Horizon Medical
1957 Thompson Rd, Suite E
Coos Bay, OR - 97420

(*) Initial Intake -_copy

General Information

Full Name: *

Preferred method of contact : * ☐ Phone Call ☐ Email

How were you referred to us? * ☐ Referral by a provider ☐ Facebook ☐ Friend or Family Member ☐ Google

If you were referred by a current patient please let us know by who so we can contact them to say thanks

Phone number Type Alternate Phone Type *

Home Address with street, house number, city and zip code (pharmacies cannot ship to PO Box) *

Marital status * ☐ Single ☐ Married ☐ In a relationship

Height : *

Weight : *

Occupation : *

Emergency Contact Name : *

Phone : *

Relationship : *

Medical History

Allergies

Allergies	Type	Severity	Reactions

Smoking History * ☐ Current ☐ Former ☐ Never

Primary health care provider : *

List any medical diagnosis you have received (i.e. diabetes, heart disease, depression, etc.) and date diagnosed: *

List any prescription medications you take including dosages and reason for taking them *

List any over counter medications or supplements you take and the reason for taking them *

Have you recently stopped any meds? If so what and when did you stop? *

List any surgeries, hospitalizations, accidents, serious illnesses and/or injuries (and estimate date occurred) *

Any known allergies to medications? * ☐ Yes ☐ No

If yes, specify them and reaction if it occurs:

Any known food or environmental allergies? * ☐ Yes ☐ No

If yes, specify them and what occurs

Family History: Please check all that apply and (Mother, Father, Grandparents, Siblings, Children) *

- ☐ Father: Diabetes
- ☐ Father: High BP
- ☐ Father: Heart problems
- ☐ Father: Stroke
- ☐ Father: Alcoholism/Drug problem
- ☐ Father: Thyroid Cancer
- ☐ Father: Other cancer
- ☐ Father: Depression
- ☐ Father: Kidney disorder
- ☐ Father: Obesity
- ☐ Mother: Diabetes
- ☐ Mother: High BP
- ☐ Mother: Heart problems
- ☐ Mother: Stroke
- ☐ Mother: Alcoholism/Drug problem
- ☐ Mother: Thyroid Cancer
- ☐ Mother: Other cancer
- ☐ Mother: Depression
- ☐ Mother: Kidney disorder
- ☐ Mother: Obesity
- ☐ Grandparent: Diabetes
- ☐ Grandparent: Heart problems
- ☐ Grandparent: Stroke
- ☐ Grandparent: Alcoholism/Drug problem
- ☐ Grandparent: Thyroid Cancer
- ☐ Grandparent: Obesity
- ☐ Aunt/Uncle: Thyroid Cancer
- ☐ Child: Thyroid Cancer
- ☐ Child: Obesity
- ☐ Child: Diabetes
- ☐ Child: Heart problem
- ☐ Other Family Member: Thyroid Cancer

Symptoms

For the following symptoms list how often you experience them - often, sometimes, never or in the past.

General :

Sleep disturbance *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Fatigue *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Head

Headaches *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Difficulty concentrating *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Memory problems *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Ears, Eyes, Nose, Throat

Significant problems:

Swollen, painful, or hard glands in neck or body
☐ Never ☐ In the past ☐ Currently

Skin

Dry skin *
☐ Often ☐ Sometimes ☐ Never ☐ In the past

Easy bruising/bleeding *
☐ Often ☐ Sometimes ☐ Never ☐ In the past

Digestion

Stomach pain and or/ cramps *
☐ Often ☐ Sometimes ☐ Never ☐ In the past

Acid reflux / heartburn *
☐ Often ☐ Sometimes ☐ Never ☐ In the past

Constipation *
☐ Often ☐ Sometimes ☐ Never ☐ In the past

Loose stools or diarrhea *
☐ Often ☐ Sometimes ☐ Never ☐ In the past

Bowel Movement Daily *
☐ Yes ☐ No

Abdominal bloating or gas *
☐ Often ☐ Sometimes ☐ Never ☐ In the past

Nausea or vomiting *
☐ Often ☐ Sometimes ☐ Never ☐ In the past

Mental / Emotional

ADD / ADHD *
☐ Often ☐ Sometimes ☐ Never ☐ In the past

Food cravings *
☐ Often ☐ Sometimes ☐ Never ☐ In the past

Mood swings *
☐ Often ☐ Sometimes ☐ Never ☐ In the past

Irritability *
☐ Often ☐ Sometimes ☐ Never ☐ In the past

Depression * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Anxiety/nervousness * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Cardiovascular

High blood pressure * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Heart attack ☐ Never ☐ Been to ER for chest pain, no heart attack ☐ Unsure if chest pain, but feel something weird ☐ Frequent chest pain

Heart palpitations * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Respiratory

Asthma * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Shortness of breath * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Neurological

Seizures * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Musculoskeletal

Joint pain or stiffness * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Neck/back pain * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Urinary

Frequent urination * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Excessive thirst * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Endocrine

Easy weight gain *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Heat or cold intolerance *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Thyroid problems *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Blood sugar problems *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

For Women :

Contraceptive Use * ☐ Yes ☐ No

If yes, what type

Absent periods *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Irregular cycle *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
PMS *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Endometriosis *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
PCOS *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Uterine fibroids *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Infertility *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

For Men :

Use of Viagra	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

Lifestyle

Do you exercise? * ☐ Yes ☐ No

If yes, indicate number of times you exercise during the week as well as the type of exercise

How many alcoholic drinks per week? *

☐ 0-2 ☐ 2-4 ☐ 4+

Do you smoke? *

☐ Yes ☐ No ☐ In the past

Do you use recreational drugs? *

☐ Yes ☐ No

Rate your current stress level(5 being the highest) *

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What things get in the way of eating healthy?

What are your biggest barriers/triggers?

How would you rate the amount of support you currently have to reach your goals?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What are the primary sources of your stress? *

Do you eat fast food *

☐ Yes ☐ No

If yes, number of times per week

Do you eat out (not fast food) *

☐ Yes ☐ No

If yes, number of times per week (not including fast food)

Number of times you eat per day *

Amount of soda (including diet) you drink in a typical day *

How many cups of coffee do you drink per day? *

☐ 0 ☐ 1-2 ☐ 2-4 ☐ 4+

How many glasses of water do you drink in a day? *

☐ 1-3 ☐ 3-5 ☐ 6-8 ☐ 8+

What is your typical breakfast & time of day?

What is your typical lunch & time of day?

What is your typical dinner & time of day?

Health Goals

What are your main health goals for this appointment? *

How motivated are you? *

How willing are you to change your habits to reach your goal? *

☐ Strongly willing ☐ Moderately willing ☐ Not willing ☐ Cannot say

What is your current goal (for wt loss pt what is your goal weight)?

What is your timeframe for reaching your goal? *