

Patient Intake Form

Patient Name: _____

DOB: _____

List in Order of importance what your problems are:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Last time you had blood work done and with what 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/Stroke:	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
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

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 **Disease (D)**, **Get Immunized (I)**, or **Neither (N)**:

Measles: D I N **Chicken Pox:** D I N **Mumps:** D I N **Rubella:** D I N
Tetanus: D I N **Whooping Cough:** D I N **Hemophilus (Hib):** D I N **Hepatitis B:** D I N
German Measles: D I N **Any vaccination reactions:** _____

List **Yes (Y)**, **No (N)** or **Past (P)** regarding use of the following:

Antacids: Y N P **Steroids:** Y N P **Smoking:** Y N P **Packs per day & number of years:** _____
Analgesics: 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

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

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

<u>SKIN</u>				
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
<u>HEAD</u>				
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

<u>NOSE</u>							
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
<u>EYES</u>							
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
Strain:	Y	N	P	Discharge:	Y	N	P
Itchy:	Y	N	P	Dark under Eyelid:	Y	N	P
<u>MOUTH/THROAT</u>							
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
<u>NECK</u>							
Stiffness:	Y	N	P	Swollen Glands:	Y	N	P
Full movement:	Y	N	P	Tension:	Y	N	P
<u>RESPIRATORY</u>							
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
<u>CARDIOVASCULAR</u>							
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:	Y	N	P	Chest Pain:	Y	N	P
<u>URINARY TRACT</u>							
Incontinence:	Y	N	P	Pain w/ Urination	Y	N	P
Frequent Infections:	Y	N	P	Kidney Stones	Y	N	P
Urgency:	Y	N	P	Discharge/Blood:	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/Constipation:	Y N P
Nausea:	Y N P		Hemorrhoids:	Y N P
Vomiting:	Y N P		Gall Bladder Disease	Y N P
Change in Appetite:	Y N P		Liver Disease:	Y N P
Pancreatitis:	Y N P		Ulcer	Y N P

MALE GENITALIA

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:	Hetero Homo Bi

FEMALE GENITALIA

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:		Diagnosis:	
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
Dexa Scan:	Y N P	If Yes, what were results:	

Please list any birth control used and ages used: _____

<u>MUSCULOSKELETAL</u>							
Weakness:	Y	N	P	Arthritis:	Y	N	P
Stiffness:	Y	N	P	Leg Cramps:	Y	N	P
Tremors:	Y	N	P	Pain:	Y	N	P
<u>NERVOUS</u>							
Paralysis:	Y	N	P	Sciatica:	Y	N	P
Tingling/numbness:	Y	N	P	Carpal tunnel syndrome:	Y	N	P
Seizures:	Y	N	P	Fainting:	Y	N	P
<u>Mental/Emotional</u>							
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

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 If so, at what age and by whom: _____
What is your greatest health concern: _____
How does it limit you the most: _____
How committed are you towards making valuable changes: Little Moderately Very