Live Well
Integrative Medicine, PLLC.

Patient Intake Health History

NAME_____ **AGE**_____ **D.O.B**_____

SYMPTOMS: **Check symptoms you are having or have had in the past year**

GENERAL
_____ Anxiety
_____ Chills
_____ Depression
_____ Dizziness
_____ Fainting
_____ Fatigue
_____ Fever
_____ Forgetfulness
_____ Headache
_____ Loss of sleep
_____ Loss of weight
_____ Nervousness
_____ Numbness
_____ Tingling
_____ Weight gain
_____ Weight loss

MUSCLE/JOINT/BONE PAIN, WEAKNESS, NUMBNESS
_____ Arms
_____ Back
_____ Feet
_____ Hands
_____ Hips
_____ Legs
_____ Neck
_____ Shoulders

PROCEDURES

_____

_____

GENITO-URINARY

GASTROINTESTINAL
_____ Poor appetite
_____ Excessive hunger
_____ Bloating
_____ Bowel changes
_____ Constipation
_____ Diarrhea
_____ Gas
_____ Hemorrhoids
_____ Rectal bleeding
_____ Indigestion
_____ Nausea
_____ Vomiting
_____ Vomiting blood
_____ Stomach pain

PROCEDURES

_____

_____

CARDIOVASCULAR
_____ Chest pain
_____ High blood pressure
_____ Irregular heart beat
_____ Low blood pressure
_____ Poor circulation
_____ Rapid heart beat
_____ Swelling of ankles
_____ Varicose veins

PROCEDURES

_____

_____

SKIN
_____ Bruise easily

EYE, EAR, NOSE, THROAT
_____ Bleeding gums
_____ Blurred vision
_____ Crossed eyes
_____ Dentures
_____ Difficulty swallowing
_____ Double vision
_____ Earache
_____ Ear discharge
_____ Hay fever
_____ Hoarseness
_____ Loss of hearing
_____ Nosebleeds
_____ Persistent cough
_____ Ringing in ears
_____ Sinus problems
_____ Vision-flashes
_____ Vision-halos

PROCEDURES

_____

_____

RESPIRATORY
_____ Shortness of breath
_____ Oxygen use

PROCEDURES

_____

_____

MEN ONLY
_____ Breast lump
_____ Erection difficulties
_____ Penile discharge
_____ Sore on penis
_____ Vasectomy
_____ OTHER

SEXUAL ACTIVITY WITH
Male ☐
Female ☐
Both ☐

WOMEN ONLY
_____ Breast lump
_____ Hot flashes
_____ Hysterectomy
_____ Nipple discharge
_____ Oopherectomy
_____ Abnormal pap
_____ Menstrual pain
_____ Painful intercourse
_____ Vaginal discharge
_____ Abnormal bleeding

AGE ONSET OF PERIOD _____

SEXUAL ACTIVITY WITH
Male ☐
Female ☐
Both ☐

_____ Blood in urine _____ Frequency _____ Lack of bladder control _____ Painful urination _____Night time frequency **PROCEDURES** _____ _____	_____ Change in moles _____ Hives _____ Itching _____ Non-healing sore _____ Rash _____ Scars _____ Swollen glands **PROCEDURES** _____ _____	**MOBILITY** _____ Cane _____ Walker _____ Wheelchair **DATE OF LAST PHYSICAL** **COLONOSCOPY** **WHERE** **DATE** _____	**NUMBER OF PREGNANCIES/LIVE BIRTHS** **DATE OF MAMMOGRAM** **LAST PAP SMEAR** **RESULT** _____ **DATE OF ONSET MENOPAUSE**

CONDITIONS: Check conditions you have or have had in the past.

____ Abnormal PAP ____ AIDS ____ Alcoholism ____ Anemia ____ Angina ____ Anorexia ____ Appendicitis ____ Arthritis ____ Asthma ____ Atrial Fibrillation ____ Benign ____ Bleeding disorder ____ Breast lump ____ Bronchitis ____ Bulimia ____ Cancer, Type _____	____ Cataracts ____ Chemical abuse ____ Chicken pox ____ Congestive Heart Failure ____ COPD ____ Diabetes ____ Emphysema ____ Epilepsy ____ Gall stones ____ Glaucoma ____ Goiter ____ Gonorrhea ____ Gout ____ Heart disease ____ Hepatitis ____ Hernia, Type _____	____ Herpes ____ High blood pressure ____ High cholesterol ____ HIV positive ____ Kidney disease ____ Kidney Stones ____ Liver disease ____ Measles ____ Migraines ____ Miscarriages ____ Mononucleosis ____ Multiple sclerosis ____ Mumps ____ Pacemaker ____ Pneumonia ____ Polio	____ Prostate problems ____ Psychiatric care ____ Rheumatic fever ____ Scarlet fever ____ Stroke ____ Suicide attempt ____ Thyroid problems ____ Tonsillitis ____ Tuberculosis ____ Typhoid fever ____ Ulcers ____ Vaginal infections ____ Venereal disease

WHY ARE YOU HERE TODAY? _____

MEDICATION LIST: Medications you are currently taking. Include over the counter medications.

ALLERGIES: List all allergies to medications or food AND your Reaction to the Medication/Food

	In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	□ No □ Yes
	In the last 12 months, has your utility company shut off your service for not paying your bills?	□ No □ Yes
	Are you worried that in the next 2 months, you may not have stable housing?	□ No □ Yes
	Do problems getting child care make it difficult for you to work or study? (leave blank if you do not have children)	□ No □ Yes
	In the last 12 months, have you needed to see a doctor, but could not because of cost?	□ No □ Yes
	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	□ No □ Yes
	Do you ever need help reading materials?	□ No □ Yes
	Are you afraid you might be hurt in your apartment building or house?	□ No □ Yes
	If you checked YES to any boxes above, would you like to receive assistance with any of these needs?	□ No □ Yes
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	□ No □ Yes

FAMILY HISTORY: Fill in health information about your family

RELATION	***DOB***	***STATE OF HEALTH***	***AGE AT DEATH***	***CAUSE OF DEATH***	***CHECK IF YOUR BLOOD RELATIVES HAD: DISEASE***	***RELATIONSHIP***
Father					Arthritis	
Mother					Asthma	
Brothers					Cancer	
					Chemical Abuse	
					Diabetes	
					Heart Disease	
Sisters					High blood pressure	
					Kidney disease	
					Tuberculosis	

HOSPITALIZATIONS Year	Hospital	Reason for hospitalization

PREGNANCY HISTORY Year/Sex	Complications, in any

HEALTH HABITS	
Caffeine, cups daily	
Tobacco	
Age started	
Age stopped	
Pack per day	
Recreational Drugs	
Type	
Alcohol	
Age started	
Age stopped	
Ounces Daily	
Type	

Have you had a blood transfusion? When?

Serious illness/injuries	Date	Outcome

CONCERNS: Check if you are exposed to the following

Occupation:	Exercise, Type, How often:

I certify that the above information is correct to the best of my knowledge. I will not hold my provider or any staff member responsible for errors or omissions that I may have made in the completion of this form.

Signature _____ **Date** _____

Directions: Please circle **1** in each row. Choose the **1** that best described you.

Area of Concern	**1**	**2**	**3**	**4**	**5**	**6**
Pain	None	Occasionally, no medication	Often need pain medication	Always use medications on a regular schedule	Severe, use medication; Pain limits activity	Unbearable, no relief
Shortness of breath	None	Occasionally after exercise, lifting groceries, walking	Regularly after exercise, lifting groceries, walking	Pulmonary, cardiac diagnosis with regular medication	Moderate, limits daily activity	Severely limits daily activities, use of oxygen
Prescribed medication	None	One or Two	Three or Four	Five or Six	Seven or more	Have had an adverse reaction
Medication over the counter	None	One or Two	Three or Four	Five or Six	Seven or more	Have had an adverse reaction
Nutrition	No problem	I am on a special diet	I do not eat 3 meals a day	I feel overweight for my frame	I feel underweight for my frame	My appetite is poor
Urination	No problem	Frequent urination, burning, dribbling	Increased urination at night (how many times? _____)	Incontinent, lose urine before getting to bathroom	I wear protective garment	I wear a urinary catheter
Bowel Movement	Daily	Every 2 days	Every 3 days	Use laxatives regularly	Diarrhea or constipation (circle one)	Lose control
Cognition	Memory accurate	Occasionally forget	Frequently forget	Forgetting recent events	Forgetting past events	Episodes of getting lost
Emotion	I cope well	I sometimes feel nervous, tense, lonely, fearful, worrisome	I sometimes feel depressed, I have trouble sleeping	I feel I may have a drinking problem	I feel hopeless, depressed, have no energy, I am losing weight, am not sleeping well	
Mobility	Independent	I do not drive, but use public transport	Cane, walker, crutches, unassisted in home and community	Up most of the day in chair, require a cane or walker	In bed most of the day, need assistance to get up, use wheelchair, cane, or walker	Bed bound, use lift, need full assistance
Self Care	Independent	Need help with household chores	Need help with shopping, meal preparation, housekeeping	Need help with bathing, dressing	Require help with bathing, dressing, toilet, meals, and housekeeping	Need help with all activity of daily living, must be fed
Health Rating	1 Excellent	2	3	4	5	6 Poor