Intake Questionnaire

General Information

Name_____ Age_____ Today's Date _____

Date of Birth _____ Email _____

Address _____ City_____ State ____ Zip_____

Phone (Home)_____ (Cell)_____ (Work) _____

Race:_____

When, where and from whom did you last receive medical or health care? _____

_____

Emergency Contact: _____ Relationship _____

Phone (Home)_____ (Cell)_____ (Work) _____

How did you hear about our practice?

Current Health Concerns

Please write current and ongoing health concerns

Current health issues needing addressing: _____

Allergies

Please list allergies and subsequent reactions:

1.
2.
3.

Lifestyle Review

Sleep

How many hours of sleep do you get each night on average?_____

Do you have problems falling asleep?_____

Staying asleep? _____

Do you have problems with insomnia? _____

Do you snore?_____

Do you feel rested upon awakening?_____

Do you use sleeping aids?_____

If yes, explain:_____

Exercise

Current Exercise Program: _____

Do you feel motivated to exercise?_____

Are there any problems that limit exercise?_____

If yes, explain:_____

Do you feel unusually fatigued or sore after exercise?_____

If yes, explain:_____

Nutrition

Do you currently follow any special diets or nutritional programs? _____

Do you have sensitivities to certain foods?_____

If yes, list food and symptoms: _____

Do you have an aversion to certain foods?_____

If yes, explain:_____

Are there any foods that you crave or binge on?_____

If yes, what foods?_____

Do you eat 3 meals a day?_____

If no, how many _____

Does skipping a meal greatly affect you?_____

How many meals do you eat out per week?_____

Diet

Please record what you eat in a typical day:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Fluids _____

How many servings do you eat in a typical week of these foods:

Fruits (not juice)_____ Vegetables (not including white potatoes) _____

Legumes (beans, peas, etc) _____ Red meat _____ Fish _____

Dairy/Alternatives _____ Nuts & Seeds _____ Fats & Oils _____

Cans of soda (regular or diet) _____ Sweets (candy, cookies, cake, ice cream, etc.) _____

Do you drink caffeinated beverages (how much)? _____

Do you drink soda? How many per day? _____

Smoking

Do you smoke currently? _____

What type of nicotine device? _____

Have you attempted to quit? _____

If yes, using what methods:_____

Have you smoked previously: _____

Alcohol

How many alcoholic beverages do you drink in a week?

_____

(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)

Have you ever had a problem with alcohol? _____

If yes, when? _____

Explain the problem: _____

Other Substances

Are you currently using any recreational drugs? _____

If yes, type: _____

Have you ever used IV or inhaled recreational drugs?_

Stress

Do you feel you have an excessive amount of stress in your life?_____

Do you feel you can easily handle the stress in your life?_____

How much stress do each of the following cause on a daily basis*(Rate on scale of 1-10, 10 being highest)*_____

Do you use relaxation techniques?_____

If yes, how often? _____

Which techniques do you use?_____

Have you ever sought counseling?_____

Are you currently in therapy?_____

If yes, describe: _____

Have you ever been abused, a victim of crime, or experienced a significant trauma?_____

What are your hobbies or leisure activities?_____

Relationships

Marital status:_____

With whom do you live? (Include children, parents, relatives, friends, pets) _____

Current occupation: _____

Previous occupations:_____

Women's History

Obstetric History:

List any pregnancies/miscarriages/abortions: _____

Birth weight of largest baby_____ Birth weight of smallest baby _____

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.?_____

Menstrual History:

Age at first period _____ Date of last menstrual period _____

Length of cycle _____ Time between cycles _____

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)?

_____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)?

_____

Any problems with hormonal birth control?_____

Use of other contraception?_____

Are you in menopause?_____

Do you currently have symptomatic problems with menopause?_____

Are you on hormone replacement therapy?_____

Other Gynecological Symptoms:_____

Gynecological Screening/Procedures: *(If applicable, provide date)*

Last Pap test: _____

Last mammogram: _____

Last bone density: _____

Other tests/procedures (list type and dates)_____

_____

Family History:

Please list any significant medical family history (siblings, parents): _____

Medical History: Illnesses/Conditions

Write Yes = a condition you currently have, **Write Past** = a condition you've had in the past.

Gastrointestinal
- Irritable bowel syndrome
- GERD (reflux)
- Crohn's disease/ulcerative colitis
- Peptic ulcer disease
- Celiac disease
- Gallstones
- Other:

Respiratory
- Bronchitis
- Asthma
- Emphysema
- Pneumonia
- Sinusitis
- Sleep apnea
- Other:

Urinary/Genital
- Kidney stones
- Gout
- Interstitial cystitis
- Frequent yeast infections
- Frequent urinary tract infections
- Sexual dysfunction
- Sexually transmitted diseases
- Other:

Endocrine/Metabolic
- Diabetes
- Hypothyroidism (low thyroid)
- Hyperthyroidism (overactive thyroid)
- Polycystic Ovarian Syndrome
- Infertility
- Metabolic syndrome/insulin resistance
- Eating disorder
- Hypoglycemia
- Other:

Inflammatory/Immune
- Rheumatoid arthritis
- Chronic fatigue syndrome
- Food allergies
- Environmental allergies
- Multiple chemical sensitivities
- Autoimmune disease
- Immune deficiency
- Mononucleosis
- Hepatitis
- Other:

Musculoskeletal
- Fibromyalgia
- Osteoarthritis
- Chronic pain
- Other:

Skin
- Eczema
- Psoriasis
- Acne
- Skin cancer
- Other:

Cardiovascular
- Angina
- Heart attack
- Heart failure
- Hypertension (high blood pressure)
- Stroke
- High blood fats (cholesterol, triglycerides)
- Rheumatic fever
- Arrythmia (irregular heart rate)
- Murmur
- Mitral valve prolapse
- Other:

Neurologic/Emotional
- Epilepsy/Seizures
- ADD/ADHD
- Headaches
- Migraines
- Depression
- Anxiety
- Autism
- Multiple sclerosis
- Parkinson's disease
- Dementia
- Other:

Cancer
- Lung
- Breast
- Colon
- Ovarian
- Skin
- Other:

Medical History *(cont.)*

Diagnostic Studies	Yes/No	
Bone density		
CT scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Other X-rays		
Barium enema		
Other:		
Injuries		
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		
Surgeries		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		
Hospitalizations	**Date**	**Reason**

Symptom Review

Please say yes if these symptoms occur presently or have occurred in the last 6 months

General
Cold hands and feet
Cold intolerance
Daytime sleepiness
Difficulty falling asleep
Early waking
Fatigue
Fever
Flushing
Heat intolerance
Night waking
Nightmares
Can't remember dreams
Low body temperature

Head, Eyes, and Ears
Conjunctivitis
Distorted sense of smell
Distorted taste
Ear fullness
Ear ringing/buzzing
Eye crusting
Eye pain
Eyelid margin redness
Headache
Hearing loss
Hearing problems
Migraine
Sensitivity to loud noises
Vision problems

Musculoskeletal
Back muscle spasm
Calf cramps
Chest tightness
Foot cramps
Joint deformity
Joint pain
Joint redness
Joint stiffness
Muscle pain
Muscle spasms
Muscle stiffness
Muscle twitches:
Around eyes
Arms or legs
Muscle weakness

Musculoskeletal *(cont.)*
Neck muscle spasm
Tendonitis
Tension headache
TMJ problems

Mood/Nerves
Agoraphobia
Anxiety
Auditory hallucinations
Blackouts
Depression
Difficulty:
Concentrating
With balance
With thinking
With judgment
With speech
With memory
Dizziness (spinning)
Fainting
Fearfulness
Irritability
Light-headedness
Numbness
Other phobias
Panic attacks
Paranoia
Seizures
Suicidal thoughts
Tingling
Tremor/trembling
Visual hallucinations

Cardiovascular
Angina/chest pain
Breathlessness
Heart attack
Heart murmur
High blood pressure
Irregular pulse
Mitral valve prolapse
Palpitations
Phlebitis
Swollen ankles/feet
Varicose veins

Symptom Review *(cont.)*

Please write yes if these symptoms occur presently or have occurred in the last 6 months

Urinary
Bed wetting
Hesitancy
Infection
Kidney disease
Kidney stone
Leaking/incontinence
Pain/burning
Urgency
Digestion
Anal spasms
Bad teeth
Bleeding gums
Bloating of:
Lower abdomen
Whole abdomen
Bloating after meals
Blood in stools
Burping
Canker sores
Cold sores
Constipation
Cracking at corner of lips
Dentures w/poor chewing
Diarrhea
Difficulty swallowing
Dry mouth
Farting
Fissures
Foods "repeat" (reflux)
Heartburn
Hemorrhoids
Intolerance to:
Lactose
All dairy products
Gluten (wheat)
Corn
Eggs
Fatty foods
Yeast
Liver disease/jaundice
(yellow eyes or skin)
Lower abdominal pain
Mucus in stools

Digestion *(cont.)*
Nausea
Periodontal disease
Sore tongue
Strong stool odor
Undigested food in stools
Upper abdominal pain
Vomiting
Eating
Binge eating
Bulimia
Can't gain weight
Can't lose weight
Carbohydrate craving
Carbohydrate intolerance
Poor appetite
Salt cravings
Frequent dieting
Sweet cravings
Caffeine dependency
Respiratory
Bad breath
Bad odor in nose
Cough – dry
Cough – productive
Hayfever:
Spring
Summer
Fall
Change of season
Hoarseness
Nasal stuffiness
Nose bleeds
Post nasal drip
Sinus fullness
Sinus infection
Snoring
Sore throat
Wheezing
Winter stuffiness

Symptom Review *(cont.)*

Please write yes if these symptoms occur presently or have occurred in the last 6 months

Nails
Bitten
Brittle
Curve up
Frayed
Fungus – fingers
Fungus – toes
Pitting
Ragged cuticles
Ridges
Soft
Thickening of:
Finger nails
Toenails
White spots/lines

Lymph Nodes
Enlarged/neck
Tender/neck
Other enlarged/tender
lymph nodes

Skin, Dryness of
Eyes
Feet
Any cracking?
Any peeling?
Hair
And unmanageable?
Hands
Any cracking?
Any peeling?
Mouth/throat
Scalp
Any dandruff?
Skin in general

Skin Problems
Acne on back
Acne on chest
Acne on face
Acne on shoulders
Athlete's foot
Bumps on back of upper arms
Cellulite
Dark circles under eyes

Skin Problems *(cont.)*
Ears get red
Easy bruising
Eczema
Herpes – genital
Hives
Jock itch
Lackluster skin
Moles w color/size change
Oily skin
Pale skin
Patchy dullness
Psoriasis
Rash
Red face
Sensitive to bites
Sensitive to poison ivy/oak
Shingles
Skin cancer
Skin darkening
Strong body odor
Thick calluses
Vitiligo

Itching Skin
Anus
Arms
Ear canals
Eyes
Feet
Hands
Legs
Nipples
Nose
Genitals
Roof of mouth
Scalp
Skin in general
Throat

Symptom Review *(cont.)*

Please write yes if these symptoms occur presently or have occurred in the last 6 months

Female Reproductive			
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			
Premenstrual:			
Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual:			
Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Readiness Assessment and Health Goals

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

Significantly modify your diet _____
Take several nutritional supplements each day _____
Keep a record of everything you eat each day Modify your lifestyle (e.g., work demands, sleep habits) Practice a relaxation technique _____
Engage in regular exercise _____

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health-related activities?
_____

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through? _____
_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? _____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program?
_____

Medications/Supplements

Current medications (include prescription and over-the-counter)

Please list any medications along with the dosage and date initially taken:
_____
_____
_____

Nutritional supplements (vitamins/minerals/herbs etc.)

Please list any nutritional supplements along with the dosage and date initially taken:
_____
_____
_____

Have medications or supplements ever caused unusual side effects or problems?
_____

Health Goals

What do you hope to achieve in your visit with us? _____

_____

_____

When was the last time you felt well? _____

_____

_____

Did something trigger your change in health? _____

_____

_____

What makes you feel better? _____

_____

_____

What makes you feel worse? _____

_____

_____

How does your condition affect you? _____

_____

_____

What do you think is happening and why? _____

_____

_____

What do you feel needs to happen for you to get better? _____

_____

_____