**Patient Intake Form**

**Date:**

**Doctor:**

**Patient Name:**  **DOB:**

**List your health concerns in order of importance:**

1)

2)

3)

4)

5)

**Name and telephone number of Primary Care physician:**

# Family History

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Father** |  | **Mother** |  | **Siblings** |  | **Grandparents** |  | **Spouse** |  | **Children** |
| Age if living: |  |  |  |  |  |  |  |  |  |  |  |
| Age when died: |  |  |  |  |  |  |  |  |  |  |  |
| Reason for death: |  |  |  |  |  |  |  |  |  |  |  |
| Cancer type: |  |  |  |  |  |  |  |  |  |  |  |
| High Blood Pressure: | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |
| Heart Attack: | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |
| Heart Disease: | [ ] Y[ ]  N  |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |
| Stroke: | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |
| Asthma/Allergies: | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |
| Mental Illness: | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |
| TB: | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |
| Auto-Immune Disease: | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |
| Diabetes Mellitus: | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |
| Osteoporosis: | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |  | [ ] Y[ ]  N |

**Other:**

**List All Surgeries & Hospitalizations, including date occurred:**

1) 4)

2) 5)

3) 6)

**Please Note When & Why You Have Had Each of the Following:**

X-Rays: MRI/Cat Scans: Ultrasounds: Accidents: TB Test: HCV:

HIV: Last Dental Visit: Last Eye Exam:

Did you have the following **D**isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**):

**Measles**: [ ] D [ ]  I [ ] N **Chicken Pox**: [ ] D [ ]  I [ ] N **Hemophilus (Hib)**:[ ] D [ ]  I [ ] N

**Rubella**: [ ] D [ ]  I [ ] N **Tetanus**: [ ] D [ ]  I [ ] N **Whooping Cough**: [ ] D [ ]  I [ ] N

**Mumps**: [ ] D [ ]  I [ ] N **Hepatitis B**: [ ] D [ ]  I [ ] N

**Any vaccination reactions:**

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

**Antacids**: [ ] Y [ ] N [ ] P **Steroids**: [ ] Y [ ] N [ ] P

**Tobacco/Nicotine/Chew/Smoking/Vaping**: [ ] Y [ ] N [ ] P

**Packs per day & number of years**:

**Analgesics/NSAIDS**: [ ] Y [ ] N [ ] P **Laxatives**: [ ] Y [ ] N [ ] P

**Coffee**: [ ] Y [ ] N [ ] P **Cups per day if Yes/Past**:

**Soda Pop**: [ ] Y [ ] N [ ] P **Ounces per day if Yes/Past**:

**Alcohol**: [ ] Y [ ] N [ ] P **How often & how much if Yes/Past**:

**Any Alcohol Addiction**: [ ] Y [ ] N [ ] P **Any Alcohol Treatment**: [ ] Y [ ] N [ ] P

**Recreational Drugs**: [ ] Y [ ] N [ ] P **Any Drug Addictions**: [ ] Y [ ] N [ ] P

**Any Drug Treatment**: [ ] Y [ ] N [ ] P

**Any Eating Disorder History (e.g. Bulimia, Orthorexia, Anorexia, etc.):** [ ] Y [ ] N [ ] P

**Any Depression, PTSD, anxiety, other psychological diagnosis:** [ ] Y [ ] N [ ] P

**List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and including dosage:**

**Review of Systems:**

**Present Weight**: **Weight one year ago**: **Height**:

**Maximum weight and when**: **Minimum weight as adult & when**:

**Ideal Weight**:

**REGARDING THE NEXT LONG SECTION**: Please circle (**Y)** if you have the problem **NOW**, (**N)** if you’ve **NEVER** had the problem, (**P)** if you had the problem in the **PAST**.

**Good Energy**: [ ] Y [ ] N [ ] P

**Fatigue**: [ ] Y [ ] N [ ] P

**If you have fatigue, when in morning, afternoon, evening is it the worst**?

**If you have fatigue, can you do what you need to during the day**? [ ] Y [ ] N

**DIET:**  List what you have eaten in the last 24 hours or a sample of your meals. Note eating times.

**AVOID:** What, if any, things do you avoid?

**Patient Name:**  **DOB:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | CONSTITUTIONAL |  |  |
| Fatigue: | [ ] Y [ ] N [ ] P |  | Fever: | [ ] Y [ ] N [ ] P |
| Weight Loss: | [ ] Y [ ] N [ ] P |  | Chills: | [ ] Y [ ] N [ ] P |
| Weight Gain: | [ ] Y [ ] N [ ] P |  | Night Sweats: | [ ] Y [ ] N [ ] P |
| Weakness: | [ ] Y [ ] N [ ] P |  | Other: | [ ] Y [ ] N [ ] P |
|  |  | SKIN |  |  |
| Rash: | [ ] Y [ ] N [ ] P |  | Color Change: | [ ] Y [ ] N [ ] P |
| Hives: | [ ] Y [ ] N [ ] P |  | Lump: | [ ] Y [ ] N [ ] P |
| Psoriasis/eczema: | [ ] Y [ ] N [ ] P |  | Itchy: | [ ] Y [ ] N [ ] P |
| Dry: | [ ] Y [ ] N [ ] P |  | Warts/moles: | [ ] Y [ ] N [ ] P |
| Cancer: | [ ] Y [ ] N [ ] P |  | Perspiration: | [ ] Y [ ] N [ ] P |
| Lesions/Wounds | [ ] Y [ ] N [ ] P |  | Change in hair or nails | [ ] Y [ ] N [ ] P |
|  |  | HEAD |  |  |
| Headache: | [ ] Y [ ] N [ ] P |  | Migraine: | [ ] Y [ ] N [ ] P |
| Dandruff: | [ ] Y [ ] N [ ] P |  | Head Injury: | [ ] Y [ ] N [ ] P |
| Oil/dry hair: | [ ] Y [ ] N [ ] P |  | Hair loss: | [ ] Y [ ] N [ ] P |
|  |  | NOSE |  |  |
| Frequent Colds: | [ ] Y [ ] N [ ] P |  | Nosebleeds: | [ ] Y [ ] N [ ] P |
| Congestion: | [ ] Y [ ] N [ ] P |  | Post Nasal Drip: | [ ] Y [ ] N [ ] P |
| Polyps: | [ ] Y [ ] N [ ] P |  | Seasonal Allergies: | [ ] Y [ ] N [ ] P |
| Loss of Smell: | [ ] Y [ ] N [ ] P |  | Sinus Pain: | [ ] Y [ ] N [ ] P |
| Runny Nose: | [ ] Y [ ] N [ ] P |  |  |  |
|  |  | EYES |  |  |
| Dry/Watery: | [ ] Y [ ] N [ ] P |  | Blurry Vision: | [ ] Y [ ] N [ ] P |
| Double Vision: | [ ] Y [ ] N [ ] P |  | Cataracts: | [ ] Y [ ] N [ ] P |
| Glaucoma: | [ ] Y [ ] N [ ] P |  | Styes: | [ ] Y [ ] N [ ] P |
| Eye Strain: | [ ] Y [ ] N [ ] P |  | Discharge: | [ ] Y [ ] N [ ] P |
| Eye Itchiness: | [ ] Y [ ] N [ ] P |  | Dark under Eyelid: | [ ] Y [ ] N [ ] P |
| Eye Pain: | [ ] Y [ ] N [ ] P |  | Vision loss: | [ ] Y [ ] N [ ] P |
|  |  | MOUTH/THROAT |  |  |
| Canker sores: | [ ] Y [ ] N [ ] P |  | Cold sores: | [ ] Y [ ] N [ ] P |
| Sore Throat: | [ ] Y [ ] N [ ] P |  | Gum disease: | [ ] Y [ ] N [ ] P |
| Dentures: | [ ] Y [ ] N [ ] P |  | Cavities: | [ ] Y [ ] N [ ] P |
| Loss of taste: | [ ] Y [ ] N [ ] P |  | Hoarseness: | [ ] Y [ ] N [ ] P |
| Change in voice: | [ ] Y [ ] N [ ] P |  | Dry Mouth: | [ ] Y [ ] N [ ] P |
|  |  | EARS |  |  |
| Ear pain: |  |  | Ear Discharge: |  |
| Loss of Hearing: |  |  | Ear Fullness: |  |
|  |  | NECK |  |  |
| Stiffness: | [ ] Y [ ] N [ ] P |  | Swollen Glands: | [ ] Y [ ] N [ ] P |
| Decreased Range of Motion: | [ ] Y [ ] N [ ] P |  | Tension: | [ ] Y [ ] N [ ] P |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | MUSCULOSKELETAL |  |  |
| Weakness: | [ ] Y [ ] N [ ] P |  | Arthritis: | [ ] Y [ ] N [ ] P |
| Stiffness: | [ ] Y [ ] N [ ] P |  | Leg Cramps: | [ ] Y [ ] N [ ] P |
| Misalignment: | [ ] Y [ ] N [ ] P |  | Pain: | [ ] Y [ ] N [ ] P |
| Trauma/Injury: | [ ] Y [ ] N [ ] P |  | Joint swelling: | [ ] Y [ ] N [ ] P |
|  |  |  | Decreased Range of Motion: | [ ] Y [ ] N [ ] P |
| Sciatica | [ ] Y [ ] N [ ] P |  | Carpel tunnel or other impingement:  | [ ] Y [ ] N [ ] P |
|  |  | NERVOUS/NEURO |  |  |
| Paralysis: | [ ] Y [ ] N [ ] P |  | Difficulty with balance: | [ ] Y [ ] N [ ] P |
| Tingling/numbness: | [ ] Y [ ] N [ ] P |  | Memory loss: | [ ] Y [ ] N [ ] P |
| Seizures: | [ ] Y [ ] N [ ] P |  | Fainting: | [ ] Y [ ] N [ ] P |
| Muscle Weakness: | [ ] Y [ ] N [ ] P |  | Tremors: | [ ] Y [ ] N [ ] P |
| Dizziness or vertigo: | [ ] Y [ ] N [ ] P |  | Mood Changes/Disturbances: |  |
|  |  | Mental/Emotional |  |  |
| Depression: | [ ] Y [ ] N [ ] P |  | Anger/irritability: | [ ] Y [ ] N [ ] P |
| Suicidal: | [ ] Y [ ] N [ ] P |  | High-strung/tense: | [ ] Y [ ] N [ ] P |
| Anxiety: | [ ] Y [ ] N [ ] P |  | Fear/Panic | [ ] Y [ ] N [ ] P |
| Eating disorder: | [ ] Y [ ] N [ ] P |  | Psych Hospitalization: | [ ] Y [ ] N [ ] P |
| Addiction: | [ ] Y [ ] N [ ] P |  | Mood Swings: | [ ] Y [ ] N [ ] P |
| Hallucinations: | [ ] Y [ ] N [ ] P |  | Hearing Voices: | [ ] Y [ ] N [ ] P |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | RESPIRATORY |  |  |
| Cough: | [ ] Y [ ] N [ ] P |  | TB: | [ ] Y [ ] N [ ] P |
| Shortness of breath w/ exertion: | [ ] Y [ ] N [ ] P |  | Bronchitis: | [ ] Y [ ] N [ ] P |
| Shortness of breath sitting: | [ ] Y [ ] N [ ] P |  | Pneumonia: | [ ] Y [ ] N [ ] P |
| Shortness of breath lying down: | [ ] Y [ ] N [ ] P |  | Asthma: | [ ] Y [ ] N [ ] P |
| Wheezing: | [ ] Y [ ] N [ ] P |  | Painful breathing: | [ ] Y [ ] N [ ] P |
| Coughing Blood: | [ ] Y [ ] N [ ] P |  | Difficult or labored breathing: | [ ] Y [ ] N [ ] P |
|  |  |  |  |  |
|  |  | CARDIOVASCULAR |  |  |
| High Blood Pressure: | [ ] Y [ ] N [ ] P |  | Rheumatic Fever: | [ ] Y [ ] N [ ] P |
| Low Blood Pressure | [ ] Y [ ] N [ ] P |  | Murmurs: | [ ] Y [ ] N [ ] P |
| Arrhythmias: | [ ] Y [ ] N [ ] P |  | Palpitations: | [ ] Y [ ] N [ ] P |
| Edema (swelling of ankles, feet, wrists) | [ ] Y [ ] N [ ] P |  | Chest Pain: | [ ] Y [ ] N [ ] P |
| Shortness of Breath: | [ ] Y [ ] N [ ] P |  | Syncope/Fainting: | [ ] Y [ ] N [ ] P |
| Fatigue:  | [ ] Y [ ] N [ ] P |  |  |  |
|  |  | URINARY TRACT |  |  |
| Incontinence: | [ ] Y [ ] N [ ] P |  | Pain or burning w/ Urination | [ ] Y [ ] N [ ] P |
| Frequent Infections: | [ ] Y [ ] N [ ] P |  | Kidney Stones | [ ] Y [ ] N [ ] P |
| Urgency: | [ ] Y [ ] N [ ] P |  | Discharge/Blood: | [ ] Y [ ] N [ ] P |
| Urinary Frequency: | [ ] Y [ ] N [ ] P |  |  |  |
|  |  | GASTROINTESTINAL |  |  |
| Heartburn: | [ ] Y [ ] N [ ] P |  | Bowel Movement Freq: |  |
| Indigestion: | [ ] Y [ ] N [ ] P |  | Recent BM Change: | [ ] Y [ ] N [ ] P |
| Bloating: | [ ] Y [ ] N [ ] P |  | Diarrhea: | [ ] Y [ ] N [ ] P |
| Nausea: | [ ] Y [ ] N [ ] P |  | Constipation: | [ ] Y [ ] N [ ] P |
| Vomiting: | [ ] Y [ ] N [ ] P |  | Hemorrhoids: | [ ] Y [ ] N [ ] P |
| Change in Appetite: | [ ] Y [ ] N [ ] P |  | Gall Bladder Disease | [ ] Y [ ] N [ ] P |
| Pancreatitis: | [ ] Y [ ] N [ ] P |  | Liver Disease: | [ ] Y [ ] N [ ] P |
| Abdominal Pain:  |  |  | Ulcer: |  |
| Gas:  |  |  | Smelly Burps: |  |
| Blood in Stool: |  |  | Blood in vomitus: |  |
|  |  | MALE  |  |  |
| Testicular pain/swelling: | [ ] Y [ ] N [ ] P |  | Sexually Active: | [ ] Y [ ] N [ ] P |
| Hernia: | [ ] Y [ ] N [ ] P |  | S.T.D.: | [ ] Y [ ] N [ ] P |
| Discharge: | [ ] Y [ ] N [ ] P |  | Prostate Disease/Symptoms: | [ ] Y [ ] N [ ] P |
| Impotency: | [ ] Y [ ] N [ ] P |  | Sexual Orientation | [ ] Y [ ] N [ ] P |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | FEMALE  |  |  |
| Age Period Began: |  |  | How Often Period Occurs: |  |
| How long period lasts: |  |  | Heavy menstrual bleeding: | [ ] Y [ ] N [ ] P |
| Menstrual cramping:  | [ ] Y [ ] N [ ] P |  | Menstrual Pain: | [ ] Y [ ] N [ ] P |
| PMS: | [ ] Y [ ] N [ ] P |  | Food cravings: | [ ] Y [ ] N [ ] P |
| Times Pregnant: |  |  | How many births: |  |
| Miscarriages: |  |  | Abortions: |  |
| Last Pap Smear: |  |  | Sexual Orientation: |  |
| Any abnormal paps: | [ ] Y [ ] N [ ] P |  | When was abnormal: |  |
| Menopausal since what age: |  |  | Use of hormones: | [ ] Y [ ] N [ ] P |
| Type of hormones used: |  |  | Healthy libido: | [ ] Y [ ] N [ ] P |
| Dry vagina: | [ ] Y [ ] N [ ] P |  | Sexually Active: | [ ] Y [ ] N [ ] P |
| Pain w/ Intercourse: | [ ] Y [ ] N [ ] P |  | Vaginitis: | [ ] Y [ ] N [ ] P |
| S.T.D.: | [ ] Y [ ] N [ ] P |  | Mammography: | [ ] Y [ ] N [ ] P |
| Bone Density Test: | [ ] Y [ ] N [ ] P |  | If Yes, what were results: |  |
| Breast Pain/lumps/skin changes: | [ ] Y [ ] N [ ] P |  | Nipple Discharge | [ ] Y [ ] N [ ] P |

­­­­­­­­­­­­­­­­­­­­

Please list any birth control used and ages used:

**Patient Name:**  **DOB:**

### Exercise

How often do you exercise? What type of exercise?

For how long? Hobbies:

### Sleep

How long per night? If you wake up frequently, what is the reason?

Nightmares: [ ] Y [ ] N [ ]  P Wake Refreshed: [ ] Y [ ] N [ ]  P Must nap during the day: [ ] Y [ ] N [ ]  P

Sleep walk: [ ] Y [ ] N [ ]  P Grind teeth: [ ] Y [ ] N [ ]  P Snore: [ ] Y [ ] N [ ]  P

### Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials?

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing?

Are you particularly sensitive to perfumes, gasoline or other vapors?

Do you use pesticides, herbicides or other chemicals around your home?

### Social Life

Enjoy job: [ ] Y [ ] N [ ]  P Hours worked per week: Highest Level of Education:

Active spiritual practice: Y N P Quality of significant relationship:

History of sexual, mental/emotional, physical abuse: [ ] Y [ ] N [ ]  P

What is your greatest health concern:

How does it limit you the most:

How committed are you towards making valuable changes: [ ] Little [ ] Moderately [ ]  Very

### Allergies

List all known Allergies and Sensitivities to food, drugs, or environment. Note the reaction for each:

**Additional Information**

Please list any additional information/topics which you believe is important we address during your office visit: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­

**Financial Consideration**

Do you have financial considerations or a budget you would like me to keep in mind for you? ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­