Arnica Clinic

Date_____ **PATIENT INTAKE FORM** Date of Birth_____

Name_____ Phone: Home_____ Cell:_____
Street:_____ City:_____Zip:_____E-mail:_____
Occupation:_____Place of Employment:_____Work Phone:_____
Physician _____Last physical exam:_____ Last blood test:_____
How did you hear about us_____Referred by:_____Ht_____Wt_____
What are your chief health concerns?_____

Past Medical History (include date – year)
Significant illnesses :□ Cancer____□ Diabetes____□ High Blood Pressure____ □ Musculoskeletal Disease_____
□ HIV/AIDS_____ □ Hepatitis _____ □ Lung Diseases_____ □ Rheumatic Fever _____□ Thyroid Disease _____
□ Ulcers_____ □ Seizures_____ □ Other_____
*Significant Trauma (*auto accidents, falls, head injury.*)*_____
*Your Birth History (*prolonged labour, forceps delivery, etc.*)*_____
*Allergies (*drugs, chemicals, food*)*_____
*Past Surgeries*_____
Medicines (taken within past 2 months include, over-the-counter drugs, herbs etc.)_____
_____
Occupation Stresses (chemical, physical, psychological, toxic exposure, pesticides / plastics / heavy metals)
*Exercise:*_____
Type of Diet: _____
Habits: □ Cigarettes; □ Coffee; □ Tea; □ Soda; □ Alcohol; □ Recreat. Drugs; □ Sweets; □ Salt
Family Medical History: □ Diabetes; □ Cancer; □ High Blood Pressure; □ Heart Disease; □ Stroke;
□ Asthma; □ Allergies; □ Alcoholism; □ Mental Illness; □ Arthritis; □ Other_____

GENERAL

Past	Now		Past	Now		Past	Now		Past	Now	
☐	☐	Poor Appetite	☐	☐	Poor Sleep	☐	☐	Night Sweats	☐	☐	Tremors
☐	☐	Change in Appetite	☐	☐	Cold Hands / Feet	☐	☐	Excessive Sweating	☐	☐	Poor Balance
☐	☐	Food Cravings	☐	☐	Frequent Colds	☐	☐	Sudden Energy Drops	☐	☐	Poor Coordination
☐	☐	Excessive Thirst	☐	☐	Chills	☐	☐	Fatigue	☐	☐	Easy Bleeding
☐	☐	Weight Gain / Loss	☐	☐	Fevers	☐	☐	Low Blood Sugar	☐	☐	Vertigo Dizziness

SKIN & HAIR

Past	Now		Past	Now		Past	Now		Past	Now	
☐	☐	Rashes	☐	☐	Hair Loss	☐	☐	Psoriasis	☐	☐	Ulceration
☐	☐	Eczema	☐	☐	Acne	☐	☐	Skin Discoloration	☐	☐	Itching
☐	☐	Dandruff	☐	☐	Scars	☐	☐	Hives	☐	☐	Nail Changes

HEAD, EYES, EARS, NOSE & THROAT

Past	Now		Past	Now		Past	Now		Past	Now	
☐	☐	Eyes Strain	☐	☐	Poor Hearing	☐	☐	Teeth Problems	☐	☐	Headaches
☐	☐	Cataracts	☐	☐	Glaucoma	☐	☐	Gum Problems	☐	☐	Facial Problem
☐	☐	Eye Pain	☐	☐	Ear Pain	☐	☐	Mouth Sores	☐	☐	Sinus Problems
☐	☐	Blurry Vision	☐	☐	Ringing in Ears	☐	☐	Nose Bleeds	☐	☐	Post Nasal Drip
☐	☐	Glasses	☐	☐	Jaw Pain / Clicking	☐	☐	Sore Throat	☐	☐	Other

CARDIOVASCULAR

Past	Now		Past	Now		Past	Now		Past	Now	
☐	☐	High Blood Pressure	☐	☐	Irregular Heart Beats	☐	☐	Blood Clots	☐	☐	Phlebitis
☐	☐	Low Blood Pressure	☐	☐	Chest Pain	☐	☐	Swelling Hands/Feet	☐	☐	Palpitations

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RESPIRATORY

Past	Now		Past	Now		Past	Now		Past	Now	
☐	☐	Cough	☐	☐	Asthma	☐	☐	Chest Pain	☐	☐	Sputum Production
☐	☐	Pneumonia	☐	☐	Emphysema/COPD	☐	☐	Resp. Allergies	☐	☐	Other

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GASTROINTESTINAL

Past	Now		Past	Now		Past	Now		Past	Now	
☐	☐	Nausea/Vomiting	☐	☐	Belching	☐	☐	Hemorrhoids	☐	☐	Constipation
☐	☐	Bloating /Gas	☐	☐	Abdominal Pain	☐	☐	Diarrhea	☐	☐	Ulcers
☐	☐	Irritable Bowel	☐	☐	Freq. of BM_____x Day	Color_____		Blood/ Mucus/Undig.Food_____			

GENITO-URINARY

Past	Now		Past	Now		Past	Now		Past	Now	
☐	☐	Painful Urination	☐	☐	Waking to Urinate	☐	☐	Urinary Tract infections	☐	☐	Kidney Stones
☐	☐	Frequent Urination	☐	☐	Blood in the Urine	☐	☐	Sexually Trans. Disease	☐	☐	Incontinence

MALE

☐	☐	Prostate Problems	☐	☐	Infections	☐	☐	Problems Urinating	☐	☐	Hernia

FEMALE

_____	Number of Pregnancies	☐	☐	Irregular Flow	☐	☐	Menopause	☐	☐	Breast Discharge	
_____	Number of Births	☐	☐	Heavy Flow	☐	☐	Pelvic Pain	☐	☐	Breast Pain	
_____	Miscarriages	☐	☐	Flow with Clotting	☐	☐	Vaginal Discharge	☐	☐	Breast Lumps	
_____	Abortions	☐	☐	Birth Control	☐	☐	C-section, Hysterectomy	Last PAP_____			
_____	Age of First Menses	☐	☐	Infertility	☐	☐	Yeast Infections	Last Mammogram_____			

NEUROPSYCHOLOGY

Past	Now		Past	Now		Past	Now		Past	Now	
☐	☐	Depression	☐	☐	Anxiety	☐	☐	Hyperactivity	☐	☐	Sleep Problems
☐	☐	Poor Memory	☐	☐	Seizures	☐	☐	Psychological Counseling	☐	☐	Other

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MUSCULOSKELETAL

Past	Now		Past	Now		Past	Now		Past	Now	
☐	☐	Joint Pain /Swelling	☐	☐	Muscle Pain	☐	☐	Sciatica	☐	☐	Balance Problems
☐	☐	Arthritis	☐	☐	Muscle Weakness	☐	☐	Knee/Hip Pain	☐	☐	Other

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INSURANCE INFORMATION

Company_____ ID Number _____