



PATIENT INTAKE FORM

NAME: _____

I have read and understand this form and acknowledge that the purposes, goals, techniques, procedures, limitations, potential risks and benefits of the service(s) to be performed have been explained to me. I understand my health information will be used and disclosed consistent with this Notice, and that I have the right to request restrictions on certain uses and disclosures of my health information. Further, I have had the opportunity to ask my practitioner questions regarding the proposed services, this consent form, and other pertinent information, including questions about him or her, and have received satisfactory explanations. I understand that I am free to discontinue service(s) at any time.

Email _____
Address _____
City, State Zip _____
Phone _____ Birthdate _____

MAIN REASON FOR VISIT

OTHER HEALTH CONCERNS (PLEASE LIST ALL AND BE AS DESCRIPTIVE AS POSSIBLE)

PLEASE LIST ALL PHYSICIANS, DIAGNOSIS, MEDICATIONS, AND/OR VITAMINS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING.

Physician Name	Diagnosis	Medication/Dosage	Supplements/Vitamins

Medical History

Please use the matrix below to help me understand your current and/or past.

	Current	Past		Current	Past
ADHD	_____	_____	HIV	_____	_____
AIDS	_____	_____	Hyperglycemia	_____	_____
Alcoholism	_____	_____	Hypoglycemia	_____	_____
Allergies	_____	_____	Immune Disorders	_____	_____
Anemia	_____	_____	Irritable Bowel Syndrome	_____	_____
Anxiety	_____	_____	Low Blood Pressure	_____	_____
Arthritis	_____	_____	Lymes Disease	_____	_____
Asthma	_____	_____	Memory Loss	_____	_____
Autoimmune Disorder	_____	_____	Mental Illness	_____	_____
Bowel Disorder	_____	_____	Menopause	_____	_____
Bloatin	_____	_____	Menstrual Irregularities	_____	_____
Cancer	_____	_____	Multiple Sclerosis	_____	_____
Candida	_____	_____	Muscular Dystrophy	_____	_____
Chemical Sensitivities	_____	_____	Numbness	_____	_____
Chronic Fatigue	_____	_____	Obesity	_____	_____
Constipation	_____	_____	Osteoporosis	_____	_____
Dementia/Alzheimer's	_____	_____	Painful Joints	_____	_____
Depression	_____	_____	Respiratory Problems	_____	_____
Diabetes	_____	_____	Rashes	_____	_____
Dizziness	_____	_____	Seizures	_____	_____
Environmental Sensitivities	_____	_____	Sexually Transmitted Diseases	_____	_____
Epilepsy	_____	_____	Shingles	_____	_____
Epstein-Barr Virus	_____	_____	Shortness of Breath	_____	_____
Excess Stress	_____	_____	Skin Disorders/Rashes	_____	_____
Eyesight Problems	_____	_____	Sleep Problems	_____	_____
Fatigue	_____	_____	Sore Throats	_____	_____
Fibromyalgia	_____	_____	Staph Infections	_____	_____
Gall Bladder Removal	_____	_____	Stiffness	_____	_____
Headaches	_____	_____	Strokes	_____	_____
Heart Attack	_____	_____	Swelling	_____	_____
Hearing Problems	_____	_____	Thyroid - Over Active	_____	_____
Heart Disease	_____	_____	Thyroid - Under Active	_____	_____
High Blood Pressure	_____	_____	Tumors	_____	_____
High Cholesterol	_____	_____	Urinary Tract Infections	_____	_____
Hepatitis A	_____	_____	Yeast Infections	_____	_____
Hepatitis B	_____	_____	Other (Describe)	_____	_____
Hepatitis C	_____	_____		_____	_____

Discovering Your Personal Constitution

Please check the statement that feels true to you:

Determining Hot and Cold

- I tend to feel warmer than others
- I tend to have a loud voice
- My entire face tends to be bright red
- My tongue tends to be bright red
- I have lots of opinions and I am not afraid to share them
- I prefer cold weather.

Total number of checks: _____

- I tend to feel colder than others.
- I tend to have a quiet voice.
- My face, lips and/or tongue tends to be pale.
- I often feel like I have low energy levels.
- I prefer warm weather.

Total number of checks: _____

Determining Damp and Dry

- I tend to sweat more easily than others.
- I often have a runny nose.
- My arms and legs can feel heavy.
- I tend to have a thick coating on my tongue.
- My skin and hair are often oily.
- I prefer dry climates and don't like humidity.

Total number of checks: _____

- My skin tends to be rough and dry.
- I often have a dry throat, nose and/or mouth.
- It's hard for me to stay hydrated.
- My hair tends to be dry.
- I often have itchy skin or scalp.
- My tongue does not usually have a coating on it.

Total number of checks: _____

Your Current Energies

Please check the statement that feels true to you:

Determining Hot and Cold

- I feel hot or have a high fever
- I am very thirsty.
- My face is red and flushed.
- I dislike hot temperatures and crave coolness.
- I am restless and/or irritable.
- I have red eyes.
- I have yellow discharges (e.g. mucus)
- I have strong odors
- My sleep is restless.
- I have a strong appetite.
- My tongue is bright red possibly with a yellow coating.

Total number of checks: _____

- I strongly dislike cold temperatures and prefer warmth.
- I feel fatigued or lethargic.
- I have white or clear discharges (e.g. mucus).
- I have loose stools or undigested food in stool.
- I have a poor appetite.
- I have a pale face, lips and/or tongue.

Total number of checks: _____

Determining Damp and Dry Qualities

- I have excess fluids (e.g. sweat or a runny nose)
- I have nausea.
- My arms and legs feel heavy.
- I have edema.
- My chest feels full or congested.
- I feel sluggish.
- My tongue has a thick coating.

Total number of checks: _____

- My skin is rough and dry.
- My fluid discharges are scanty or thick (e.g. mucus)
- I often have a dry throat, nose, and/or mouth.
- I have hot flashes or night sweats.
- I am unusually thirsty.
- I am constipated with dry stools.
- My tongue looks dry and cracked and does not have a coating.

Total number of checks: _____

Immune System

Please use the matrix below to help me understand your current and/or past.

	Current	Past		Current	Past
Allergies	_____	_____	Immunodeficiency	_____	_____
Autoimmune Disorders	_____	_____	Infections	_____	_____
Celiac	_____	_____	Lupus	_____	_____
Chronic Fatigue	_____	_____	Mononucleosis	_____	_____
Cushing's Disease	_____	_____	Rheumatoid Arthritis	_____	_____
Enlarged Spleen	_____	_____	Sore Throats	_____	_____
Grave's Disease	_____	_____	White Blood Cell Counts	_____	_____
Hashimoto's Thyroiditis	_____	_____	Other	_____	_____
Heal Slowly	_____	_____	Other	_____	_____

Additional Notes About Immune System

Digestion

Please use the matrix below to help me understand your current and/or past.

	Current	Past		Current	Past
Anorexia	_____	_____	Hemorrhoids	_____	_____
Belching	_____	_____	Indigestion	_____	_____
Bulimia	_____	_____	Irritable Bowel Syndrome	_____	_____
Crohn's Disease	_____	_____	Large Appetite	_____	_____
Constipation	_____	_____	Liver Problems	_____	_____
Diarrhea	_____	_____	Low Appetite	_____	_____
Diverticulitis	_____	_____	Nausea	_____	_____
Dysentary	_____	_____	Pain After Eating	_____	_____
Eating Disorder	_____	_____	Parasites	_____	_____
Enlarged Spleen	_____	_____	Stomach Aches	_____	_____
Flatulence	_____	_____	Sudden Weight Change	_____	_____
Food Unappetizing	_____	_____	Ulcers	_____	_____
Gallstones	_____	_____	Ulcerative Colitis	_____	_____
Grave's Disease	_____	_____	Vomitting	_____	_____
Hashimoto's Thyroiditis	_____	_____	Other	_____	_____
Heal Slowly	_____	_____	Other	_____	_____
Heartburn	_____	_____	Other	_____	_____

Additional Notes About Digestion System

Body Temperature

Please use the matrix below to help me understand your current and/or past.

	Hot	Cold		Hot	Cold
Hands	_____	_____	Legs	_____	_____
Palms	_____	_____	Feet	_____	_____
General Body	_____	_____	Head	_____	_____
Arms	_____	_____	Chest	_____	_____
Fingers	_____	_____	Stomach	_____	_____
				Yes	No
Do you hate it when it is cold out?				_____	_____
Do you hate it when it is cold out?				_____	_____
Are you always cold?				_____	_____
Are you always hot?				_____	_____
Additional notes about body temperature	_____				

Mouth and Throat

Please use the matrix below to help me understand your current and/or past.

	Current	Past		Current	Past
Canker Sores	_____	_____	Oral Herpes	_____	_____
Cavities	_____	_____	Painful/Tight Jaw	_____	_____
Constant Dryness	_____	_____	Receding Gums	_____	_____
Difficulty Swallowing	_____	_____	Sinus Problems	_____	_____
Excess Saliva	_____	_____	Sore Gums	_____	_____
Excess Mucous	_____	_____	Sore Throat	_____	_____
Lip Sores	_____	_____	Swollen Glands	_____	_____
Loose Teeth	_____	_____	White Coating on Tongue	_____	_____
Mouth Sores	_____	_____	Other	_____	_____
Additional notes about mouth and throat	_____				

Urinary Tract

Please use the matrix below to help me understand your current and/or past.

	Current	Past		Current	Past
Bloating	_____	_____	Lower Back Pain	_____	_____
Blood in urine	_____	_____	Strong Smelling Urine	_____	_____
Frequent urge to urinate	_____	_____	Urinary Tract Infection	_____	_____
Kidney/Bladder Stones	_____	_____	Water Retention	_____	_____
Kidney Pain	_____	_____	Other	_____	_____

After you urinate, does it fee like you still have to go? _____

Have you ever had a urinary tract infection? _____

Additional notes about urinary tract _____

Cardiovascular

Please use the matrix below to help me understand your current and/or past.

	Current	Past		Current	Past
Angina	_____	_____	Low Blood Pressure	_____	_____
Irregular Heartbeat	_____	_____	Fast Heart Beat (Tachycardia)	_____	_____
Arteriosclerosis	_____	_____	Heart Attack (Myocardial Infarction)	_____	_____
Blood Clotting Disorder	_____	_____	Heart Flutter	_____	_____
Bruise Easily	_____	_____	Mitral Valve Prolapse	_____	_____
Bleed Easily	_____	_____	Palpitation	_____	_____
Capillary Fragility	_____	_____	Pericarditis	_____	_____
Chest Pains	_____	_____	Poor Circulation	_____	_____
Congenital Deformities	_____	_____	Rheumatic Fever	_____	_____
Congestive Heart Failure	_____	_____	Slow Heart Beat (Bracycardia)	_____	_____
Edema	_____	_____	Stroke	_____	_____
Heart Irregularities	_____	_____	Varicose Veins	_____	_____
Heart Murmur	_____	_____	Other	_____	_____
High Blood Pressure	_____	_____			

Additional notes about cardiovascular _____

Respiratory

Please use the matrix below to help me understand your current and/or past.

	Current	Past		Current	Past
Asthma	_____	_____	Respiratory Inflammation	_____	_____
Bronchitis	_____	_____	Runny Nose	_____	_____
Chest Pain	_____	_____	Shortness of Breath	_____	_____
Common Cold	_____	_____	Sneezing	_____	_____
Coughing	_____	_____	Stuffy Nose	_____	_____
Difficulty Smelling	_____	_____	Tight Around Lungs	_____	_____
Flu	_____	_____	Trouble Breathing In	_____	_____
Fluid in Lungs	_____	_____	Trouble Breathing Out	_____	_____
Hay Fever	_____	_____	Wheezing	_____	_____
Laryngitis	_____	_____	Tuberculosis	_____	_____
Pleuritis	_____	_____	Other	_____	_____

Additional notes about respiratory _____

Reproductive Health

Please use the matrix below to help me understand your current and/or past.

	Current	Past		Current	Past
Bacterial Vaginosis	_____	_____	Miscarriage	_____	_____
Benign Prostatic	_____	_____	Painful Ejaculation	_____	_____
Blood in Semen	_____	_____	Painful Intercourse	_____	_____
Blood in Urine	_____	_____	Painful Prostate	_____	_____
Breast Pain	_____	_____	Painful to Urinate	_____	_____
Cervical Dysplasia	_____	_____	Pelvic Inflammatory Disease	_____	_____
Cysts	_____	_____	Penis Pain	_____	_____
Difficulty getting urine	_____	_____	Prostate Pain	_____	_____
Dribbling	_____	_____	Testicle Pain	_____	_____
Endometriosis	_____	_____	Tumors	_____	_____
Erectile Dysfunction	_____	_____	Unusual PAP	_____	_____
Fibroids	_____	_____	Vaginal Discharge	_____	_____
Frequent Urination	_____	_____	Vaginal Dryness	_____	_____
Impotence	_____	_____	Vaginal Infection	_____	_____
Infertility	_____	_____	Vaginitis	_____	_____
			Other	_____	_____

Additional notes about reproductive health _____

Nervous System and Health

Please use the matrix below to help me understand your current and/or past.

	Current	Past		Current	Past
Anxiousness	_____	_____	Memory Loss	_____	_____
Bipolar	_____	_____	Nervousness	_____	_____
Butterflies in Stomach	_____	_____	Numbness	_____	_____
Cannot Stay Asleep	_____	_____	Pain	_____	_____
Constant Feeling of Stress	_____	_____	Panic Attacks	_____	_____
Diminished Taste	_____	_____	Dramatic Seasonal Emotional Changes	_____	_____
Depression	_____	_____	Sudden Mood Swings	_____	_____
Fear of Facing New Day	_____	_____	Trouble Falling Asleep	_____	_____
Fluctuating Vision	_____	_____	Mental Disorder	_____	_____
Hard to Concentrate	_____	_____	Schizophrenia	_____	_____
Involuntary Spasms	_____	_____	Twitching	_____	_____
Mania	_____	_____	Worsening Coordination	_____	_____
			Other	_____	_____

Additional notes about nervous system _____

Headaches

Please use the matrix below to help me understand your current and/or past.

Do you suffer from headaches? Describe _____

Where are your headaches located? _____

Bowel Movements

Please use the matrix below to help me understand your current and/or past.

Is it difficult to have a bowel movement? _____

Do your BM's tend to be loose? _____

Do your BM's tend to be hard? _____

Are you constipated? _____

Do you have a BM daily? _____

Sexual and Reproductive Health

Please use the matrix below to help me understand your current and/or past.

	Current	Past		Current	Past
AIDS	_____	_____	Herpes	_____	_____
Candida	_____	_____	HIV	_____	_____
Chlamydia	_____	_____	Human Papilloma Virus	_____	_____
Crabs/Lice	_____	_____	Syphilis	_____	_____
Gardnerella	_____	_____	Trichomonas	_____	_____
Genital Warts	_____	_____	Urethritis	_____	_____
Gonorrhea	_____	_____	Other	_____	_____

Additional notes about sexual and reproductive Health

Pregnancy

Please use the matrix below to help me understand your current and/or past.

Are you pregnant?

Are you planning to become pregnant in near future?

Are you breastfeeding?

Menstrual Cycle

Please use the matrix below to help me understand your current and/or past.

How many days is your cycle?

	Current	Past		Current	Past
Acne or skin changes	_____	_____	Dark colored flow	_____	_____
Bleeding between	_____	_____	Heavy flow	_____	_____
Bloating	_____	_____	Scanty flow	_____	_____
Painful mensus	_____	_____	Slow flow	_____	_____
Bright red flow	_____	_____	Other	_____	_____
Clots	_____	_____		_____	_____

Additional notes about sexual and reproductive Health

Nutritional Deficiencies Symptoms

Please check all the symptoms that have applied to you over the past recent weeks.

<input type="checkbox"/>	Acne	EFA, Vitamin A, Vitamin B6, Zinc
<input type="checkbox"/>	Agitation	Calcium, Magnesium
<input type="checkbox"/>	Alopecia (hair loss)	Copper, EFA, Riboflavin, Vitamin B6, Zinc
<input type="checkbox"/>	Anemia	Copper, Iron, Magnesium, Vitamin B6
<input type="checkbox"/>	Anemia (megoblastic)	Folate
<input type="checkbox"/>	Anorexia (poor appetite)	Folate, Iron, Magnesium, Niacin, Thiamine, Vitamin B6, Zinc
<input type="checkbox"/>	Anxiety	Calcium, Chromium, EFA, Excess Alcohol, Excess Caffeine, Sugar, Magnesium, Niacin, Pyridoxine, Thiamine
<input type="checkbox"/>	Apathy	Folate, Zinc
<input type="checkbox"/>	Brittle Nails	Niacin
<input type="checkbox"/>	Canker Sores	Niacin
<input type="checkbox"/>	Cognitive Impairment	Calcium, Potassium
<input type="checkbox"/>	Cold Hands and Feet	Magnesium
<input type="checkbox"/>	Cold, Sensitivity To	Iron
<input type="checkbox"/>	Constipation	Folate, Iron, Potassium, Thiamine, Vitamin B12
<input type="checkbox"/>	Delusions	Calcium
<input type="checkbox"/>	Depression	Calcium, Copper, Excess Caffeine, Excess Sugar, Folic Acid, Iron, Magnesium, Niacin, Potassium, Riboflavin, Rubidium, Thiamine, Vitamin B12, Vitamin B6, Vitamin C, Zinc
<input type="checkbox"/>	Diarrhea	EFA, Niacin, Vitamin D, Zinc
<input type="checkbox"/>	Disorientation	Magnesium
<input type="checkbox"/>	Dizziness	Iron, Riboflavin, Vitamin B12, Vitamin B6
<input type="checkbox"/>	Eczema	EFA, Calcium, Zinc
<input type="checkbox"/>	Edema (Swelling, water)	Magnesium, Potassium
<input type="checkbox"/>	Fatigue	Chromium, Copper, Excess Caffeine, Excess Sugar, Folate, Iron, Magnesium, Niacin, Potassium, Thiamine, Vitamin A, Vitamin B12, Vitamin B6, Vitamin C, Vitamin E, Zinc
<input type="checkbox"/>	Gallstones	EFA
<input type="checkbox"/>	Gums, Bleeding	Vitamin C
<input type="checkbox"/>	Hair, Dry	EFA, Vitamin A
<input type="checkbox"/>	Hallucinations	Magnesium
<input type="checkbox"/>	Headache	Folate, Iron, Vitamin B12, Niacin
<input type="checkbox"/>	Hyperactivity	Calcium, Copper, Iron, Magnesium, Niacin, Pyridoxine, Thiamine, Zinc
<input type="checkbox"/>	High Cholesterol	Chromium, Copper, Potassium, Selenium, Zinc
<input type="checkbox"/>	Hypertension (High BP)	Calcium, Magnesium, Potassium
<input type="checkbox"/>	Hypotension (Low BP)	Magnesium, Potassium

Immunodepression	Copper, EFA, Folic Acid, Iodine, Iron, Magnesium, Pantothenic Acid, Riboflavin, Selenium, Vitamin A, Vitamin B12, Vitamin B6, Vitamin C, Vitamin E, Zinc
Impotence	Zinc
Infertility (Male or	EFA
Infertility (Male)	Zinc
Insomnia	Calcium, Copper, Folate, Iron, Magnesium, Niacin, Thiamine, Vitamin B12, Vitamin B6, Vitamin C
Irritability	Calcium, Excess Sugar, Iron, Lithium, Magnesium, Niacin, Thiamine, Vitamin B12, Vitamin B6, Vitamin C
Kidney Stones	Magnesium
Legs, Restless	Folate, Calcium, Magnesium
Lethargy	Zinc
Memory, Poor	Folate, Niacin, Thiamine, Zinc
Mental Confusion	Iron, Magnesium, Niacin, Thiamine
Muscle Cramps	Calcium, Magnesium
Muscle Pain	Magnesium
Muscle Spasm	Calcium
Muscle Tension	Calcium
Muscle Tremor	Magnesium
Muscle Weakness	Magnesium, Niacin, Potassium
Nausea	Magnesium, Niacin, Vitamin B6
Nervousness	Calcium, Magnesium, Potassium, Thiamine, Vitamin B6, Vitamin D
Numbness of Limbs	Calcium, Thiamine, Vitamin B12
Palpitations	Calcium, Iron, Vitamin B12
Paranoia	Folate, Zinc
Parasthesia (nerve	Calcium, Magnesium
Periodontal Disease	Calcium
Skin Inflammation	Niacin, Riboflavin
Startle Reflex	Magnesium
Teeth, Loose	Vitamin C
Teeth, Decay	Calcium
Vertigo (Dizziness)	Magnesium
Vision, Blurred	Riboflavin
Vision, Night Blindness	Vitamin A
Weakness	Copper, Folate, Thiamine, Vitamin B6
Wound Healing, Slow	Vitamin C, Zinc, EFA, Vitamin B6

I certify that the above information is true to the best of my ability.

Sign Name _____

Date _____

Nutritional Deficiencies Worksheet

DO NOT COMPLETE THIS SECTION

- Calcium _____
- Chromium _____
- EFA _____
- Excess Caffeine _____
- Excess Sugar _____
- Excess Alcohol _____
- Folate _____
- Iodine _____
- Iron _____
- Lithium _____
- Magnesium _____
- Niacin _____
- Pantothenic Acid _____
- Potassium _____
- Pyridoxine _____
- Riboflavin _____
- Rubidium _____
- Selenium _____
- Thiamine _____
- Vitamin A _____
- Vitamin B6 _____
- Vitamin B12 _____
- Vitamin C _____
- Vitamin D _____
- Vitamin E _____
- Zinc _____