

Intake Form

Name _____ Age _____ DOB _____ Gender _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____

Work _____

Email _____

(This is used solely for the quarterly newsletter. Your email will never be shared.)

Occupation _____

Number of hours worked per week _____

Emergency Contact:

Name _____ Phone _____

Relationship _____

How did you hear about us?

CHEIF COMPLAINT: Please list health concerns in order of importance

1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

7 _____ 8 _____

CURRENT SUPPLEMENTS: Please list homeopathics, herbs, vitamins, minerals with dosage and frequency

1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

7 _____ 8 _____

CURRENT MEDICATIONS: Please list current medications with dosage and frequency

1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

7 _____ 8 _____

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ALLERGIES: Please list any allergies or adverse reactions to inhalants, foods, medicines, perfumes, smoke, chemicals... _____

Describe your allergy attack or reaction _____

Are you allergic to any medications? _____

If 'yes', please list _____

What happens when you have an allergic reaction to medication? _____

Hospitalizations: List reason, year & duration _____

Date of last physical exam _____

SOCIAL HISTORY

Are you currently: Married/Domestic Partnered _____ Single _____

Separated/Divorced _____ Widowed _____

Number of children _____ Ages _____

DIET & LIFESTYLE

Coffee, colas or black tea: How much daily? _____

Alcohol: What kind & how many per day or week? _____

Water: Tap, spring, well, filtered or distilled; how many per day? _____

Other fluids not listed above: _____

How many glasses per day? _____

Do you use tobacco? _____

What kind & how much? _____

Do you salt your food? Heavily, moderately, lightly, not at all?

How often do you eat salted foods: chips, pickles, fries? _____

How often do you eat processed or fast food? _____

Any diet restrictions or regimen? Describe _____

Are you usually relaxed when you eat? _____

What is your appetite like ate breakfast? _____

At lunch? _____ At dinner? _____

When do you eat your largest meal? _____

What foods or beverages do you crave? _____

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Are you satisfied with your current diet? _____

Do you exercise? _____

What kind & how often? _____

How do you describe your general energy level (without caffeine or stimulants)? _____

REVIEW OF SYSTEMS

Y=Yes (within the past year)

N=Never

P=Past

FEMALE REPRODUCTIVE

Age menses began _____

Average # of days _____

Length of cycle _____

Bleeding bet. periods _____

Are cycles regular _____

Pain during intercourse _____

Painful menses _____

Excessive flow _____

Are you sexually active? _____

Sexual Partners:

Men _____ Women _____

Current birth control method _____

Past birth control methods used _____

Sex transmitted infections _____

Do you do self breast exam? _____

Breast lumps _____

Breast pain or tenderness _____

Nipple discharge _____

Date of last Pap/gyn exam _____

History of abnormal Paps? _____

MALE REPRODUCTIVE

Hernias _____

Testicular masses _____

Testicular pain _____

Are you sexually active? _____

Sexual partners:

Men _____ Women _____

Sexual difficulties _____

Prostate disease _____

Sex transmitted infections _____

MUSCULOSKELETAL

Joint pain or stiffness _____

Arthritis _____

Broken bones _____

Muscle spasms or cramps _____

Weakness _____

PERIPHERAL VASCULAR

Deep leg pain _____

Cold hands/feet _____

Varicose veins _____

Thrombophlebitis _____

NEUROLOGICAL

Fainting _____

Seizures _____

Paralysis _____

Muscle Weakness _____

Numbness or tingling _____

Loss of memory _____

EMOTIONAL

Depression _____

Mood swings _____

Anxiety or nervousness _____

Tension or stress _____

ENDOCRINE

Hypothyroid _____

Heat or cold intolerance _____

Excessive hunger _____

Excessive thirst _____

BLOOD

Anemia _____

Easy bleeding or bruising _____

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REVIEW OF SYSTEMS (continued)

Y=Yes (within the past year)

N=Never

P=Past

SKIN

Rashes _____
Eczema, hives _____
Acne, boils _____
Itching _____
Color change _____
Night sweats _____

HEAD

Headache _____
Head injury _____

EYES

Impaired vision _____
Glasses or contacts _____
Eye pain _____
Tearing or Dryness _____
Double vision _____
Glaucoma _____
Cataracts _____

EARS

Impaired hearing _____
Ringing _____
Earache _____
Dizziness _____

NOSE & SINUSES

Frequent colds _____
Nose bleeds _____
Stuffiness _____
Hay fever _____
Sinus problems _____

MOUTH & THROAT

Frequent sore throat _____
Sore tongue _____
Gum problems _____
Hoarseness _____
Cavities _____

NECK

Lumps _____
Swollen glands _____
Goiter _____
Pain or stiffness _____

RESPIRATORY

Cough _____
Sputum _____
Spitting up blood _____
Wheezing _____
Asthma _____
Bronchitis _____
Pneumonia _____
Pleurisy _____
Emphysema _____
Difficulty breathing _____
Pain on breathing _____
Shortness of breath (SOB) _____
 SOB At Night _____
 SOB Lying down _____
Tuberculosis _____

CARDIOVASCULAR

Heart disease _____
Angina _____
High blood pressure _____
Murmurs _____
Rheumatic fever _____
Chest pain _____
Swelling in ankles _____
Palpitations, fluttering _____

GASTROINTESTINAL

Trouble swallowing _____
Heartburn _____
Change in thirst _____
Change in appetite _____
Nausea _____
Vomiting _____
Vomiting blood _____
Jaundice _____

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REVIEW OF SYSTEMS (continued)

Y=Yes (within the past year)

P=Past

N=Never

GASTROINTESTINAL (cont)

Bowel movements:
How often? _____
Is this a change? _____
Blood in stool _____
Hemorrhoids _____
Belching or passing gas _____

URINARY

Pain on urination _____
Increase in frequency _____
Frequency at night _____
Inability to hold urine _____
Frequent infections _____
Kidney stones _____

FAMILY HISTORY

Please list any major illnesses or diseases for your first degree relatives: Mother, Father, Brother, Sister or Children.

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Name _____

Signature _____

Date _____