaginal infections	Yes	No
Breast Pain	Yes	No	Abnormal Vaginal Discharge	Yes	No
Infertility	Yes	No	Recurrent UTIs	Yes	No
Ovarian Cysts	Yes	No	Sexually Active Monogamous Non-Monogamous	Yes	No
Breast Cancer	Yes	No	STD Treatment	Yes	No
Heavy Periods	Yes	No	Irregular Periods	Yes	No
Abnormal PAP	Yes	No	Bleeding between Periods	Yes	No

Additional information for any **Yes** Answers:_____

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Last Menstrual Cycle: _____ # of days between Menstrual Cycles:

_____

Age of Menarche: _____ Heavy days#_____Average length of cycle _____(days)_

Cramping: Yes/No Bloating: Yes/No Clotting: Yes/No PMS: Yes/No

Do you use contraception? Yes/No Current use? Yes/No Past use? Yes/No Type(s):

_____

Number of Pregnancies:_____ Number Live Children:_____

Menopausal Women: Last period date:_____ Postmenopausal Bleeding: Yes/No

Circle any of these symptoms you are experiencing: Hot flashes/Night Sweats/Fatigue/ Mood Swings/Sleep Problems/Dry Skin/Vaginal Dryness/Hair Loss/Low Libido/Painful Sex/Inability to have Orgasm/

Past or Present Hormone Replacement Therapies:

_____

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Provider Notes:

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Males Only:

Enlarged Prostate	Yes	No	History of Prostate Infection(s)	Yes	No
Prostate Cancer	Yes	No	Vasectomy	Yes	No
Bladder Cancer	Yes	No	History Infertility	Yes	No
Testicular Cancer	Yes	No	Difficulty Starting/ Stopping Urine Stream	Yes	No
Swollen or Painful Testicles	Yes	No	Penile Discharge	Yes	No
Low Libido	Yes	No	Abnormal PSA	Yes	No
Erectile Dysfunction	Yes	No	Morning Erections	Yes	No
Loss of Motivation	Yes	No	Recurrent UTIs	Yes	No
Premature Ejaculation	Yes	No	Sexually Active Monogamous Non-Monogamous	Yes	No
Undescended Testicle(s)	Yes	No	STD Treatment	Yes	No

Please Provide Details for any **Yes** Answers:_____

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Provider Notes:

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Review of Symptoms:

Constitutional Symptoms			**Musculoskeletal**		
Good General Health	Yes	No	Joint Pain	Yes	No
Recent Weight Change Weight Loss pounds: Weight gain pounds:	Yes	No	Joint stiffness or swelling	Yes	No
Fever	Yes	No	Weakness of muscle or joints	Yes	No
Fatigue	Yes	No	Back Pain	Yes	No
Headaches	Yes	No	Cold Extremities	Yes	No
Night sweats	Yes	no			
Eyes			Difficulty walking	Yes	No
Eye disease or injury	Yes	No	**Integumentary**		
Wear glasses/ contacts	Yes	No	Rash, itching or Urticaria	Yes	No
Blurred/Double Vision	Yes	No	Change in skin Color	Yes	No
Glaucoma	Yes	No	Change in hair or nails	Yes	No
Eye pain / redness or Abnormal discharge	Yes	No	Change in mole/ warts	Yes	No
Sudden Change in Vision	Yes	No	Difficulty with healing cuts	Yes	No
Ears/Nose/ Mouth/Throat			Varicose veins	Yes	No
Hearing loss or ringing	Yes	No	Eczema	Yes	No
Ear ache or Drainage	Yes	No	Psoriasis	Yes	No
Chronic sinus Problems	Yes	No	**Neurological**		
Nose Bleeds	Yes	No	Paralysis	Yes	No

Post Nasal Drainage			Weakness	Yes	No
Recurrent Strep Infection	Yes	No	Migraines	Yes	No
Enlarged Tonsils	Yes	No	Nerve Pain	Yes	No
Mouth sores	Yes	No	Freq/recurring headaches	Yes	No
Bleeding gums	Yes	No	Lightheaded/ Dizzy or Vertigo	Yes	No
Bad Breath or Bad Taste	Yes	No	Seizure	Yes	No
Sore Throat or Voice change	Yes	No	Numbness/ tingling sensation Location(s)	Yes	No
Swollen Glands in neck	Yes	No	Tremors Intermittent Constant	Yes	No
Cardiovascular			Memory Loss	Yes	No
High Blood Pressure	Yes	No	Acute Head injury/ Concussion	Yes	No
Chest Pain or Angina	Yes	No	**Psychiatric**		
Rapid heart rate	Yes	No	Bipolar/ uncontrolled	Yes	No
Shortness of breath Cough @ night	Yes	No	Memory Loss/ confusion	Yes	No
Swelling of feet, ankle, or hands	Yes	No	Nervousness	Yes	No
Respiratory			Depression	Yes	No
Chronic cough	Yes	No	Insomnia	Yes	No
Spitting up blood	Yes	No	Anxiety	Yes	No
Shortness of breath	Yes	No	Post Traumatic Stress Disorder	Yes	No
Pain with breathing	Yes	No	**Endocrine**		
Asthma or wheezing	Yes	No	Known Glandular or Hormonal Condition Type:	Yes	No
Gastrointestinal			Intermittent sweating	Yes	No

Loss of Appetite	Yes	No	Awakens @night with no known cause	Yes	No
Increase in appetite	Yes	No	Excessive thirst	Yes	No
Change in bowel Movements	Yes	No	Excessive urination	Yes	No
Nausea and/or vomiting	Yes	No	Dry skin	Yes	No
Painful Bowel Movements/ constipation	Yes	No	Heat or cold Intolerance	Yes	No
Loose stools/ diarrhea Number of stools per day	Yes	No	Shakiness and trembling	Yes	No
Rectal Bleeding or Blood in stool	Yes	No	Pain in joints/ muscles later in the day	Yes	No
Heartburn/reflux	Yes	No	Hypoglycemia	Yes	No
Abdominal pain	Yes	No	Excessive drowsiness after eating	Yes	No
Ulcer (stomach or Duodenal)	Yes	No	**Blood/Lymph Gland Abnormalities**		
Gas, Bloating	Yes	No	Slow to heal after cuts / injuries	Yes	No
Malabsorption	Yes	No	Enlarged Lymph Nodes	Yes	No
Food Intolerance	Yes	No	Symptoms of Blood clot	Yes	No
Genitourinary			Bleeding or Bruising tendency	Yes	No
Frequent urination	Yes	No	Anemia/Low Iron	Yes	No
Burning or painful urination	Yes	No	Pain in Blood Vessel(s)	Yes	No
Discharge with urination			Too much iron in the blood	Yes	No
Blood in urine	Yes	No	Past BloodTransfusion	Yes	No
Change in stream or strain with urination	Yes	No	New Mass or Swelling	Yes	No

Incontinence or dribbling	Yes	No	Frequent illnesses (viral or bacterial)	Yes	No
Other			**Other**		
	Yes	No		Yes	No
	Yes	No		Yes	No
	Yes	No		Yes	No
	Yes	No		Yes	No

Current Details for any **Yes** Answers:_____

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Provider Notes:

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Labs/Diagnostics/Vaccinations:

Procedure	Date	Facility
Full Blood Test Panels		
EKG		
Chest X-ray		
Colonoscopy		
Mammogram		
Pap Smear		
Bone Density/Dexa Scan		
CT scan or MRI scan		

Ultrasound (s)		
Vaccine	**Date**	**Facility**
Flu Vaccine		
Pneumonia Vaccine		
Shingles Vaccine		
Tetanus Vaccine		
COVID-19 Vaccine		
Other		