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New Patient Intake

Patient Demographic Information

Today's Date:_____

First Name: _____ Middle Initial: _____ Last Name: _____ Title: _____

Nickname or Preferred Name: _____ Birthdate: _____ Age:_____

Street Address: _____ City, State, Zip:_____

Home Phone: _____ Work/Mobile Phone:_____

Email: _____ Preferred Method of Communication?: □ Email □Phone

Occupation: _____ If retired, previous occupation: _____

Employer/School:_____ Level of Education: _____

Marital/Partnership Status: □Married □Single □Divorced □Widowed □Significant Other

Name of Spouse/Partner:_____ Number and Ages of Children: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us?_____

Goals and Expectations

Please tell us three goals or expectations for our practice:

1) _____

2) _____

3) _____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

Summary of Current Condition

What is your most important health concern/concerns?

This condition interferes with: □ Work/School □ Sleep □ Exercise/Movement □ Other:

This condition is: □ Getting Worse □ Getting Better □ Staying the Same □ Worse in the Morning □ Worse in the Evening

How long have you had this concern or condition?

What do you believe is the cause?

Other Conditions

Please list other health concerns.

When was your last visit to a doctor's office, medical clinic or hospital and what was the reason?

Please list the names and clinic names of your current health care providers including MDs, Dos, Naturopaths, Acupuncturists, Chiropractors or any other specialists.

Medical History

Family History

Does anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma/Cataracts
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay Fever	Hives	Headaches
Alcoholism	Infertility	Skin Disorder	Autoimmune Disease

Please circle whether you have had any of the following as a child:

Diptheria	Chicken Pox	Rheumatic Fever	Mumps	German Measles (Rubella)
Scarlet Fever	Strep Throat	Measles	Other:_____	

Did you receive typical childhood vaccines? Yes / No

Please list any travel vaccines that you have had:_____

Have you received a Tetanus vaccine? Yes / No If yes, when was the last one?_____

Have you received an Influenza vaccine? Yes / No If yes, when was the last one?_____

Hospitalizations/Surgery/Imaging

What hospitalizations, surgeries, x-rays, colonoscopies, MRIs, CAT scans, EEG, EKGs or other diagnostic exams have you had?

_____ Year_____ _____ Year_____

_____ Year_____ _____ Year_____

_____ Year_____ _____ Year_____

Date of last physical exam:_____ Date of last dental exam:_____

Date of last eye exam:_____ Date of last bloodwork:_____

Allergies

Are you hypersensitive or allergic to:

Any drugs?_____

Any foods?_____

Any environmentals or chemicals?_____

Prescription Medications – List all prescription medications you are currently taking. Please attach list if more space is needed.

Medication	Dosage	Prescribing Doctor Name	Related Medical Condition

Over-the-Counter Medications, Vitamins and Supplements -- (e.g. aspirin, multivitamin, decongestant, etc) Please attach list if more space is needed.

Brand Name	Supplement/Drug	Dosage	Related Medical Condition

Review of Systems – Please check all categories which you consider significant to your current or past health

Head	Mouth/Throat	Skin (continued)	Vascular
___Headaches	___Frequent sore throat	___Skin cancer	___Anemia
___Migraines	___Sore tongue, lips	___Rosacea	___Cold hands/feet
___Head Injury	___Gum problems	___Flushing/hot flashes	___Varicose veins
___Jaw, TMJ	___Metallic taste in mouth	___Slow wound healing	___Easy bleeding/bruising
___Jaw clicks	___Hoarseness	Respiratory	___Thrombophlebitis
___Vertigo	___Dental cavities	___Asthma	Endocrine
Ears	___Grinding of teeth	___Difficulty breathing	___Fatigue
___Dizziness	___Bad breath	___Emphysema	___Intolerance of heat
___Earaches	___Excessive saliva	___Pain on breathing	___Intolerance of cold
___Impaired hearing	___Dryness of mouth	___Pneumonia	___Increasing hunger
___Ringing, tinnitus	___Cold sores	___Pleurisy	___Increasing thirst
___Excessive wax	___Swollen glands	___Rib fracture	___Seasonal depression
___Itching	___Tonsils/Adenoids Removed	___Chronic cough	Musculoskeletal
Eyes	Neck	___Coughing up blood	___Arthritis
___Blurry vision	___Goiter	___Tuberculosis	___Broken bones
___Cataracts	___Lumps	___Excessive sputum	___Joint pain or stiffness
___Diminished night vision	___Pain or stiffness	___Wheezing	___Joint heat or redness
___Double vision	___Whiplash injury	___Shortness of breath:	___Joint swelling
___Eye pain	Skin	___At night	___Osteopenia
___Glasses/Contacts	___Acne	___Lying down	___Osteoporosis
___Glaucoma	___Rashes	___With Exertion	___Sciatica
___Impaired Vision	___Eczema	Cardiovascular	___Lower back pain
___Dry eyes	___Hives	___Angina	___Muscle spasms, cramps
___Watery eyes	___Hair loss	___Chest pain/pressure	___Swelling in ankles
___Retinal detachment	___Boils	___Fainting	___Cold hands or feet
___Spots/floaters in vision	___Itching	___Heart disease	Mental/Emotional
___Sensitivity to light	___Color change	___High cholesterol	___Anxiety/nervousness
Nose, Sinus	___Lumps	___High blood pressure	___Decreased memory
___Hay fever	___Night sweats	___Heart murmurs	___Difficulty concentrating
___Frequent nosebleeds	___Moles	___Swelling of feet/ankles	___Mood swings
___Frequent colds	___Sun sensitivity	___Palpitations/Fluttering	___Depression
___Runny nose	___Psoriasis	___Rheumatic fever	___Experienced major trauma
___Sinus problems	___Tightness of skin		___Previous treatment for mental or emotional concerns

Review of Systems (continued)

Gastrointestinal	___Diarrhea	Reproductive	Reproductive
___Abdominal Pain	___Constipation	**Female**	**Male**
___Alternating Diarrhea/Constipation	___Jaundice (yellow skin)	___Bleeding between cycles	___Penile discharge
___Belching/Burping	___Spastic colon	___Hot flashes	___Penile sores
___Blood in stool	___Trouble swallowing	___PMS	___Painful intercourse
___Change in stool	___Vomiting	___Difficulty conceiving	___Difficulty getting erection
___Difficult bowel movements	___Vomiting blood	___Genital herpes	___Difficulty maintaining erection
___Change in appetite	Urinary	___Genital warts	___Low libido
___Fatigue after eating	___Bed wetting	___Painful intercourse	___Testicular lump
___Flatulence/Gassiness	___Frequent infections	___Nipple discharge	___Testicular pain
___Irritable Bowel (IBS)	___Frequent night urination	___Vaginal discharge	___Genital herpes
___Itching or pain in rectum	___Inability to hold urine	___Vaginal itching	___Genital warts
___Heartburn/Acid Reflux	___Increased frequency	___Vaginal dryness	___ Sexually transmitted infection
___Hemorrhoids	___Retention difficulty	___Sexually transmitted infection	___Ejaculation concerns
___Nausea	___Pain with urination	___Low libido	___Fertility concerns
___Painful stool	___Kidney stones	___Breast lumps	___Hernia concerns
___Liver disease	___Urgency with urination	___Breast pain	___Prostate concerns
___Parasites	___Low force of urine		

Reproductive History

Sexual Orientation: _____ Are you sexually active? Yes / No

Females Only

Date of last menstrual period:_____Date of last female exam_____Have you ever had HPV? Yes / No

History of Abnormal PAP? Yes / No Explain:_____Type of Birth Control Used:_____

History of Oral Contraceptive Use? Yes / No If yes, for how long?_____

Age period began:_____Length of period:_____days Length of monthly cycle:____days Are cycles regular? Yes / No

Menstrual Pain/Cramps: □none □mild □significant □severe Menstrual Flow: □light □moderate □heavy □very heavy

Are you pregnant? Yes / No Are you breastfeeding? Yes / No Have you ever breastfed? Yes / No For how long?_____

Number of pregnancies:_____Number of live births:_____Number of miscarriages:_____

Number of caesarian deliveries:_____Number of therapeutic abortions:_____

Are you menopausal? Yes / No If yes, date of last period:_____at age:_____Have you had a hysterectomy? Yes / No

Have you had an oophorectomy? Yes / No Were you ever on hormone replacement therapy? Yes / No For how long?_____

Uterine fibroids? □Past □Current Fibrocystic breasts? □Past □Current Polycystic Ovaries? □Past □Current

Do you do self-breast exams? Yes / No Date of last Mammogram: _____Normal? Yes / No, Explain:_____

Lifestyle Review

Please describe your typical daily food intake:

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

Do you follow a specific diet? (Check all that apply)

□Atkins	□Ovo-Lacto Vegetarian	□Macrobiotic	□Vegan
□Raw foods	□Whole foods	□Blood-type diet	□Weight-reduction plan
□Zone	□Paleo/Caveman	□Other:	

Do you eat at least three times per day? Yes / No

Glasses of water daily:___Cups of coffee daily:_____Cups of tea daily:_____Soda? Yes / No If yes, how many per day?_____

Alcohol? Yes / No If yes, drinks per week?_____

Tobacco? Yes / No □Past Usage How many years?_____Type?_____How much per day?_____

Use Recreational Drugs? Yes / No □Past Usage How many years?_____Types?_____

Current Weight:_____Weight one year ago:_____What's the most you have weighed?_____

I consider my weight to be: □Not a factor in my current illness □Somewhat a factor □A significant factor

Height:_____Blood Type:_____

Do you sleep well? Yes / No Do you wake feeling rested? Yes / No Do you get enough sleep? Yes / No Average hours/night:____

Do you enjoy your work? Yes / No How many hours do you work per week?_____

Do you spend time outdoors? Yes / No Do you take vacations? Yes / No Average number of sick days per year:_____

Do you watch T.V.? Yes / No Average hours per day:_____Hours/day on computer:_____

Do you exercise? Yes / No Describe activity and hours/week:_____

Energy Level: (circle) Lowest 0 1 2 3 4 5 6 7 8 9 10 Highest

Do you follow a spiritual practice? Yes / No Type of practice:_____

Please list your hobbies and interests:_____

Please list your predominant emotions:_____

What causes stress for you?_____

Who do you turn to for support?_____

All information will be contained in your confidential medical file