Patient Intake Form

Date: _____

Dr.: _____

Patient Name: _____ **DOB:** _____

List your health concerns in order of importance:

1) _____
2) _____
3) _____
4) _____
5) _____

Name and telephone number of Primary Care physician: _____

_____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when died:						
Reason for death:						
Cancer type:						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

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Patient Name: _____ **DOB:** _____

Please Note When & Why You Have Had Each of the Following:

X-Rays: _____ MRI/Cat Scans: _____ Ultrasounds: _____
Accidents: _____ TB Test: _____ HCV: _____
HIV: _____ Last Dental Visit: _____ Last Eye Exam: _____

Did you have the following **D**isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**):

Measles: D I N **Chicken Pox**: D I N **Hemophilus (Hib)**: D I N
Rubella: D I N **Tetanus**: D I N **Whooping Cough**: D I N
Mumps: D I N **Hepatitis B**: D I N
Any vaccination reactions: _____

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Antacids: Y N P **Steroids**: Y N P **Smoking**: Y N P **Packs per day & number of years**:___
Analgesics: Y N P **Laxatives**: Y N P **Coffee**: Y N P **Cups per day if Yes/Past**: _____
Soda Pop: Y N P **Ounces per day if Yes/Past**: _____
Alcohol: Y N P **How often & how much if Yes/Past**: _____
Any Alcohol Addiction: Y N P **Any Alcohol Treatment**: Y N P
Recreational Drugs: Y N P **Any Drug Addictions**: Y N P
Any Drug Treatment: Y N P

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and including dosage:

_____

_____

Review of Systems:

Present Weight: _____ **Weight one year ago**: _____ **Height**: _____
Maximum weight and when: _____ **Minimum weight as adult & when**: _____
Ideal Weight: _____

REGARDING THE NEXT LONG SECTION: Please circle (**Y)** if you have the problem **NOW**, (**N)** if you've **NEVER** had the problem, (**P)** if you had the problem in the **PAST**.

Good Energy: Y N P
Fatigue: Y N P
If you have fatigue, when in morning, afternoon, evening is it the worst? _____
If you have fatigue, can you do what you need to during the day? Y N

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SKIN

Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
Cancer:	Y N P		**Perspiration:**	Y N P

HEAD

Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
Oil/dry hair:	Y N P		**Hair loss:**	Y N P

NOSE

Frequent Colds:	Y N P		**Nosebleeds:**	Y N P
Congestion:	Y N P		**Post Nasal Drip:**	Y N P
Polyps:	Y N P		**Seasonal Allergies:**	Y N P

EYES

Dry/Watery:	Y N P		**Blurry Vision:**	Y N P
Double Vision	Y N P		**Cataracts:**	Y N P
Glaucoma:	Y N P		**Styes:**	Y N P
Strain:	Y N P		**Discharge:**	Y N P
Itchy:	Y N P		**Dark under Eyelid:**	Y N P

MOUTH/THROAT

Canker sores:	Y N P		**Cold sores:**	Y N P
Sore Throat:	Y N P		**Gum disease:**	Y N P
Dentures:	Y N P		**Cavities:**	Y N P
Loss of taste:	Y N P		**Hoarseness:**	Y N P

NECK

Stiffness:	Y N P		**Swollen Glands:**	Y N P
Full movement:	Y N P		**Tension:**	Y N P

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RESPIRATORY

Cough:	Y N P		**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P		**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P		**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P		**Asthma:**	Y N P
Wheezing:	Y N P		**Painful breathing:**	Y N P

CARDIOVASCULAR

High Blood Pressure:	Y N P		**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P		**Murmurs:**	Y N P
Arrhythmias:	Y N P		**Palpitations:**	Y N P
Edema:	Y N P		**Chest Pain:**	Y N P

URINARY TRACT

Incontinence:	Y N P		**Pain w/ Urination**	Y N P
Frequent Infections:	Y N P		**Kidney Stones**	Y N P
Urgency:	Y N P		**Discharge/Blood:**	Y N P

GASTROINTESTINAL

Heartburn:	Y N P		**Bowel Movement Freq:**	
Indigestion:	Y N P		**Recent BM Change:**	Y N P
Bloating:	Y N P		**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P		**Hemorrhoids:**	Y N P
Vomiting:	Y N P		**Gall Bladder Disease**	Y N P
Change in Appetite:	Y N P		**Liver Disease:**	Y N P
Pancreatitis:	Y N P		**Ulcer**	Y N P

MALE GENITALIA

Testicular pain/swelling:	Y N P		**Sexually Active:**	Y N P
Hernia:	Y N P		**S.T.D.:**	Y N P
Discharge:	Y N P		**Prostate Disease/Symptoms:**	Y N P
Impotency:	Y N P		**Sexual Orientation**	

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FEMALE GENITALIA

Age Period Began:			How Often Period Occurs:	
How long period lasts:			Heavy menstrual bleeding:	Y N P
Menstrual cramping:	Y N P		Menstrual Pain:	Y N P
PMS:	Y N P		Food cravings:	Y N P
Times Pregnant:			How many births:	
Miscarriages:			Abortions:	
Last Pap Smear:			Sexual Orientation:	
Any abnormal paps:	Y N P		When was abnormal:	
Menopausal since what age:			Use of hormones:	Y N P
Type of hormones used:			Healthy libido:	Y N P
Dry vagina:	Y N P		Sexually Active:	Y N P
Pain w/ Intercourse:	Y N P		Vaginitis:	Y N P
S.T.D.:	Y N P		Mammography:	Y N P
Bone Density Test:	Y N P		If Yes, what were results:	

Please list any birth control used and ages used: _____

_____

MUSCULOSKELETAL

Weakness:	Y N P		Arthritis:	Y N P
Stiffness:	Y N P		Leg Cramps:	Y N P
Tremors:	Y N P		Pain:	Y N P

NERVOUS

Paralysis:	Y N P		Sciatica:	Y N P
Tingling/numbness:	Y N P		Carpal tunnel syndrome:	Y N P
Seizures:	Y N P		Fainting:	Y N P

Mental/Emotional

Depression:	Y N P		Anger/irritability:	Y N P
Suicidal:	Y N P		High-strung/tense:	Y N P
Anxiety:	Y N P		Fear/Panic	Y N P
Eating disorder:	Y N P		Psych Hospitalization:	Y N P

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Exercise

How often do you exercise? _____ What type of exercise? _____

For how long? _____ Hobbies: _____

Sleep

How long per night? _____ If you wake up frequently, what is the reason? _____

Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P

Sleep walk: Y N P Grind teeth: Y N P Snore: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

_____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

Social Life

Enjoy job: Y N P Hours worked per week: _____ Highest Level of Education: _____

Active spiritual practice: Y N P Quality of significant relationship: _____

History of sexual, mental/emotional, physical abuse: Y N P

What is your greatest health concern: _____

How does it limit you the most: _____

How committed are you towards making valuable changes: Little Moderately Very

Allergies

List all known Allergies (food, drugs, environment): _____

_____

Additional Information

Please list any additional information/topics which you believe is important we address during your office visit: