Dr. Christina Sahni Radie
1306 NW Hoyt Ave. Suite #405 Portland, OR 97209
(503) 404-2333

Intake Form

Today's Date:_____
Name: _____
Address: _____ City, State, Zip _____
Telephone Number:_____ Cell Number: _____
Email address: _____ Date of Birth: _____ Gender: _____
Marital Status (circle one): Married Divorced Separated Single Widowed Partnership
Current living situation: _____
Occupation: _____ Employer: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone Number: _____
How did you hear about us? _____
Please list your most important current health problems, in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

How committed are you to your health?

0 1 2 3 4 5 6 7 8 9 10
Not at all Very committed

How open are you to lifestyle changes such as changes to your current diet and exercise regimen?

0 1 2 3 4 5 6 7 8 9 10
Not at all Very open

Personal health history:

Allergies (including drugs, antibiotics, foods, environmental): _____
_____
Current medications (please list all current medications including supplements and over the counter medications, how much you are taking and how often):
_____
_____
_____
Current diet: Please list what you typically eat for
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Water intake: _____ Other Beverages: _____
Alcohol Use: Y N If yes, how many drinks per week? _____
Tobacco use: Y N If yes, please indicate what time and how much: _____
Exercise: Do you currently exercise? Y N Times per week: _____ Activities:_____ _____
_____
Sleep: Hours per night _____ Do you wake feeling rested? Y N
Stress, please describe your biggest stressors: _____
Previous hospitalizations/Surgeries: _____
Other accidents: _____
Current Primary Care Physician Name & Phone #: _____
Please list any other physicians, including chiropractors, naturopaths, acupuncturists, etc. that you are currently seeing:
_____
_____

Current/Past Ailments: Please indicate which of the following conditions you currently have (Y), have had in the past (P), or have never had (N)

High blood pressure	Y	P	N	Cataracts	Y	P	N
Heart disease	Y	P	N	Glaucoma	Y	P	N
Stroke	Y	P	N	Macular degeneration	Y	P	N
Rheumatic fever	Y	P	N	Thyroid disease (hyper- or hypo-)	Y	P	N
Heart murmur	Y	P	N	Irritable Bowel Disease (IBD)	Y	P	N
Ear infections	Y	P	N	Diabetes- Type I or II	Y	P	N
Anemia	Y	P	N	Cancer _____	Y	P	N

Current/Past Symptoms: Please indicate whether you currently experience this symptom (Y), have experienced it in the past (P) or have never experienced it (N)

Gastrointestinal:				Headache	Y	P	N
Nausea	Y	P	N	Migraines	Y	P	N
Vomiting	Y	P	N	Head injury	Y	P	N
Diarrhea	Y	P	N	TMJ problems	Y	P	N
Constipation	Y	P	N	Teeth grinding	Y	P	N
Abdominal Pain	Y	P	N	Blurred vision	Y	P	N
Gas/indigestion	Y	P	N	Double vision	Y	P	N
Heartburn	Y	P	N	Impaired hearing	Y	P	N
Cardiovascular:				Ear pain	Y	P	N
Chest Pain	Y	P	N	Ringing in ears	Y	P	N
Heart palpitations	Y	P	N	Sinus infections	Y	P	N
Varicose veins	Y	P	N	Nasal congestion	Y	P	N
Blood clots	Y	P	N	Frequent colds	Y	P	N
Foot/ankle swelling	Y	P	N	Nose bleeds	Y	P	N
Respiratory:				Hay fever/ seasonal allergies	Y	P	N
Shortness of breath	Y	P	N	Gum/tooth problems	Y	P	N
Cough	Y	P	N	Mouth sores	Y	P	N
Asthma	Y	P	N	Swollen glands	Y	P	N
Wheezing	Y	P	N	Difficulty swallowing	Y	P	N
Neurological:				**Urinary:**			
Numbness/tingling	Y	P	N	Frequent Urination	Y	P	N
Vertigo/dizziness	Y	P	N	Frequent Infections	Y	P	N
Loss of consciousness/fainting	Y	P	N	Kidney Stones	Y	P	N
Seizures	Y	P	N	Pain with urination	Y	P	N
Skin:				Blood in urine	Y	P	N
Rashes	Y	P	N	**Male Reproductive**:			
Itching	Y	P	N	Frequent Urination	Y	P	N
Hair loss	Y	P	N	Pain with urination	Y	P	N
Eczema	Y	P	N	Urination at night	Y	P	N
Acne	Y	P	N	Inability to hold urine	Y	P	N
Color changes	Y	P	N	Frequent infections	Y	P	N
Musculoskeletal:				**Female Reproductive**:			
Joint pain	Y	P	N	Pain with cycle	Y	P	N
Muscle pain	Y	P	N	Irregular cycle	Y	P	N
Back pain	Y	P	N	Vaginal discharge	Y	P	N
Neck pain	Y	P	N	Frequent infections	Y	P	N
Muscle spasms	Y	P	N	Breast pain	Y	P	N
Muscle weakness	Y	P	N	Breast lumps	Y	P	N
HEENT:				Nipple discharge	Y	P	N

Family history: Please indicate who in your family has or had any of the following conditions

High blood pressure	Y	N	_____
Heart disease	Y	N	_____
Diabetes- Type I or II	Y	N	_____
Heart murmur	Y	N	_____
Stroke	Y	N	_____
Rheumatic fever	Y	N	_____
Thyroid disease (hyper- or hypo-)	Y	N	_____
Macular degeneration	Y	N	_____
Glaucoma	Y	N	_____
Cataracts	Y	N	_____
Cancer _____	Y	N	_____

Financial Policy:
Payment is due at time of service.
Upon request a bill can be provided to you to send to your insurance company in the event that the services provided at this clinic will be covered, so that you can be reimbursed.

Cancellation Policy:
At least 24 hour notice is required to cancel your appointment. If it is not cancelled at least 24 hours prior to your scheduled appointment, you may be charged up to 100% of the missed appointment.

All of the above information is true to the best of my knowledge and I agree to the financial and cancellation policies of this office as stated above.

_____ _____
Patient Signature (or Parent or Legal Guardian if patient is under 18) Date

_____
Printed Name